Work Book

Supplement: State Highlights

Improving the Quality of Home and Community Based Services and Supports

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Centers for Medicare & Medicaid Services
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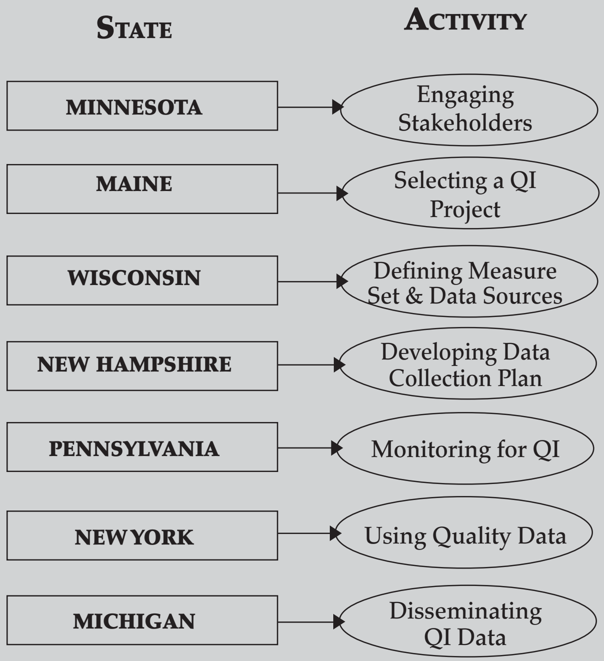
SUPPLEMENT
State Highlights



Summary:

States are doing exciting work in quality improvement. This supplement highlights the efforts of seven states working in various aspects of designing and implementing quality improvement activities for their HCBC programs. Each summary focuses on a single aspect of a much broader quality oversight and improvement program within a state. Our goal is to demonstrate how the lessons of the Work Book are practically applied to address specific needs and circumstances of a state.

MINNESOTA
Engaging Stakeholders

MINNESOTA - Summary

Administering Agency:
Minnesota Department of Human Services
Program:
Continuing Care for People with Disabilities -Administration
Organizational Structure for Quality Management:
Disability Services Division Community Quality Initiatives Unit
Stakeholder involvement:
Statewide Quality Commission
Regional Quality Assurance Commission
Regional Quality Assurance Review Council
Individual Quality Assurance Review
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http://www.dhs.state.mn.us/Contcare/disability/cqipage1.htm
http://www.mn-voice.org

Background: The Minnesota Department of Human Services aims to instill a consumer-directed philosophy throughout all levels of its delivery system for people with disabilities and long-term illnesses. Lessons learned at the regional level where quality assurance and improvement activities are value-based and consumer-centered are being replicated at the state level. Many of the current efforts in Minnesota are directed toward the creation of a statewide Quality Design Commission that is consumer driven and directed.

Statewide Coordination of Quality Assurance and Improvement Activities

The Minnesota Department of Human Services formed a new Community Quality Initiatives unit to coordinate quality assurance activities for community services for people with disabilities. This new unit builds on and coordinates previous quality assurance projects such as the development of performance indicators in mental health, reviews of chemical health services and a variety of consumer surveys for people with disabilities, people living with HIV/AIDS, and people with traumatic brain injury. The unit is broadening its traditional scope of quality assurance activities which focus on health and safety to include issues that are of value to people with disabilities including their quality of life, relationships, and involvement with communities. The unit has three primary areas of focus:

1. citizen engagement in the design and monitoring of quality assurance and improvement activities;
2. performance measurement;
3. evaluation and policy development and implementation.

Statewide Quality Design Commission

A Statewide Quality Design Commission has been created to oversee all quality related activities of programs that serve people with disabilities and older adults and to provide ongoing input into the design, monitoring and evaluation of consumer-driven quality assurance and improvement in the

Quality Design Commission

Purpose: To provide input into the design, monitoring and evaluation of consumer-driven quality assurance and improvement in the delivery of community-based continuing care services.

Membership:

15 members
8 consumers
7 family members or providers

Integrated Approach to Quality Improvement

The regional Quality Assurance System combines three types of quality review processes:

- Quality assurance to evaluate whether people are receiving person-driven supports and services
- Quality improvement to assist providers in the ongoing effort to help people achieve better life outcomes
- Licensing of programs that use public funds

delivery of community-based continuing care services. The Commission is a 15-member group with 51% of the members being people with disabilities. Members were selected across disability groups and stakeholder groups including consumers, family members, advocates, providers, county agencies. There are no state governmental people on the Commission. The Commission is part of a larger effort to develop a central information system that will improve consumer access to information, referral and assistance. Selection of Commission members was the result of an extensive public recruitment effort that included outreach efforts through the media (radio, newspaper), community and organizational newsletters and other networks to assure a balanced representation of disability groups, ethnic groups, income and geography. Representatives on the Commission are responsible for connecting with their communities to assure that voices are heard and information is shared.

Regional Quality Assurance System

Many of the innovations in quality assurance in Minnesota started at the regional level. In the mid-90s a group of stakeholders in Region 10, consisting of people with developmental disabilities, family members, legal representatives, advocates and support providers began to discuss local efforts to assure quality for people with developmental disabilities. Stakeholders wanted to assure that the quality of services for people with disabilities would be assured.

