

# Status Report on MI Choice Quality Assurance Indicators, Quality Improvement Plans and Critical Incidents

(FY2011 Appropriation Bill - Public Act 187 of 2010)

April 1, 2011

**Section 1690:** (1) The department shall submit a report to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by April 1 of the current fiscal year, to include all data collected on the quality assurance indicators in the preceding fiscal year for the home- and community-based services waiver program, as well as quality improvement plans and data collected on critical incidents in the waiver program and their resolutions. (2) The department shall submit a report to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by April 1 of the current fiscal year, to include all data collected on the quality assurance indicators in the preceding fiscal year for the adult home help program, as well as quality improvement plans and data collected on critical incidents in the adult home help program and their resolutions.

*Michigan Department  
of Community Health*



**Rick Snyder, Governor  
James K. Haveman, Director**

**Report to the Michigan Legislature  
Status Report on MI Choice Quality Assurance Indicators,  
Quality Improvement Plans and Critical Incidents  
January 2013**

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# STATUS REPORT ON MI CHOICE WAIVER PROGRAM

## Report of Quality Assurances Indicators, Quality Improvement Plans and Critical Incidents for FY 2011

### INTRODUCTION

The following report summarizes the quality management activities of the Department of Community Health (MDCH), Home and Community-Based Services (HCBS) Section, for the MI Choice waiver program for fiscal year (FY) 2011. This report addresses requests by the House and Senate Appropriations subcommittees on Community Health, the House and Senate Fiscal agencies, and the State Budget Director as defined in Public Act 131. Where possible, the data is from FY 2011. Clinical and Administrative Quality Reviews conducted in FY 2011 review records from FY 2010, so that is the most recent data available.

Michigan developed its strategy to address quality management with meaningful contributions from consumers, advocates and caregivers who participate in the Quality Management Collaborative created in 2003.

#### A. Quality Management Framework

MDCH formulates the quality management for the MI Choice Waiver Program on Centers for Medicare and Medicaid services' (CMS) Quality Framework. This framework contains seven desired outcomes for home and community- based services:

- 1) **Participant Access** – Participants have ready access to home and community based care and supports in their community.
- 2) **Participant-Centered Service Planning & Delivery** – Services and supports are planned and implemented in accordance with participant needs, preferences and decisions.
- 3) **Provider Capacity and Capabilities** – There are sufficient qualified agency and individual providers.
- 4) **Participant Safeguards** – Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- 5) **Participant Rights and Responsibilities** – Participants receive support to exercise their rights and accept personal responsibilities.
- 6) **Participant Outcomes and Satisfaction** – Participants are satisfied with their services and achieve desired outcomes.
- 7) **System Performance** – The system supports participants effectively and efficiently and strives to improve quality.

## **B. Quality Management Plans**

- 1) **MDCH Plan:** The first Home and Community Based Quality Management Plan was developed and implemented in 2005. The state updated the quality management plan in September 2007 to include statewide implementation of Person-Centered Planning and the Self Determination option. The MDCH continued all required assurances and improvements contained in the FYs 06 and 07 plans used to meet CMS and MDCH requirements. MDCH continued to utilize the Minimum Data Set for Home Care (MDS-HC) Quality Indicators in FY 08. In 2009, MDCH began using the iHC Quality Indicators and has been using them ever since. The iHC Statewide Quarterly Quality Indicator Summary Reports for the period of 10/1/2010 to 9/30/2011 are attached.
- 2) **Waiver Agent's Plan:** Each waiver agent provided a Quality Management summary to the state on January 15, 2012. The requested information included; reporting of all required assurances and improvements, and quality indicators. Quality Management Summary Data from the waiver agent plans for FY 2011 is attached.

## **C. Administrative Quality Assurance Reviews (AQAR) & Clinical Quality Assurance Reviews (CQAR)**

The MI Choice Waiver Agents receive an Administrative Quality Assurance Review (AQAR) on a bi-annual schedule. The review involves a team of MDCH employees working on-site at the waiver agency reviewing policies, procedures, billing records and other documents in order to evaluate the agency infrastructure needed to administer the program and meet the performance standards defined in the Clinical Quality Assurance Reviews and other documents. The AQAR is based upon the nine focus areas identified in the Quality Management Plan.

The statewide Administrative Quality Assurance Review data for FY 2010-2011 are attached.

The Clinical Quality Assurance Reviews (CQARs) are conducted by a team of reviewers, all of whom have worked in the MI Choice program. 371 case records were reviewed for 2010. The 2010 CQAR reviews also included 109 home visits.

The statewide Clinical Quality Assurance Review data for FY 2010 are attached.

## **D. Critical Incident Management**

MDCH continued to require the reporting of Critical Incidents for FY 11. MDCH requires waiver agents to report Critical Incidents twice a year on January 15 and July 15. Statewide Critical Incident and Resolution Report Data for Year 2011 is attached.

**Statewide Quarterly Quality Indicators Summary Reports  
For  
October 2010 to September 2011**

# WISP - CAPS, QI, RUGS

## iHC QI Summary Report

Agent: Statewide  
 Reporting Period (required): OCT-2010 through DEC-2010  
 Program: WA-Y  
 Current County: No Preference  
 Current SC1 Initials: No Preference  
 Current SC2 Initials: No Preference

**Participants Included**

**N = Numerator**

**D = Denominator**

**(N)um.**

**\*(D)enom.**

**Agency %**

**\*\*Statewide %**

### NUTRITION

**W7 - Prevalence of inadequate meals**

N: Participants who ate 1 or fewer meals in 4 of the last 7 days

225

6931

3.3 %

3.3 %

D: All participants

**W24 - Prevalence of weight loss**

N: Participants with unintended weight loss

333

6439

5.2 %

5.2 %

D: All participants, excluding those with end-stage disease on prior assessment

**HP6 - Prevalence of dehydration**

N: Insufficient fluid intake

269

6931

3.9 %

3.9 %

D: All participants

### INCONTINENCE

**W18A - Failure to improve/Incidence of bladder incontinence**

N: Participants whose incontinence has not improved or is worse than prior assessment -OR- those with control on prior assessment now experiencing some level of incontinence

3763

5836

64.5 %

64.5 %

D: All participants with urine output on current and prior assessment

**W19A - Failure to improve/Incidence of bladder or bowel incontinence**

N: Participants who have a decline in either bladder or bowel continence between previous and current assessments -OR- participants who have developed a new bladder OR bowel continence problem

4014

4375

91.8 %

91.8 %

D: All participants with urine or bowel output on current and prior assessment

### ULCERS

**W23 - Failure to improve/Incidence of skin ulcers**

N: Participants with pressure or other skin ulcer on prior assessment who did not improve - OR - participants with a new pressure or other skin ulcer on current assessment

776

6507

12.0 %

12.0 %

D: All participants excluding 'not codeable' response for most severe pressure ulcer

### PHYSICAL FUNCTION

**W9 - Prevalence of no assistive device among clients with difficulty in locomotion**

N: Participants with impaired locomotion who are not using an assistive device

197

2653

7.5 %

7.5 %

D: All participants with impaired locomotion on current assessment (excludes those for whom locomotion did not occur)

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.