Consumer Direction and Involvement at Many Levels

- Regional Quality Assurance Commission – A stakeholder group that establishes the process and protocols used to operate the Quality Assurance Review System

- Quality Assurance Review Council – A stakeholder group that oversees the ongoing quality assurance process in the county, resolves disputes, develops plans to support quality improvement and makes recommendations regarding licensing of programs.

Region 10 Consumer Involvement

Quality Assurance Commission
Quality Assurance Review Council
Quality Assurance Teams
Quality Circle
VOICE

- Quality Assurance Team – A team, usually of 2 volunteers, who conduct reviews, onsite interviews and submit the assessment reports (called VOICE - Value of Individual Choices and Experience) to the Quality Assurance managers.

- Quality Circle – A circle of support persons, friends, family members and the individual receiving supports. The Circle facilitates the process of gathering information for review and quality improvement.

Lessons Learned

Be persistent: Reorienting the service and delivery system for people with disabilities and long-term to be consumer focused is a major effort. It takes time and patience to develop the buy-in from all groups but it ultimately is worth the effort.

MAINE
Selecting A Quality Improvement Project

MAINE - Summary

Administering Agency:
Bureau of Elder and Adult Services
Department of Human Services
Program: Home and Community Based Waivers for People with Disabilities and People over the Age of 60
Population: People over 60 and people with disabilities who are seeking long term care services
Organizational Structure for Quality Assurance:
Bureau of Elder and Adult Services responsible for quality assurance and improvement of HCBC Waivers
Stakeholder Involvement:
Long Term Care Steering Committee
Long Term Care Implementation Committee
Regional Quality Assurance Review Committees
External Contractors: Muskie School of Public Service
Contact Person:
Christine Gianopoulos, Director, 207-287- 9200
christine.gianopoulos@state.me.us
Website: http://www.state.me.us/dhs/beas/

Background: The long term care system in Maine was significantly restructured in the 1990s to reduce reliance on nursing home care and increase the availability of home and community-based services. Increased access to home and community-based services was accompanied by an increased interest on the part of consumers, legislators and policy makers in the quality of Maine's home and community-based care system. In response to this interest, The Bureau of Elder and Adult Services initiated a series of meetings with a number of stakeholders to identify areas of quality concern. The high prevalence of falls was chosen as a topic for a quality improvement project in one area of the state.

Preliminary Assessment: Members of four regional Quality Assurance Review Committees (QARCs) and Maine's Long Term Care Steering Committee were asked to review a list of quality domains and prioritize the top five areas of concern.

The quality domains in order of priority were:

Rank	Quality Areas
1	Medications
2	Safety
3	ADLs
4	Falls and Fractures
5	Skin Integrity
6	Nutrition
7	Cognitive Impairment
8	ER/Hospital/NF use
9	Behavior Problems
10	Communication Difficulties

Year Ending 2000
Clinical Profiles
People receiving Home Care (N=6483)

Condition	Percent of Beneficiaries
0 meds	2%
1-4 meds	40%
5-8 meds	43%
9+ meds	15%
Safety	
Fractures	4%
Falls	
Falls –last 180 days	48%
ADLS	
Limited / extensive assist. in late loss ADLs[1]	6%
Limited / extensive assist. in 2 early loss ADLs[2]	36%
Skin Integrity	
Presence of ulcers –due to any cause	4%

[1] Late loss ADLs including bed mobility, transfer, toileting, eating.
[2] Early loss ADLs including personal hygiene and dressing.

The Bureau of Elder and Adult Services then contracted with the Muskie School of Public Service to review literature and identify potential quality measures for each of these areas. Data from Maine's MECARE system, a database of uniform consumer level assessment information, was analyzed to profile the use of medications and prevalence of various conditions. These are listed in the sidebar.

Selection of QI Project Topic: Upon review of the data analysis and after further discussion with various stakeholders, the Bureau of Elder and Adult Services decided to focus on the prevalence of falls among community living elderly as a topic for a quality improvement project. Factors considered in making this decision included.

High Prevalence: Forty-eight percent of Maine people seeking long term care services in the home had fallen in the last six months. This was compared with 32% of the people in residential care facilities and 38% of people in nursing homes.

High Relevance: The Maine Bureau of Health, in its report, "Healthy Maine 2000, A Decade in Review," identified falls as the leading cause of injury hospitalizations in Maine. This reinforced the importance of this issue as a public health concern.

Available Guidance: The American Geriatrics Society published guidelines (JAGS, 2001) for the prevention of falls in older persons. The guidelines identified the risk factors associated with falling and the protocols for assessment and evaluation. These guidelines were helpful in designing the pilot demonstration project.

Target population: Having selected the reduction of falls as the focus of a quality improvement project, the Maine Bureau of Elder and Adult Services convened a meeting of interested providers, professionals and consumers to exchange information concerning fall prevention programs that were already in operation in the state. Based on input from this meeting, the Bureau decided to conduct a pilot program in one region of the state where there were existing resources for people at risk of falling.

The Bureau chose to implement a demonstration project in three counties in Maine: Knox, Waldo and Lincoln. A provider within this region had developed a fall evaluation program for people at home and this program provided a prototype for use in the demonstration. To further contain the scope of the project, the Bureau decided to focus its quality improvement project in one region of the state and on those people who were at highest risk of falling.

Published literature on falls among the elderly was reviewed to determine the risk factors associated with falling. An analysis of the research on falls identified the most common factors for falling. The top four risk factors included muscle weakness, history of falls, gait deficit, and balance deficit. The risk of falling also increases as the number of risk factors increase. In order to keep the criteria for inclusion in the demonstration straightforward and simple, the Bureau decided to offer the fall evaluation program to those older adults receiving home and community based services who had fallen at least once in the last six months.

Maine's MECARE assessment database was used to identify people eligible for the demonstration project.

QI Project: People receiving long term care services in Knox, Waldo and Lincoln Counties who reported falling at least once in the last six months are offered a home visit and a fall evaluation by the home health agency in the region. During the visit, the home health agency conducts an evaluation including a review of gait and balance, medications and home safety. Based on this evaluation, further recommendations are made including: assessment and evaluation by other health professionals, modifications in the home environment or other fall prevention activities.

Lessons Learned: The fall prevention pilot demonstration was implemented in Spring 2002. Some of the lessons that Maine learned in the implementation of this demonstration are:

- Start small – It was helpful to identify a region and a provider within the region to pilot this program. By starting small, it was easier to work out the protocols for inclusion in the demonstration and to monitor the progress of the demonstration.

- Keep it simple – Although the literature suggests multiple factors contribute to falls among the elderly, it was difficult to include all those factors as criteria for inclusion in the demonstration. Using one criteria to define the target population simplified the protocols for the demonstration but required more individualized review of case records prior to referral to the fall prevention program. For example, some people were excluded from referral based on other conditions, e.g., people with Alzheimer's.

WISCONSIN
Defining Measure Set and Data Sources

WISCONSIN - Summary

Administering Agency:
Department of Health and Family Services
Program : Family Care
Organizational Structure for Quality Management:
Family Care contracts with aging and disability resource centers for information and referral services and with Care Management Organizations (CMOs) to manage and deliver the Family Care benefit. Contracts with CMOs include structure and process standards. CMOs select a performance improvement project focused on one consumer outcome.
Stakeholder involvement:
Consumers, providers, advocates, and staff of the Department's Center for Delivery Systems Development, Bureau of Developmental Disabilities, Bureau of Aging and Long-Term Care Resources and Division of Health Care Financing were involved in identification of member outcomes.
External Contractors
Metastar, a quality improvement organization
Contacts
Monica Deignan, Family Care Project Manager
deignma@dhfs.state.wi.us
608-261-7807
Website: http://www.dhfs.state.wi.us/LTCare/

Background: Family care is a long-term care program being piloted in nine counties in Wisconsin. The program is designed to provide cost-effective, comprehensive and flexible benefits that foster consumers' independence and quality of life while recognizing the need for interdependence and support. A cornerstone of the Family Care Program is a "start to finish focus on member outcomes."

Family Care Program

The Family Care Program serves adults with physical disabilities, adults with developmental disabilities, and frail elders. The goals of the Family Care Program are to give people better choices about where they live, what kind of services and supports they get to meet their needs, and improve access to and quality of services through a focus on health and social outcomes in a cost-effective system. The program has two major components:

- Aging and Disability Resource Centers that are designed to be "one-stop shopping" where older people and adults with disabilities and their families can get information and advice about resources available in their communities. Resource centers also serve as the access point for Family Care and other available community-based long-term care programs.

- Care Management Organizations (CMO), which manage and deliver the Family Care benefit, which combines funding and services from a number of programs into one flexible benefit tailored to each individual's needs, circumstances and preferences.

Member Outcomes

The Family Care Program is all about results and program members define those results. The program uses member outcomes as a foundation for its quality assessment and improvement activities. Family care case managers work with program members to identify what is important to them and to find the supports and services that help them achieve those goals. The

Family Care Member Personal Outcomes

- Self-determination and choice outcomes
    - People are treated fairly
    - People have privacy
    - People have personal dignity and respect
    - People choose their services
    - People choose their daily routine
    - People achieve their employment objectives
    - People are satisfied with services

Community integration outcomes

- People choose where and with whom they live
- People participate in the life of the community
- People remain connected to informal support networks

Health and Safety Outcomes

- People are free from abuse and neglect
- People have the best possible health
- People are safe
- People experience continuity and security

Use of Member Outcomes

- To provide direction for quality improvement activities of the CMOs
- To develop baseline information
- To compare results across counties and populations
- To find best practices and improve provider performance
- To inform various boards and councils
- To promote a consistent attention to quality at all levels — local, state and federal

program has identified 14 member outcomes, such as "people have privacy," "people live where and with whom they choose," "people have the best possible health." The 14 member outcomes are in the sidebar.

Annual Survey

The Family Care Program conducts an annual survey of a random sample of members and their care managers. Interviews are conducted by people trained in assessment techniques developed by the Council on Quality and Leadership (the Council), a nationally recognized authority for accreditation of long-term care programs for people with disabilities. These techniques, which were originally developed for people with disabilities, were adapted for use in Wisconsin in consultation with the Council. For example, the outcome, "People achieve their employment objectives" was framed for elderly individuals to assess whether they were in involved in daytime activities that they considered meaningful and fulfilling. Interviews with case managers are used to determine if the CMO is providing the supports the member needs to work toward achievement of his / her personal outcomes.