\*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

N = Numerator

D = Denominator

(N)um.

\*(D)enom.

Agency %

\*\*Statewide %

**W16 - Prevalence of capacity to improve functional performance without relevant therapies**

N: Participants not receiving occupational (OT) or physical (PT) therapy

2713

3247

83.6 %

83.6 %

D: Participants who could improve ADL's

**W25A - Incidence of decline in ADLs**

N: Participants whose ADL Hierarchy score indicates a decline from the prior assessment

360

6239

5.8 %

5.8 %

D: All participants, excluding those with end-stage disease or an ADL Hierarchy score of "Total Dependence" on prior assessment

**W25B - Failure to improve in ADLs/Incidence non-improvement in ADLs**

N: Participants with some impairment on ADL Hierarchy score who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL Hierarchy score

4143

6439

64.4 %

64.4 %

D: All participants, excluding those with end-stage disease on prior assessment

**W25C - Incidence of decline on ADLs long form scale**

N: Participants whose ADL Long Form scale declined from prior assessment

807

6263

12.9 %

12.9 %

D: All participants, excluding those with end-stage disease on prior assessment or whose ADL Long Form Scale could not decline

**W25D - Failure to improve/Incidence of decline on ADL long form**

N: Participants with some impairment on ADL long form who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL long form scale

4624

6439

71.9 %

71.9 %

D: All participants, excluding those with end stage disease on prior assessment

**HP15 - Failure to improve/Incidence of impaired locomotion in the home**

N: Participants who fail to improve in locomotion in the home -OR- participants who have a new impairment in locomotion in the home

2455

6431

38.2 %

38.2 %

D: All participants, excluding those with end-stage disease on prior assessment

**HP10 - Prevalence of falls**

N: Participants who recorded a fall on follow-up assessment

1686

6404

26.4 %

26.4 %

D: All participants excluding those completely dependent in bed mobility

**COGNITIVE FUNCTION****W8 - Prevalence of social isolation with distress**

N: Participants who are alone for long periods of time or always AND who also report feeling lonely -OR- Participants who are distressed by declining social activity

992

6922

14.4 %

14.4 %

D: All participants

**W28 - Failure to improve/Incidence of cognitive decline**

N: Participants who have experienced a decline (or remained the same if not independent) in cognitive performance between prior and current assessment -OR-

4303

6341

67.9 %

67.9 %

\*(D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.

\*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

N = Numerator

D = Denominator

(N)um.

\*(D)enom.

Agency %

\*\*Statewide %

those who experience a new cognitive impairment  
 D: All participants excluding those with very severe  
 impairment on either prior or current assessment

**CQ13\_1 - Prevalence of acute change in mental function**

N: Participants with acute change in mental function  
 D: All participants

280 6922 4.1 % 4.1 %

**CQ15\_1 - Prevalence of negative mood**

N: Any participant with sad mood on current assessment  
 AND at least 2 symptoms of functional depression are  
 exhibited 1 or more of the last 3 days  
 D: All participants

807 6921 11.7 % 11.7 %

**HP17 - Failure to improve/Incidence of difficulty in communication**

N: Participants with failure to improve in communication  
 (understood or understands) - OR - participants with new  
 difficulties in these areas  
 D: All participants who answered prior and current  
 Understands question - OR- prior and current Understood  
 question.

2678 6506 41.2 % 41.2 %

**PAIN****CQ17\_1 - Prevalence of pain with inadequate pain control**

N: Participants who experience pain -AND- experience  
 inadequate pain control on regimen or breakthrough pain  
 or sometimes severe or excruciatingly intense pain  
 D: All participants

2064 6910 29.9 % 29.9 %

**CQ17\_1A - Prevalence of daily pain (regardless of pain control)**

N: Participants who experience daily pain -AND-  
 experience breakthrough pain or sometimes severe or  
 excruciatingly intense pain  
 D: All participants

1587 6907 23.0 % 23.0 %

**M8 - Prevalence of inadequate pain management**

N: Participants who experience daily pain AND pain  
 intensity is sometimes severe or excruciating AND no  
 adequate pain control on followed pain regimen  
 D: Participants who experience daily pain that is severe or  
 excruciating

379 1002 37.9 % 37.9 %

**SAFETY/ENVIRONMENT****W3 - Prevalence of neglect/abuse**

N: Participants who have been neglected/abused, have  
 poor hygiene, are fearful of family member, or have been  
 restrained  
 D: All participants

344 6926 5.0 % 5.0 %

**W5 - Incidence of failure to improve in home safety**

N: Participants whose environment problems did not  
 improve  
 D: All participants with at least one home environment  
 problem on prior assessment

995 1153 86.3 % 86.3 %

**CQ11\_1 - Prevalence of any injuries**

N: Participants with fractures or major skin problems,  
 excluding current pressure or stasis ulcers  
 D: All participants

578 6926 8.4 % 8.4 %

**OTHER**

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.

\*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

**N = Numerator**

**D = Denominator**

	<b>(N)um.</b>	<b>*(D)enom.</b>	<b>Agency %</b>	<b>**Statewide %</b>
<b>W31 - Prevalence of hospitalization</b>				
N: Participants who have been hospitalized or visited emergency room in last 90 days	1816	6923	26.3 %	26.3 %
D: All participants				

*\*(D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.*

*\*\* Statewide % = All participants for the selected programs(s) and reporting period.*

# WISP - CAPS, QI, RUGS

## iHC QI Summary Report

Agent: Statewide  
 Reporting Period (required): JAN-2011 through MAR-2011  
 Program: WA-Y  
 Current County: No Preference  
 Current SC1 Initials: No Preference  
 Current SC2 Initials: No Preference