Use of Results for Quality Improvement

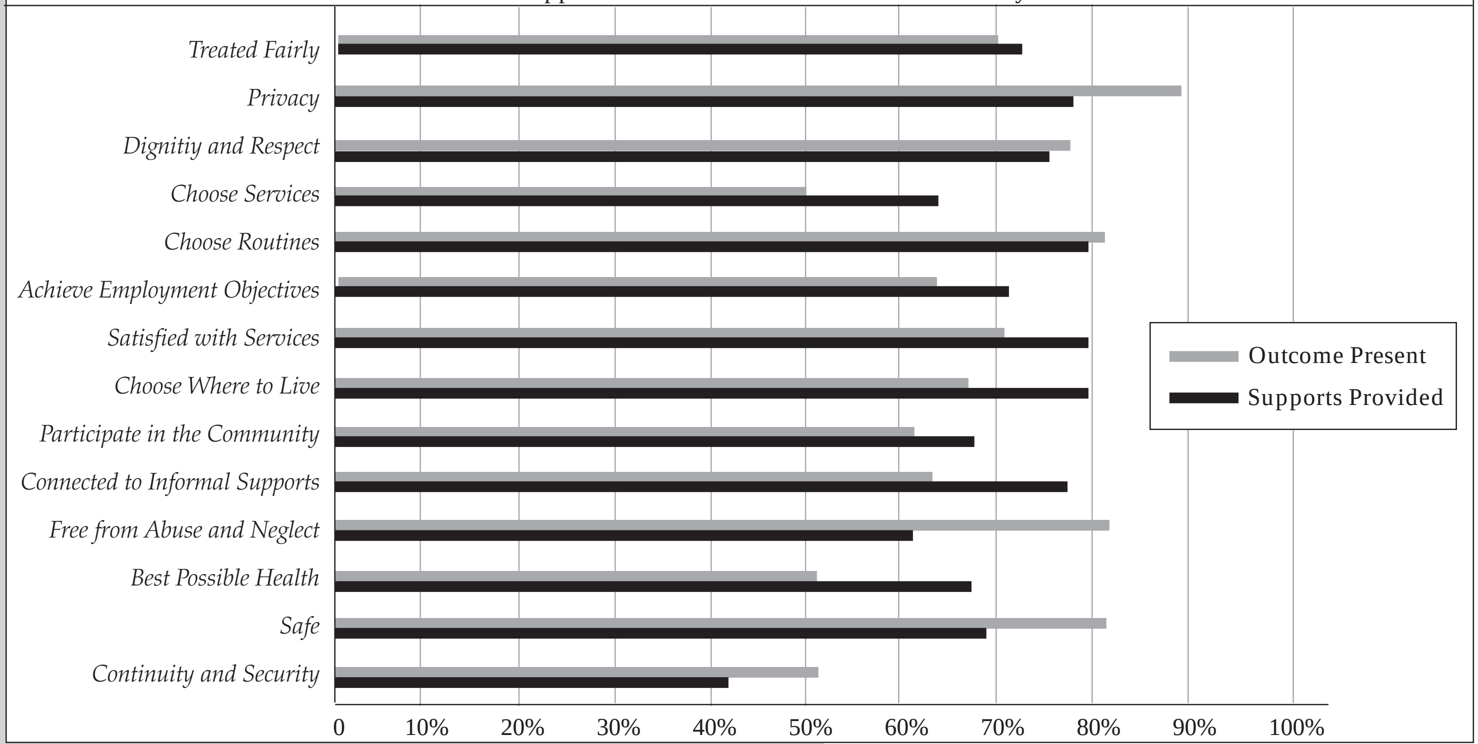
The results from the member outcome surveys are used in a variety of ways. Initially, the baseline information provides guidance in identifying quality improvement efforts. For example, in one county, the CMO was concerned with the results for the outcome "People choose where and with whom they live." The CMO focused on this one outcome as a quality improvement initiative and worked on reducing the size of several residential facilities to provide more private rooms and alternate living situations. As a result of these efforts, the percent of interviewees with developmental disabilities who indicated that this outcome was present more than doubled between the first and second round of interviews.

The results of the surveys also provide guidance to the Department in comparing results by target groups and by counties. This information is used in discussion with the CMOs to identify ongoing quality improvement activities in their communities, to improve the performance of providers in the areas and to inform various boards and councils.

Perhaps most importantly, the focus on member outcomes “promotes a consistent attention at all levels to the ultimate purpose of the program; improving the quality of life for people who need services. At the local level, the outcomes-focused care managers and providers will listen to the individuals who receive services and find flexible creative ways to provide support for the desired outcomes. At the Department level, outcome-focused staff will find ways to identify and share best practices among local programs to assist them in meeting high levels of performance. Outcome focused-state and federal policy makers will direct resources to the most cost-effective programs.”

FAMILY CARE MEMBER OUTCOME INTERVIEW RESULTS

Percent of Members with Outcome Present or Supports Provided - Interviews Conducted May 2001 - November 2001



NEW HAMPSHIRE
Developing Data Collection Plan

NEW HAMPSHIRE - Summary

Administering Agency:
New Hampshire Developmental Disabilities Services System
Program: New Hampshire Quality Outcomes Partnership
Population: Adults and children with mental retardation and developmental disabilities, families of adults and children who receive family supports, and the agencies that organize and deliver services.
Organizational Structure for Quality Assurance:
Partnership between the New Hampshire Division of Developmental Services, the Community Support Network, Inc., and the Institute on Disability.
Stakeholder Involvement:
Advisory Council of the Partnership
Multiple feedback forums across the state
Contact:
Karen Kimball, kkimball@dhhs.state.nh.us
603-271-4272
Website: www.nhdds.org

Background: Using a collaborative and inclusive process, New Hampshire Outcomes Partnership developed and implemented a comprehensive set of outcome indicators that stakeholders throughout the state use to better understand and improve the performance of the developmental disabilities system. Multiple forums across the state were held to get input into the design of the indicators and the process for collecting information. A comprehensive and detailed data collection plan was developed to outline agreed upon expectations regarding data reports that would be produced.

Domains and Indicators

The New Hampshire Outcomes Partnership identified seven domains of quality and over 60 indicators across those domains. The seven domains are:

- Community Inclusions
- Choice, Control and Communications
- Access to Quality Supports and Services
- Personal Growth, Accomplishments
- Health and Safety
- Family Support
- Agency Strength

The indicators for each domain are shown in the sidebar beginning on page 14.

Data Collection Plan

The New Hampshire Quality Outcomes Partnership developed a data collection plan that sets out expectations regarding data reports that the Division and area agency system would produce to inform each indicator of quality.

The plan identified the data collection instruments that would be used for initial data collection and nine additional instruments for later data collection. For each instrument, a data collection and analysis plan was developed. This plan included the following core information:

Population of Interest

- Definition of the universe of target population – This included an estimate of the number of people included in the universe.

- Sample – The number of people to be included in a sample, if applicable, and the sampling stratification plan.

Data Collection Plan

- Preparation – This includes the identification of data collection instruments, parties responsible for drafting, reviewing and assuring the quality of the data items, and training protocols.

- Draft instrument – The draft of the proposed instrument is developed.

- Responsible persons – The staff who will be responsible for collecting the data and the areas/regions where the data will be collected are identified.

- Time frame for data collection – The start and end dates for data collection are specified.

- Location/type of data files: This includes whether the data are collected manually, are submitted in electronic form and where the data is housed.

- Subsequent periodicity: How frequently the data is collected is specified.

- Data to be submitted for analysis – This includes how many data records, the number of data items per record, the number of records per individual and where the data is to be sent.

QUALITY MEASURES IN NEW HAMPSHIRE

Community Inclusion and Relationships
- Community Participation
- Small Households
- Family Communication
- Not Feeling Lonely
- Transportation Available

Choice, Control and Communication
- Like where they are living
- Exercise Choice
- Assistive Technology
- Services Important to Individuals
- Services Important to Third Parties
- Control Own Spending

Access to Quality Supports and Services
- Satisfied with Service Coordinator
- Services Available
- Solicit Feedback

Personal Growth and Accomplishments
- Satisfied with Daily Activities
- Satisfied with Jobs
- Proportion Employed
- Range of Hours Worked
- Above Minimum Wage Pay
- Careers on Target
- Employer / Co-worker support > 1 hour

Health and Safety
- Employer Provided Benefits
- Understand Their Rights
- Third Party Understand Rights
- Know How File Formal Complaint
- 3rd Parties Know How File Formal Complaint
- Feel Safe
- Annual Dentist Visit
- Dentist Respectful
- Not Experience Major Injuries
- Not a Victim of Crime

Continued on Page 16

Analysis

- Tabulations – This specifies how the responses to each data element will be tabulated and cross tabulated.

- Other analysis plans – This describes how responses will be tabulated in successive years once more data is collected.

- Time to complete – This specifies when the analysis is to be completed.

Data Collection and Analysis

The New Hampshire Quality Outcomes Partnership pilot tested its data collection process in two of the twelve regions of the state in 1999. In the summer of 2000, the statewide data collection effort started. Data was collected from nine data sources, including interviews with individuals and surveys distributed to families and service providers. The results of the data collection are summarized in the New Hampshire Quality Outcomes Partnership Annual Report. This report is widely disseminated throughout the state. The report provides a graphic summary of the quality indicators by domain and discusses the data sources, sample sizes and implications of the analysis.

Use of Data in Program Planning

The use of quality indicators are an integral part of the strategic planning activities of the New Hampshire Division of Developmental Services. One of the goals of the department is to promote quality supports and services through the monitoring and reporting of well-defined outcome indicators. Detailed, regionally specific reports are prepared and shared with area agency staff, board of directors and family support councils. Comprehensive reports are produced which identify positive practices and include recommendations for continuous quality improvement which agencies incorporate into their biennial plans.

Continued from Page 15

Family Support
- Information
- Area Agency Support
- Involved in Planning
- Services Available
- Facilitate Goals
- Career on Target
- Respite Services
- Caretakers Who Can Work
- Estate Planning Info
- Safety Needs Addressed
- Health Needs Addressed
- Dental Needs Addressed
- Access to Gov't Assistance
- Services Convenient
- Positive Impact of Services
- Transition to School
- Full Inclusion in School
- After School Activities
- Advocate Special Ed
- Transition to Work
- Home Accessibility
- Adaptive Communication

Agency Strength
- Operating Cash > 15 days
- Current Ratio > 1.5 to 1
- Positive Operating Results
- Liabilities / Net Worth Ratio > 4 to 1
- Assets / Liabilities Ratio > 1.25 to 1
- Receivables < 30 days
- Employees Not Injured
- Direct Support Employee Pay
- Rate of Positions Filled
- Agency Longevity

Lessons Learned

• *Collaboration leads to successful product:* The New Hampshire Quality Outcomes were the product of four years of collaborative effort which included the development of the indicators, the distribution of surveys and the collection of the data. The final reporting provides guidance and a roadmap for improvements and future directions for the service system

• *Review, modify and validate indicators:* During the data collection and analysis, some original indicators were deferred due to the inability or difficulty in collecting the data. Other indicators were removed because it became apparent the indicators were not valid. Taking the time to monitor and assess original assumptions is an important part of the data collection and analysis process.