**Participants Included**

**N = Numerator**

**D = Denominator**

**(N)um.**

**\*(D)enom.**

**Agency %**

**\*\*Statewide %**

### NUTRITION

**W7 - Prevalence of inadequate meals**

N: Participants who ate 1 or fewer meals in 4 of the last 7 days

211

7077

3.0 %

3.0 %

D: All participants

**W24 - Prevalence of weight loss**

N: Participants with unintended weight loss

328

6521

5.1 %

5.1 %

D: All participants, excluding those with end-stage disease on prior assessment

**HP6 - Prevalence of dehydration**

N: Insufficient fluid intake

260

7077

3.7 %

3.7 %

D: All participants

### INCONTINENCE

**W18A - Failure to improve/Incidence of bladder incontinence**

N: Participants whose incontinence has not improved or is worse than prior assessment -OR- those with control on prior assessment now experiencing some level of incontinence

3907

5899

66.3 %

66.3 %

D: All participants with urine output on current and prior assessment

**W19A - Failure to improve/Incidence of bladder or bowel incontinence**

N: Participants who have a decline in either bladder or bowel continence between previous and current assessments -OR- participants who have developed a new bladder OR bowel continence problem

4179

4519

92.5 %

92.5 %

D: All participants with urine or bowel output on current and prior assessment

### ULCERS

**W23 - Failure to improve/Incidence of skin ulcers**

N: Participants with pressure or other skin ulcer on prior assessment who did not improve - OR - participants with a new pressure or other skin ulcer on current assessment

796

6594

12.1 %

12.1 %

D: All participants excluding 'not codeable' response for most severe pressure ulcer

### PHYSICAL FUNCTION

**W9 - Prevalence of no assistive device among clients with difficulty in locomotion**

N: Participants with impaired locomotion who are not using an assistive device

215

2839

7.6 %

7.6 %

D: All participants with impaired locomotion on current assessment (excludes those for whom locomotion did not occur)

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.  
 \*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

N = Numerator

D = Denominator

(N)um.

\*(D)enom.

Agency %

\*\*Statewide %

**W16 - Prevalence of capacity to improve functional performance without relevant therapies**

N: Participants not receiving occupational (OT) or physical (PT) therapy

2847

3358

84.8 %

84.8 %

D: Participants who could improve ADL's

**W25A - Incidence of decline in ADLs**

N: Participants whose ADL Hierarchy score indicates a decline from the prior assessment

446

6306

7.1 %

7.1 %

D: All participants, excluding those with end-stage disease or an ADL Hierarchy score of "Total Dependence" on prior assessment

**W25B - Failure to improve in ADLs/Incidence non-improvement in ADLs**

N: Participants with some impairment on ADL Hierarchy score who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL Hierarchy score

4253

6521

65.3 %

65.3 %

D: All participants, excluding those with end-stage disease on prior assessment

**W25C - Incidence of decline on ADLs long form scale**

N: Participants whose ADL Long Form scale declined from prior assessment

986

6341

15.6 %

15.6 %

D: All participants, excluding those with end-stage disease on prior assessment or whose ADL Long Form Scale could not decline

**W25D - Failure to improve/Incidence of decline on ADL long form**

N: Participants with some impairment on ADL long form who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL long form scale

4740

6521

72.7 %

72.7 %

D: All participants, excluding those with end stage disease on prior assessment

**HP15 - Failure to improve/Incidence of impaired locomotion in the home**

N: Participants who fail to improve in locomotion in the home -OR- participants who have a new impairment in locomotion in the home

2618

6517

40.2 %

40.2 %

D: All participants, excluding those with end-stage disease on prior assessment

**HP10 - Prevalence of falls**

N: Participants who recorded a fall on follow-up assessment

1772

6519

27.2 %

27.2 %

D: All participants excluding those completely dependent in bed mobility

**COGNITIVE FUNCTION****W8 - Prevalence of social isolation with distress**

N: Participants who are alone for long periods of time or always AND who also report feeling lonely -OR- Participants who are distressed by declining social activity

979

7067

13.9 %

13.9 %

D: All participants

**W28 - Failure to improve/Incidence of cognitive decline**

N: Participants who have experienced a decline (or remained the same if not independent) in cognitive performance between prior and current assessment -OR-

4420

6420

68.9 %

68.9 %

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.

\*\* Statewide % = All participants for the selected programs(s) and reporting period.

<b>Participants Included</b>	<b>(N)um.</b>	<b>*(D)enom.</b>	<b>Agency %</b>	<b>**Statewide %</b>
<b>N = Numerator</b>				
<b>D = Denominator</b>				
those who experience a new cognitive impairment				
D: All participants excluding those with very severe impairment on either prior or current assessment				
<b><i>CQ13_1 - Prevalence of acute change in mental function</i></b>				
N: Participants with acute change in mental function	276	7069	4.0 %	4.0 %
D: All participants				
<b><i>CQ15_1 - Prevalence of negative mood</i></b>				
N: Any participant with sad mood on current assessment AND at least 2 symptoms of functional depression are exhibited 1 or more of the last 3 days	843	7069	12.0 %	12.0 %
D: All participants				
<b><i>HP17 - Failure to improve/Incidence of difficulty in communication</i></b>				
N: Participants with failure to improve in communication (understood or understands) - OR - participants with new difficulties in these areas	2809	6591	42.7 %	42.7 %
D: All participants who answered prior and current Understands question - OR- prior and current Understood question.				
<b>PAIN</b>				
<b><i>CQ17_1 - Prevalence of pain with inadequate pain control</i></b>				
N: Participants who experience pain -AND- experience inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain	2099	7058	29.8 %	29.8 %
D: All participants				
<b><i>CQ17_1A - Prevalence of daily pain (regardless of pain control)</i></b>				
N: Participants who experience daily pain -AND- experience breakthrough pain or sometimes severe or excruciatingly intense pain	1639	7058	23.3 %	23.3 %
D: All participants				
<b><i>M8 - Prevalence of inadequate pain management</i></b>				
N: Participants who experience daily pain AND pain intensity is sometimes severe or excruciating AND no adequate pain control on followed pain regimen	429	1055	40.7 %	40.7 %
D: Participants who experience daily pain that is severe or excruciating				
<b>SAFETY/ENVIRONMENT</b>				
<b><i>W3 - Prevalence of neglect/abuse</i></b>				
N: Participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained	355	7069	5.1 %	5.1 %
D: All participants				
<b><i>W5 - Incidence of failure to improve in home safety</i></b>				
N: Participants whose environment problems did not improve	1016	1173	86.7 %	86.7 %
D: All participants with at least one home environment problem on prior assessment				
<b><i>CQ11_1 - Prevalence of any injuries</i></b>				
N: Participants with fractures or major skin problems, excluding current pressure or stasis ulcers	576	7070	8.2 %	8.2 %
D: All participants				
<b>OTHER</b>				

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.  
 \*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

**N = Numerator**

**D = Denominator**

	<b>(N)um.</b>	<b>*(D)enom.</b>	<b>Agency %</b>	<b>**Statewide %</b>
<b>W31 - Prevalence of hospitalization</b>				
N: Participants who have been hospitalized or visited emergency room in last 90 days	1869	7062	26.5 %	26.5 %
D: All participants				

*\*(D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.*

*\*\* Statewide % = All participants for the selected programs(s) and reporting period.*

# WISP - CAPS, QI, RUGS

## iHC QI Summary Report

Agent: Statewide  
 Reporting Period (required): APR-2011 through JUN-2011  
 Program: WA-Y  
 Current County: No Preference  
 Current SC1 Initials: No Preference  
 Current SC2 Initials: No Preference

### Participants Included

N = Numerator

D = Denominator

	(N)um.	*(D)enom.	Agency %	**Statewide %
<b>NUTRITION</b>				
<b>W7 - Prevalence of inadequate meals</b>				
N: Participants who ate 1 or fewer meals in 4 of the last 7 days	224	7037	3.2 %	3.2 %
D: All participants				
<b>W24 - Prevalence of weight loss</b>				
N: Participants with unintended weight loss	327	6456	5.1 %	5.1 %
D: All participants, excluding those with end-stage disease on prior assessment				
<b>HP6 - Prevalence of dehydration</b>				
N: Insufficient fluid intake	243	7037	3.5 %	3.5 %
D: All participants				
<b>INCONTINENCE</b>				
<b>W18A - Failure to improve/Incidence of bladder incontinence</b>				
N: Participants whose incontinence has not improved or is worse than prior assessment -OR- those with control on prior assessment now experiencing some level of incontinence	3883	5859	66.3 %	66.3 %
D: All participants with urine output on current and prior assessment				
<b>W19A - Failure to improve/Incidence of bladder or bowel incontinence</b>				
N: Participants who have a decline in either bladder or bowel continence between previous and current assessments -OR- participants who have developed a new bladder OR bowel continence problem	4164	4528	92.0 %	92.0 %
D: All participants with urine or bowel output on current and prior assessment				
<b>ULCERS</b>				
<b>W23 - Failure to improve/Incidence of skin ulcers</b>				
N: Participants with pressure or other skin ulcer on prior assessment who did not improve - OR - participants with a new pressure or other skin ulcer on current assessment	752	6537	11.6 %	11.6 %
D: All participants excluding 'not codeable' response for most severe pressure ulcer				
<b>PHYSICAL FUNCTION</b>				
<b>W9 - Prevalence of no assistive device among clients with difficulty in locomotion</b>				
N: Participants with impaired locomotion who are not using an assistive device	208	2872	7.3 %	7.3 %
D: All participants with impaired locomotion on current assessment (excludes those for whom locomotion did not occur)				

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.  
 \*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

N = Numerator

D = Denominator

(N)um.

\*(D)enom.

Agency %

\*\*Statewide %

**W16 - Prevalence of capacity to improve functional performance without relevant therapies**

N: Participants not receiving occupational (OT) or physical (PT) therapy

2914

3461

84.2 %

84.2 %

D: Participants who could improve ADL's

**W25A - Incidence of decline in ADLs**

N: Participants whose ADL Hierarchy score indicates a decline from the prior assessment

416

6258

6.7 %

6.7 %

D: All participants, excluding those with end-stage disease or an ADL Hierarchy score of "Total Dependence" on prior assessment

**W25B - Failure to improve in ADLs/Incidence non-improvement in ADLs**

N: Participants with some impairment on ADL Hierarchy score who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL Hierarchy score

4285

6456

66.4 %

66.4 %

D: All participants, excluding those with end-stage disease on prior assessment

**W25C - Incidence of decline on ADLs long form scale**

N: Participants whose ADL Long Form scale declined from prior assessment

961

6288

15.3 %

15.3 %

D: All participants, excluding those with end-stage disease on prior assessment or whose ADL Long Form Scale could not decline

**W25D - Failure to improve/Incidence of decline on ADL long form**

N: Participants with some impairment on ADL long form who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL long form scale

4694

6456

72.8 %

72.8 %

D: All participants, excluding those with end stage disease on prior assessment

**HP15 - Failure to improve/Incidence of impaired locomotion in the home**

N: Participants who fail to improve in locomotion in the home -OR- participants who have a new impairment in locomotion in the home

2617

6449

40.6 %

40.6 %

D: All participants, excluding those with end-stage disease on prior assessment

**HP10 - Prevalence of falls**

N: Participants who recorded a fall on follow-up assessment

1800

6470

27.9 %

27.9 %

D: All participants excluding those completely dependent in bed mobility

**COGNITIVE FUNCTION****W8 - Prevalence of social isolation with distress**

N: Participants who are alone for long periods of time or always AND who also report feeling lonely -OR- Participants who are distressed by declining social activity

959

7022

13.7 %

13.7 %

D: All participants

**W28 - Failure to improve/Incidence of cognitive decline**

N: Participants who have experienced a decline (or remained the same if not independent) in cognitive performance between prior and current assessment -OR-

4400

6363

69.2 %

69.2 %

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.

\*\* Statewide % = All participants for the selected programs(s) and reporting period.

<b>Participants Included</b>	<b>(N)um.</b>	<b>*(D)enom.</b>	<b>Agency %</b>	<b>**Statewide %</b>
<b>N = Numerator</b>				
<b>D = Denominator</b>				
those who experience a new cognitive impairment				
D: All participants excluding those with very severe impairment on either prior or current assessment				
<b><i>CQ13_1 - Prevalence of acute change in mental function</i></b>				
N: Participants with acute change in mental function	275	7021	4.0 %	4.0 %
D: All participants				
<b><i>CQ15_1 - Prevalence of negative mood</i></b>				
N: Any participant with sad mood on current assessment AND at least 2 symptoms of functional depression are exhibited 1 or more of the last 3 days	821	7020	11.7 %	11.7 %
D: All participants				
<b><i>HP17 - Failure to improve/Incidence of difficulty in communication</i></b>				
N: Participants with failure to improve in communication (understood or understands) - OR - participants with new difficulties in these areas	2791	6536	42.8 %	42.8 %
D: All participants who answered prior and current Understands question - OR- prior and current Understood question.				
<b>PAIN</b>				
<b><i>CQ17_1 - Prevalence of pain with inadequate pain control</i></b>				
N: Participants who experience pain -AND- experience inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain	2124	7013	30.3 %	30.3 %
D: All participants				
<b><i>CQ17_1A - Prevalence of daily pain (regardless of pain control)</i></b>				
N: Participants who experience daily pain -AND- experience breakthrough pain or sometimes severe or excruciatingly intense pain	1624	7010	23.2 %	23.2 %
D: All participants				
<b><i>M8 - Prevalence of inadequate pain management</i></b>				
N: Participants who experience daily pain AND pain intensity is sometimes severe or excruciating AND no adequate pain control on followed pain regimen	406	1050	38.7 %	38.7 %
D: Participants who experience daily pain that is severe or excruciating				
<b>SAFETY/ENVIRONMENT</b>				
<b><i>W3 - Prevalence of neglect/abuse</i></b>				
N: Participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained	341	7024	4.9 %	4.9 %
D: All participants				
<b><i>W5 - Incidence of failure to improve in home safety</i></b>				
N: Participants whose environment problems did not improve	1004	1162	86.5 %	86.5 %
D: All participants with at least one home environment problem on prior assessment				
<b><i>CQ11_1 - Prevalence of any injuries</i></b>				
N: Participants with fractures or major skin problems, excluding current pressure or stasis ulcers	563	7024	8.1 %	8.1 %
D: All participants				
<b>OTHER</b>				