PENNSYLVANIA
Monitoring for Quality Improvement

PENNSYLVANIA - Summary

Administering Agency:
Department of Public Welfare Office of Mental Retardation (OMR)

Program:
State funded and federal waiver services for people with mental retardation

Population:
Persons with mental retardation receiving home or community based residential services

Organizational Structure for Quality Management:
- OMR designs the quality framework; monitors 46 county program administrators; collects and analyzes quality indicators; trains supports coordinators, and qualifies providers
- 4 OMR Regional Offices: conducts waiver compliance activities, incident management, and death investigations.
- 8 Health Care Quality Units (HCQU): provide support and training to consumers, providers, counties and health care practitioners regarding health and health promotion.
- Counties: contract for and supervise support coordination which develops individual plans and monitors services' approve individual care plans, and authorize services, contracts with providers and monitor contract performance, oversees the independent monitoring team (see IM4Q below).

Stakeholder Involvement:
Planning Advisory Committee Independent Monitoring for Quality (IM4Q): persons with disabilities, family members and concerned citizens who assess consumer experience and satisfaction with services.

External Contractors
Temple University

Contacts
John Sloyer, Director, Quality Improvement and Policy
717-783-5729 • jsloyer@state.pa.us http://www.dpw.state.pa.us

Website
http://www.dpw.state.pa.us

Background: Vocal consumer concerns about the availability and quality of supports for persons with mental retardation living in the community prompted Pennsylvania's Office of Mental Retardation (OMR) to re-think its approach to quality management. These efforts were aided by the implementation of an information system that will ultimately integrate financial, client, provider, and quality management data within and across departments.

The re-designed quality approach includes systematic processes for OMR to monitor the counties and for the counties to monitor its providers of care. Two components of the new approach are highlighted here: the Independent Monitoring for Quality or IM4Q and the incident management system.

Independent Monitoring for Quality (IM4Q)

Background: The IM4Q is a process that provides a strong role for people with disabilities and their families to conduct independent assessments of consumer satisfaction and experience with care. The concept for IM4Q came out of a multi-year plan to improve the quality of services in the state's mental retardation system.

Selection of local IM4Q Programs: Counties are responsible for soliciting qualified entities to perform the functions of the IM4Q. All IM4Q programs are screened by the State IM4Q Steering Committee and must show evidence of:

- independence from service delivery entities
- consumer and family involvement on governing boards
- involvement of individuals receiving supports and families in data collection

Local IM4Q Programs represent a variety of organizations, including the Association of Retarded Citizens, consumer satisfaction teams (in the mental health system) parent groups, colleges and universities, and newly formed entities.

Survey instrument administered under IM4Q: The Essential Data Elements (EDE) survey consists of 105 questions, 39 of which must be answered by the individuals receiving supports or services. The EDE includes:

- a pre-survey completed by the county MH/MR program prior to the consumer in- person interview. Elements include factual information such as address, communication needs, degree and type of disabilities.
- Consumer in-person interview questions. This section of the survey captures all questions included on the National Core Indicators Project (NCIP) Consumer Survey[1], addressing issues of satisfaction, dignity, respect and rights, choice and control, relationships, and inclusion.
- Impressions of the monitoring team.
- A separate family/friend/guardian survey is conducted by telephone or mail to assess the families' satisfaction with their relative's living situation, as well as perceived satisfaction of their relative.

IM4Q Team members: monitoring teams include at least two persons who represent persons with disabilities, family members and/or concerned citizens who are independent of services being monitored.
Training: IM4Q team members receive training on the survey instrument and interview protocol from the Institute on Disabilities/University Center for Excellence at Temple University.

Survey Sample: The FY 2000-01 survey sample included 5,298 persons who were receiving for the most part residential supports in the community. Approximately one-third of the respondents lived independently, with families or in unlicensed living arrangements. Participation in the interview is voluntary.

How are findings used: Summaries of findings are shared with the County MH/MR Administrator and at bi-monthly meetings of the IM4Q Advisory Board. A summary of IM4Q findings is prepared for dissemination to the public. Through a "closing the loop" process, findings are used to enhance

service and supports at the individual, county and state levels.
Further information: Information on the IM4Q and reports generated can be found at www.dpw.state.pa.us/omr/dpwmr.asp.