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 \*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

**N = Numerator**

**D = Denominator**

	<b>(N)um.</b>	<b>*(D)enom.</b>	<b>Agency %</b>	<b>**Statewide %</b>
<b><i>W31 - Prevalence of hospitalization</i></b>				
N: Participants who have been hospitalized or visited emergency room in last 90 days	1872	7019	26.7 %	26.7 %
D: All participants				

*\*(D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.*

*\*\* Statewide % = All participants for the selected programs(s) and reporting period.*

# WISP - CAPS, QI, RUGS

## iHC QI Summary Report

Agent: Statewide  
 Reporting Period (required): JUL-2011 through SEP-2011  
 Program: WA-Y  
 Current County: No Preference  
 Current SC1 Initials: No Preference  
 Current SC2 Initials: No Preference

### Participants Included

N = Numerator

D = Denominator

	(N)um.	*(D)enom.	Agency %	**Statewide %
<b>NUTRITION</b>				
<b>W7 - Prevalence of inadequate meals</b>				
N: Participants who ate 1 or fewer meals in 4 of the last 7 days	229	7092	3.3 %	3.3 %
D: All participants				
<b>W24 - Prevalence of weight loss</b>				
N: Participants with unintended weight loss	339	6469	5.3 %	5.3 %
D: All participants, excluding those with end-stage disease on prior assessment				
<b>HP6 - Prevalence of dehydration</b>				
N: Insufficient fluid intake	259	7092	3.7 %	3.7 %
D: All participants				
<b>INCONTINENCE</b>				
<b>W18A - Failure to improve/Incidence of bladder incontinence</b>				
N: Participants whose incontinence has not improved or is worse than prior assessment -OR- those with control on prior assessment now experiencing some level of incontinence	3968	5832	68.1 %	68.1 %
D: All participants with urine output on current and prior assessment				
<b>W19A - Failure to improve/Incidence of bladder or bowel incontinence</b>				
N: Participants who have a decline in either bladder or bowel continence between previous and current assessments -OR- participants who have developed a new bladder OR bowel continence problem	4269	4655	91.8 %	91.8 %
D: All participants with urine or bowel output on current and prior assessment				
<b>ULCERS</b>				
<b>W23 - Failure to improve/Incidence of skin ulcers</b>				
N: Participants with pressure or other skin ulcer on prior assessment who did not improve - OR - participants with a new pressure or other skin ulcer on current assessment	770	6551	11.8 %	11.8 %
D: All participants excluding 'not codeable' response for most severe pressure ulcer				
<b>PHYSICAL FUNCTION</b>				
<b>W9 - Prevalence of no assistive device among clients with difficulty in locomotion</b>				
N: Participants with impaired locomotion who are not using an assistive device	209	2972	7.1 %	7.1 %
D: All participants with impaired locomotion on current assessment (excludes those for whom locomotion did not occur)				

\* (D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.  
 \*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

N = Numerator

D = Denominator

(N)um.

\*(D)enom.

Agency %

\*\*Statewide %

**W16 - Prevalence of capacity to improve functional performance without relevant therapies**

N: Participants not receiving occupational (OT) or physical (PT) therapy

2994

3518

85.2 %

85.2 %

D: Participants who could improve ADL's

**W25A - Incidence of decline in ADLs**

N: Participants whose ADL Hierarchy score indicates a decline from the prior assessment

456

6246

7.4 %

7.4 %

D: All participants, excluding those with end-stage disease or an ADL Hierarchy score of "Total Dependence" on prior assessment

**W25B - Failure to improve in ADLs/Incidence non-improvement in ADLs**

N: Participants with some impairment on ADL Hierarchy score who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL Hierarchy score

4424

6469

68.4 %

68.4 %

D: All participants, excluding those with end-stage disease on prior assessment

**W25C - Incidence of decline on ADLs long form scale**

N: Participants whose ADL Long Form scale declined from prior assessment

931

6275

14.9 %

14.9 %

D: All participants, excluding those with end-stage disease on prior assessment or whose ADL Long Form Scale could not decline

**W25D - Failure to improve/Incidence of decline on ADL long form**

N: Participants with some impairment on ADL long form who failed to improve between prior and current assessment -OR- participants who have a new ADL impairment based on ADL long form scale

4818

6469

74.5 %

74.5 %

D: All participants, excluding those with end stage disease on prior assessment

**HP15 - Failure to improve/Incidence of impaired locomotion in the home**

N: Participants who fail to improve in locomotion in the home -OR- participants who have a new impairment in locomotion in the home

2726

6456

42.3 %

42.3 %

D: All participants, excluding those with end-stage disease on prior assessment

**HP10 - Prevalence of falls**

N: Participants who recorded a fall on follow-up assessment

1818

6516

28.0 %

28.0 %

D: All participants excluding those completely dependent in bed mobility

**COGNITIVE FUNCTION****W8 - Prevalence of social isolation with distress**

N: Participants who are alone for long periods of time or always AND who also report feeling lonely -OR- Participants who are distressed by declining social activity

969

7079

13.7 %

13.7 %

D: All participants

**W28 - Failure to improve/Incidence of cognitive decline**

N: Participants who have experienced a decline (or remained the same if not independent) in cognitive performance between prior and current assessment -OR-

4555

6370

71.6 %

71.6 %

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\*\* Statewide % = All participants for the selected programs(s) and reporting period.