Incident Management

Scope: All providers of mental retardation services and supports, including private and state-operated facilities, are required to report incidents. This includes incidents that occur when providers, their employees or contracted agents are present in the private home of a consumer.
Reportable incidents: Fourteen categories of incidents must be reported. These include:

- Abuse, including neglect, physical abuse, psychological abuse, sexual abuse and verbal abuse.
- Accidents or injuries requiring treatment beyond first aid.
- Emergency closure of a home or program facility for one or more days.
- Emergency room visit
- Fire
- Hospitalization
- Law enforcement activity
- Medication error, including wrong medication, wrong dose, omission.
- Missing person
- Misuse of funds
- Psychiatric hospitalization
- Restraints, including physical, mechanical or chemical
- Rights violation
- Suicide attempt

Timeframe and method of reporting: All incident reports must be submitted electronically. Initial notification must be made within 24 hours of the incident or when a provider learns of the incident. An incident report is due within 5 days of the initial notification. A Final Report must be submitted within 30 days of the incident.

Follow-up action. Designated incidents are to be investigated, either jointly or independently, by the provider, the county and / or OMR. All investigations must be conducted by certified investigators who have been trained and approved by OMR. A protocol for conducting investigations has been developed by OMR. Family members are notified of any reportable incident and the outcome of any investigation when it is complete.
Trend analysis: The 8 Health Care Quality Units (HCQU) within the state have access to incident data from the counties they serve. The HCQU is required to:

- review data related to medication errors, emergency room visits, in-patient hospitalizations, suicide attempts, deaths, and other health related matters;
- determine where trends suggest training, a change in procedures, or where medical supports are needed;
- determine the need for technical assistance, in conjunction with the counties.

In addition, the counties are required to develop procedures that include at least quarterly reviews of reported incidents to assess where trends may be developing. OMR issues an annual report reviewing statewide incident trends.

For further information on Incident Management contact:
Paul Hindman, Director, Division of Quality Improvement and Risk Management, 717-783-5771 or email at phindman@state.pa.us

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[1] The National Core Indicators Project is a multi-state collaborative effort, sponsored by the Human Services Research Institute (HSRI), to measure the effectiveness of the State Mental Retardation / Developmental Disabilities Service systems. For more information, go to the HSRI web site at www.hsri.org.

NEW YORK
Using Quality Data

NEW YORK - Summary

Administering Agency:
Office of Mental Health Bureau of Quality Management

Program: New York State Incident Management and Reporting System (NIMRS)

Population: Applies to all programs under the auspices of state-operated psychiatric facilities as well as to state-licensed mental health programs.

Organizational Structure for Quality Management:
Central Office of Mental Health operates psychiatric centers and regulates, certifies and oversees non profit and proprietary mental health programs; some operated by local government. In its regulatory role, the Office of Mental Health requires programs under the auspices of state-operated psychiatric facilities to establish clinical risk management programs, including the submittal of reportable incidents. Six clinical risk managers, 3 service positions and 2 systems positions review incident reports, conduct training of provider and Field Office staff, and manage the program at the state level.

Mental Health Field Offices: Quality management staff assigned regionally are responsible for monitoring providers' incident reporting and follow-up, and for providing ongoing training of providers' staff regarding all aspects of incident reporting and clinical risk management.

Stakeholder Involvement: The incident reporting system was developed with extensive input from both state and licensed provider stakeholders. Incident reports are considered privileged and confidential and are not released to the public.

External Contractors:
- Behavioral and Organizational Consultant Associates (BOCA) assess system problems observed from incident trends.
- Lana Norwood Associates, a private consulting firm, provides special investigation training.

Contact
Jayne Van Bramer, Director of Quality Management, New York State Office of Mental Health • E-mail: coqajvv@omh.state.ny.us

Background: The purpose of the New York State Incident Management and Reporting System (NIMRS) is to identify high-risk processes and develop strategies for risk reduction and error prevention. The concept moves away from a blame-setting environment and creates a vehicle for shared learning across psychiatric facilities and community mental health programs within the state.

Definition of Reportable Incidents:
The following incidents must be reported:
- Abuse or neglect, allegation of;
- Adverse drug reaction, severe;
- Assault;
- Child Missing from Staff Supervision
- Crime;
- Death of a patient;
- Fight;
- Fire setting;
- Injury of accidental or unknown origin;
- Medication error;
- Missing patient (for inpatient and residential programs only);
- Missing subject of Assisted Outpatient Treatment (AOT) court order;
- Self abuse;
- Sexual assault;
- Suicide attempt;
- Any other event identified as an incident by the facility or program.

Incident reporting requirements vary depending on whether the incident occurred within a state-operated facility or a state licensed program, whether the program is an inpatient, residential, outpatient or case management provider, and / or whether the incident occurred on program property or under the supervision of program staff.

Reporting:
State-operated facilities must report all incidents to the State through the New York State Incident Management and Reporting System (NIMRS). State-licensed providers are required to report the most serious incidents to the State, according to criteria established in State statutes. NIMRS is an Intranet or Internet based tool, which provides on-line incident definitions and guidance on documenting and submitting an incident report. On-line links are available to eliminate duplicate reporting requirements to other agencies, such as the Department of Health and the Commission on Quality of Care for the Mentally Disabled (CQC).

Investigations and Root Cause Analysis: State statute mandates that all mental health programs operated and / or licensed by the State shall develop, implement and monitor a clinical risk management program that provides for all aspects of incident management and proactive risk management. In State-operated facilities a Clinical Risk Manager and Clinical Risk Management Specialists are responsible for overseeing this program, assuring that all incidents are reported in a timely manner, reviewing the incidents to determining the circumstances surrounding the incident through a preliminary assessment, establishing the severity of the incident, and assuring the appropriate level of investigation and review. Special investigations are required for all high-risk incidents involving the serious injury or death of a patient or staff member as well as allegations of patient abuse. A special investigation is a comprehensive, objective investigation conducted by the clinical risk manager or other specialist trained in investigative procedures. Its purpose is to identify the fundamental reasons for the occurrence, including human factors and actions as well as clinical and non-clinical systems, processes, and risk areas that contributed to the event.