<b>Participants Included</b>	<b>(N)um.</b>	<b>*(D)enom.</b>	<b>Agency %</b>	<b>**Statewide %</b>
<b>N = Numerator</b>				
<b>D = Denominator</b>				
those who experience a new cognitive impairment				
D: All participants excluding those with very severe impairment on either prior or current assessment				
<b><i>CQ13_1 - Prevalence of acute change in mental function</i></b>				
N: Participants with acute change in mental function	296	7079	4.2 %	4.2 %
D: All participants				
<b><i>CQ15_1 - Prevalence of negative mood</i></b>				
N: Any participant with sad mood on current assessment AND at least 2 symptoms of functional depression are exhibited 1 or more of the last 3 days	871	7078	12.4 %	12.4 %
D: All participants				
<b><i>HP17 - Failure to improve/Incidence of difficulty in communication</i></b>				
N: Participants with failure to improve in communication (understood or understands) - OR - participants with new difficulties in these areas	2948	6546	45.1 %	45.1 %
D: All participants who answered prior and current Understands question - OR- prior and current Understood question.				
<b>PAIN</b>				
<b><i>CQ17_1 - Prevalence of pain with inadequate pain control</i></b>				
N: Participants who experience pain -AND- experience inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain	2068	7070	29.3 %	29.3 %
D: All participants				
<b><i>CQ17_1A - Prevalence of daily pain (regardless of pain control)</i></b>				
N: Participants who experience daily pain -AND- experience breakthrough pain or sometimes severe or excruciatingly intense pain	1614	7066	22.9 %	22.9 %
D: All participants				
<b><i>M8 - Prevalence of inadequate pain management</i></b>				
N: Participants who experience daily pain AND pain intensity is sometimes severe or excruciating AND no adequate pain control on followed pain regimen	438	1084	40.5 %	40.5 %
D: Participants who experience daily pain that is severe or excruciating				
<b>SAFETY/ENVIRONMENT</b>				
<b><i>W3 - Prevalence of neglect/abuse</i></b>				
N: Participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained	353	7082	5.0 %	5.0 %
D: All participants				
<b><i>W5 - Incidence of failure to improve in home safety</i></b>				
N: Participants whose environment problems did not improve	1051	1202	87.5 %	87.5 %
D: All participants with at least one home environment problem on prior assessment				
<b><i>CQ11_1 - Prevalence of any injuries</i></b>				
N: Participants with fractures or major skin problems, excluding current pressure or stasis ulcers	526	7081	7.5 %	7.5 %
D: All participants				
<b>OTHER</b>				

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 \*\* Statewide % = All participants for the selected programs(s) and reporting period.

**Participants Included**

**N = Numerator**

**D = Denominator**

	<b>(N)um.</b>	<b>*(D)enom.</b>	<b>Agency %</b>	<b>**Statewide %</b>
<b><i>W31 - Prevalence of hospitalization</i></b>				
N: Participants who have been hospitalized or visited emergency room in last 90 days	1904	7078	27.0 %	27.0 %
D: All participants				

*\*(D)enom. = Results with fewer than 20 observations in the denominator need to be viewed with caution due to the potential for high instability in the test.*

*\*\* Statewide % = All participants for the selected programs(s) and reporting period.*

**Strategy for Assuring and Improving the  
Quality of MI Choice Waiver  
Services and Supports FY 2010-2011**

**STRATEGY FOR ASSURING AND IMPROVING  
THE QUALITY OF MI CHOICE WAIVER SERVICES AND SUPPORTS  
FY 2010-2011**

The following strategy is designed to assess and improve the quality of services and supports managed by twenty Organized Health Care Delivery Systems (OHCDs) (hereafter referred to as waiver agents) in the Home and Community Based Services Medicaid Waiver Program for the Elderly and Adults with Disabilities (hereafter referred to as MI Choice). The state agency responsible for establishing the components of the quality management plan (QMP) listed here is the Michigan Department of Community Health's (MDCH), Medical Services Administration (MSA), which assigned this function to the Home and Community Based Services Section.

**1. STRUCTURE AND PROCESS FOR DEVELOPING, REVIEWING AND REVISING MICHIGAN'S STRATEGY FOR QUALITY MANAGEMENT**

The MI Choice program operates through an agreement with the Centers for Medicare and Medicaid Services (CMS). This agreement, or waiver application, delineates MDCH's responsibilities for managing quality assurance and quality improvement in the waiver program. The Home and Community Based Services Section and the Long-Term Care Policy Section jointly developed the waiver agreement.

The MI Choice Quality Management Collaborative is an advisory group that contributes to development of the state's QMP, provides input to implementation activities, and is involved in interpreting data from quality activities. The collaborative meets approximately six times per year. A MI Choice participant chairs the collaborative, and the membership includes program participants, caregivers, staff from waiver agencies, and MDCH staff members.

The MDCH QMP encompasses the following elements.

- a. Design: The Quality Management strategy includes processes and safeguards to:
  - prevent problems with quality;
  - ensure the delivery of high quality services and supports;
  - implement performance measures to assure the quality of providers;
  - assure participants' health and safety; and
  - ensure appropriate and accurate payments.
- b. Discovery: MDCH uses several methods for gathering information to verify that the QMP is implemented and functioning as intended.
- c. Remediation: Using the results from the discovery methods, MDCH and the waiver agents develop action plans to remediate problems and ensure continuous quality improvement.

- d. Improvement: MDCH and waiver agents use participant assessment data and other information to identify methods to improve participants' experiences in the program. Together, they develop and implement Quality Improvement interventions and assess the interventions for effectiveness.
- e. Stakeholder Input: The MI Choice program benefits from the involvement of the MI Choice Quality Management Collaborative. This group's membership includes at least 7 members who are program participants, family members, caregivers and advocates. The group has an equal number of members that represent the MI Choice Waiver Agents, typically Program Directors or Quality Management staff persons. The Collaborative has two co-chairpersons from the participant/advocate members. The Collaborative provides input on the analysis of quality data reports, selection of quality indicators and design of instruments or initiatives aimed at quality management. The Collaborative meets bi-monthly.

## 2. HOME AND COMMUNITY-BASED SERVICES (HCBS) QUALITY FRAMEWORK

MDCH based the QMP on the CMS HCBS Quality Framework. The HCBS Quality Framework provides a common reference that encourages productive dialogue among all parties with interest in the quality of services and supports for the HCBS waiver population. The HCBS Quality Framework's focus on desired outcomes also keeps the essential goal of the MI Choice program, to support program participants effectively in the community, in the forefront of discussions regarding quality.