The Root Cause Analysis process is used for the most extreme sentinel events (e.g., rape, suicide, homicide) and involves using a team approach and structured tools to identify and act upon the basic causal factors involved. The goal is to safeguard systems and processes to avoid future occurrences.

Incident Review Committee: Each provider facility or agency must appoint an Incident Review Committee. For State-operated facilities, this committee must include the Director of Quality Management, the Clinical Director, a physician, a social worker, a nurse, a therapy aide, and appropriate clinical risk management staff. The purpose of the committee is to review incident trends and assure appropriate preventive and corrective measures are taken.

Use of Incident Report Data: The NIMRS reporting system is used to generate reports for internal provider use and to detect quality trends at the regional and state levels.

The Central Office regularly generates aggregate data and disseminates to Licensing and Certification staff for use in the survey process. NIMRS includes a comprehensive report package that allows providers to compare their performance to statewide averages or benchmarks. Over 25 summary reports are available by incident type, program ward, client injury, shift, day of week, rate per 1000 client day, intervention type, and types and reasons for restraint techniques.

Providers identify and develop quality improvement initiatives on the basis of individual incident report findings and aggregate data patterns and trends.

The Central Office publishes periodic “Alerts” on salient topics identified through the reporting system (e.g., Use of Plastic Bags in Inpatient Areas).

MICHIGAN - Summary
Administering Agency: Department of Community Health
Program: Home and Community Based Waiver
Population: Persons with developmental disabilities
Organizational Structure for Quality Management:
Department of Community Health certifies 48 Community Mental Health Services Programs (CMHSP) to oversee implementation of the waiver program.

The Department of Community Health:

- Conducts annual review of program policies, including sample review of clinical records;
- Interviews 10 percent of waiver clients;
- Establishes performance indicators;
- Negotiates program-performance objectives through contracts.
- Conducts annual adult consumer survey via mail to assess with CMHSP services.
- Conducts annual in-person quality of life surveys.

Community Mental Health Services:

- Programs provide or arrange for the provision of waiver services as well as:
- Establishes internal quality management program with quality coordinator position and an Oversight Quality Improvement Council that has representation from the organization and the community;
- Submits quarterly aggregate report on performance indicators;
- Conducts local consumer satisfaction surveys that the local Quality Improvement Council reviews.

Quarterly meetings between state and CMHSP Quality Coordinators focus on shared learning.

Peer Review Organization conducts independent quality of care assessment of behavioral health services provided to waiver participants through samples of record reviews.

Stakeholder Involvement:

- Quality Improvement Council: now disbanded statewide council of CMHSP directors, advocacy organizations and Department staff to advise on consumer and quality of life surveys.
- Specialty Services and Supportive Selection Panel: Governor of consumers, advocates and state government representatives to monitor
- Prepaid Health Plans, including CMHSPs.

External Contractors: Peer Review Organization
Contacts: Judy Webb, Director, Quality Management and Services Research, Michigan Department of Community Health, Email: webb@michigan.gov

MICHIGAN
Dissemination of Quality Improvement Data

Background: Since 1997, Michigan has used performance indicators to assess the performance of its waiver program for persons with developmental disabilities. Initially intended for internal oversight by the Department of Community Health of its contracts with 48 community mental health programs, data are now broadly shared with external stakeholders to detect quality problems, compare performance and improve care.

Performance indicators are part of a larger quality management system for community mental health services. Other components of the system include (1) certification standards that serve as prospective safeguards to the contracting process; (2) onsite visits to assess compliance with contracts; (3) submission of performance indicator data; (4) statewide consumer surveys; and (5) analysis of consumer characteristics and service use patterns.

Performance Indicators: The Performance Indicator System was designed with the input of consumers, advocates and community mental health system program staff. Based on a review of national measures in current use, 40 indicators were selected covering four domains: access, efficiency, outcome, and quality and appropriateness. Measures are further described with respect to their primary use as a (1) compliance indicator; (2) quality improvement indicator; and (3) monitoring measure. Appendix G of the Work Book includes a list of Michigan’s quality indicators.

Performance indicators are designed to:

- Clearly delineate the dimensions of quality that must be addressed by the public mental health system.

- Hold the system publicly accountable to the legislature.
- Provide a mechanism for overseeing the state's contracts with community mental health services programs
- Facilitate the development and implementation of local quality improvement systems.
- Serve as a foundation for consumer monitoring of the public mental health system.

Benchmarks: Standards are established for compliance indicators and are used as a basis for possible contract sanctions, plans of improvement or termination. Benchmarks are established based on statewide averages.

Collection of performance indicators: Community mental health system programs are required to collect data and calculate their performance measures using standardized report formats. Submission to the state is required on a quarterly basis.

Dissemination and use of performance indicators: Data obtained from the performance indicators are broadly disseminated. Quarterly reports comparing the performance of community mental health services programs on each indicator are prepared for advocates, legislature and libraries.

In addition, more detailed quarterly reports for the community mental health services programs are prepared comparing their performance on each indicator.