The HCBS Quality Framework contains seven focus areas with desired outcomes for home and community-based services. MDCH incorporates each of these focus areas and added two additional focus areas:

- 1) Participant Access – Participants have ready access to home and community based care and supports in their community.
- 2) Participant-Centered Service Planning & Delivery – Services and supports are planned and implemented in accordance with participant needs, preferences and decisions.
- 3) Provider Capacity and Capabilities – There are sufficient qualified agency and individual providers.
- 4) Participant Safeguards – Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- 5) Participant Rights and Responsibilities – Participants receive support to exercise their rights and accept personal responsibilities.
- 6) Participant Outcomes and Satisfaction – Participants are satisfied with their services and achieve desired outcomes.
- 7) System Performance – The system supports participants effectively and efficiently and strives to improve quality.

- 8) Administration – The MI Choice program is administered efficiently and effectively to maximize Medicaid buying power while giving precedence to the participant's best interests.
- 9) Services - Participants receive the MI Choice waiver services most appropriate for their needs.

### 3. QUALITY MANAGEMENT PLANS

MDCH utilizes a two-tiered approach to the design and development of the QMP. The first tier is the statewide MDCH QMP. The second tier is a waiver agent specific QMP.

#### a. MDCH QMP

Every two years, MDCH establishes a QMP that includes statewide goals and strategies. The MDCH QMP focuses on meeting CMS assurances and requirements for protecting the health and welfare of MI Choice participants, MDCH contract requirements, and targeted participant outcome improvement goals. MDCH reviews each waiver agent's annual QMP outcomes and adjusts its QMP to assure statewide continuous quality improvement. MDCH assists waiver agents in preparing and updating their specific QMPs based on agency results from quality reviews, participant outcomes, consumer survey results, complaint history, and other performance measured outcomes.

#### b. Waiver Agent QMPs

Each waiver agent establishes a QMP that includes a quality assurance and quality improvement strategies. MDCH requires that waiver agents update QMPs at least every two years. The QMP addresses how the waiver agent intends to meet State and Federal assurances. These assurances include requirements stipulated in the MI Choice contract, the CMS-approved waiver plan, and CMS requirements for assuring the health and welfare of MI Choice participants. Waiver Agents include the required goals from the MDCH QMP in their plans and add their own unique quality improvement goals. Waiver Agent plans focus on meeting waiver requirements and any MDCH or self-targeted quality improvement strategies, including service provider performance requirements, and administrative improvements.

### 4. QUALITY ASSURANCE

The waiver agent develops processes to ensure that activities and programs assure the quality of HCBS services and supports. The waiver agent QMP must include a systematic approach designed to continuously improve care and prevent or minimize problems prior to occurrence. Each waiver agent's QMP must include the following assurances.

Level of Care:

STRATEGY FOR ASSURING AND IMPROVING THE QUALITY OF MI CHOICE WAIVER SERVICES AND SUPPORTS FY 2010-2011

- Waiver agents provide applicants for whom there is reasonable indication that services may be needed in the future with an individual nursing facility level of care (NFLOC) evaluation.
- The waiver agent reevaluates MI Choice participants at least annually to assure each participant continues to meet NFLOC criteria.
- The waiver agent uses the processes and instruments described in the approved waiver when making NFLOC determinations.

Plan of Care (POC):

- The POC addresses all of the participant's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
- The waiver agent monitors the POC development process in accordance with its policies and procedures.
- The waiver agent updates, monitors, or revises the POC at least every 90 days or more frequently when warranted by changes in participant needs.
- The waiver agent assures that providers deliver services in accordance with the POC, including the type, scope, amount, duration, and frequency specified.
- The waiver agent assures that it affords each participant with the opportunity to choose between MI Choice enrollment and institutional care and among waiver services and providers.

Qualified Providers:

- The waiver agent verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing waiver services.
- The waiver agent monitors non-licensed/non-certified providers to assure adherence to MI Choice requirements.
- The waiver agent establishes policies and procedures for verifying that providers furnish training in accordance with State requirements and the approved waiver.

Health and Welfare

- On a continual basis, the waiver agent identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. The waiver agent educates participants regarding their rights and responsibilities. The waiver agent establishes a system to monitor participant outcomes and satisfaction.

Financial Accountability:

- The waiver agent has processes in place to assure that staff code and pay claims in accordance with the reimbursement methodology specified in the approved waiver.

Administrative Authority:

- MDCH retains the administrative authority and responsibility for the operation of the MI Choice program by exercising oversight of the performance of waiver functions by waiver agents and other contracted entities.

## 5. MDCH QUALITY ASSURANCE REVIEWS

The MI Choice Site Review Protocol is structured according to the CMS Protocol for Conducting Full Reviews of State Medicaid HCBS Waiver Programs, the CMS Interim Procedural Guidance for Assessing HCBS Waiver Programs, and the CMS HCBS Quality Framework. MDCH addresses the discovery element of the state's QMP using several methods. MDCH staff and contractors review program, clinical, and administrative activities annually to assure that waiver agents meet CMS and MDCH requirements, thereby assuring the health and welfare of MI Choice participants.

### a. Clinical Quality Assurance Reviews (CQAR)

MDCH developed the CQAR process to meet CMS requirements for the review of POC authorizations and case record reviews. The number of records reviewed is at least 5% of the waiver agent's MI Choice participants, with a maximum of 30 and a minimum of 10 records per waiver agent. MDCH conducts the CQAR on-site and includes interviews with waiver agent staff. In addition, MDCH interviews at least 10 MI Choice participants in their homes. The overall purpose of this review is to determine, based on written case record documentation and discussion with supports coordinators, whether the waiver agent protects each participant's health and welfare during the implementation and delivery of services and supports. If MDCH finds significant issues, concerns, or questions in the first set of case records reviewed, it may opt to review additional records to verify initial findings.

The CQAR process looks at nine focus areas consisting of 84 standards. Registered nurse (RN) reviewers examine participant enrollment, assessment data, NFLOC eligibility, the POC and care planning process, and reassessment data. The RN reviewers collect both qualitative and quantitative data, evaluate the waiver agent's assessment and POC, and review the actions of supports coordinators to assure that the waiver agent protects the health and welfare of the participants to the greatest extent possible, given participant preferences.

The RN reviewers compile CQAR data into reports and submit them to MDCH. The HCBS Section staff examines, summarizes, and forwards the reports to the waiver agent. Each report includes a summary of successes in practice and areas in need of improvement. HCBS Section staff divides the areas in need for improvement into citations and recommendations based upon algorithms for each standard. The waiver agent has 30 days to respond to the citations with a corrective action plan. MDCH either accepts the corrective action plan, or suggests other actions to bring each waiver agent into full compliance with this portion of the review. The HCBS Section staff works with the waiver agent to assure the corrective action plan will produce quality improvements. MDCH monitors implementation of the corrective action plan.

b. Administrative Quality Assurance Reviews (AQAR)

The AQAR process examines nine focus areas consisting of 194 standards. HCBS Section staff conducts on site visits to verify administrative and program policy and procedural requirements on a biennial basis. The AQAR includes an examination of each waiver agent's policy and procedure manuals, peer review reports, results from client satisfaction surveys, provider monitoring reports, provider contract templates, financial systems, claims accuracy, QMP, and required provider licenses to verify that the waiver agent meets all applicable requirements. HCBS Section staff also conducts home visits to assure participant satisfaction with services and assure that the POC meets all of the participant's needs.

While conducting the AQAR, HCBS Section staff thoroughly review waiver agent policy and procedure manuals and other related documents, compare required compliance items with items in the documents, and check off each item on the review tools when it is evident that the item met the requirement. If the HCBS Section staff determine that the waiver agent does not meet a requirement, staff discusses the missing requirements with waiver agent staff prior to issuing the AQAR report. Following the review of the entire compliance document, the HCBS Staff prepare the AQAR report. For each of the standards examined in the AQAR, the report identifies one of the following findings:

- 1) The HCBS Section staff found evidence that the waiver agent met the requirement.
- 2) The HCBS Section staff did not find evidence that the waiver agent met the requirement.
- 3) The HCBS Section staff found incomplete evidence that the waiver agent met the requirement.

As with the CQAR report, the AQAR report includes a summary of successes in practice and areas in need of improvement. The areas in need of improvement section of the report identifies instances where required documentation was not evident or not found. HCBS Section staff forward the report to the waiver agent. The waiver agent then has 30 days to respond to the findings. After receiving the waiver agent's written response and engaging in any necessary clarifying discussion, HCBS Section staff notifies the waiver agent of its acceptance of the corrective action plan. The HCBS Section provides the waiver agent 30 additional days to correct any deficiencies noted in the final corrective action plan. HCBS Section staff continue to monitor the waiver agent's progress toward meeting goals identified in the corrective action plan.

The MDCH Audit Office also conducts an audit on a sample of waiver agents every two to three years to validate that each waiver agent uses generally acceptable accounting procedures and meet financial assurances. The specific

criteria used for each audit changes depending on identified or suspected problems or issues.

c. Consumer Surveys

Michigan uses Consumer Satisfaction and Quality of Life Surveys as tools to identify weaknesses and problems in the MI Choice program so that MDCH and waiver agents can make improvements in the quality of services and supports participants receive. MDCH requires each waiver agent to conduct consumer surveys. At this time, the waiver agents use their own instruments and protocols. A standard instrument will be developed as part of this QMP.

d. Critical Incidents Management

CMS requires a formal plan, developed and implemented by the state, to define, identify, investigate and resolve incidents, events, or occurrences that jeopardize the health and welfare of a participant. Currently, waiver agents submit critical incident reports twice a year to the HCBS Section. MDCH anticipates changing to a continuous reporting process in FY 2010. The report includes the findings, actions taken to protect the health and welfare of the participant, resolution, prevention strategies, and trends.

## 6. QUALITY IMPROVEMENT

MDCH strives for continuous quality improvement in administering the MI Choice program. The quality improvement program is based on four key elements; design, discovery, remediation, and improvement. MDCH requires waiver agents to develop clear and quantifiable goals for improvement.

a. Existing Quality Improvement Goals

1) Integrity of Data

Goal: To Decrease the percent of missing data items in the MI Choice Assessment System by waiver agents and in statewide reports.

2) Access to Services

Goal: Decrease the percent of provider “No Shows” reported by waiver agents and statewide. Increase the percentage of planned services actually delivered through the decrease of provider “No Shows.”

3) Timeliness of Service Delivery

Goal: Improve the timeliness of service delivery following the assessment and enrollment of each participant to less than 5 days from the date of enrollment into the MI Choice program.

4) No Waiver Services

STRATEGY FOR ASSURING AND IMPROVING THE QUALITY OF MI CHOICE WAIVER SERVICES AND SUPPORTS FY 2010-2011

Goal: Decrease the number of enrolled MI Choice participants who did not receive MI Choice services for 30 or more continuous days to “0”.

5) Participant Outcomes

Goal: Decrease the percent of participants with a prevalence of disruptive or intense daily pain. MDCH defines “disruptive or intense daily pain” as daily pain, severe or excruciating pain, or pain that disrupts usual activities.

b. New Quality Improvement Goals for 2010 – 2011

1) Quality Indicators: Add clinical quality indicators once interRAI develops the methodology for the new iHC assessment tool (formerly MDS-HC).

2010 Goal: Select Quality Indicators from i-HC.

2011 Goal: Implement, measure, and report selected Quality Indicators

2) Self Determination Option

2010 Goal: Each waiver agent enrolls at least 5% of its total MI Choice participants in the self-determination option.

2011 (tentative) Goal: Each waiver agent enrolls at least 10% of total MI Choice participants in the self-determination option.

3) Nursing Facility Transition (NFT)

2010 Goal: Each waiver agent must meet the NFT benchmarks provided to them by MDCH.

2011 Goal: MDCH will develop and assign new NFT benchmarks based upon 2010 performance and funding appropriated for the program.

4) Consumer Survey

2010 Goal: MDCH will work with waiver agents and the Quality Management Collaboration Committee to develop a statewide consumer satisfaction and quality of life survey for MI Choice participants. This will include the development of a methodology for administering survey.

2011 Goal: Implement the consumer survey and report results.

5) Local Consumer, Provider, Waiver Agent Quality Collaborative Committees

Goal: Each waiver Agent will establish a local Quality Collaborative Committee during 2010 or develop the Quality Collaborative role within an existing group.

**2012 Updates on Goals for  
MI Choice Waiver Services and Supports  
Quality Management Plans**

**Updates on Goals for MI Choice Waiver  
Quality Management Plans  
January 2012**

*a. Existing Quality Improvement Goals*

**1) Integrity of Data**

Goal: To Decrease the percent of missing data items in the MI Choice Assessment System by waiver agents and in statewide reports.

- According to the figures provided by Waiver Agencies, there was 0.12% of missing assessment items on the iHC assessment tool. This statewide figure has been decreased from last year's percentage of 2.50%.
- Reporting of this percentage has changed and now more accurately reflects only those data items that are required.
- Supervisory review of assessments and reassessments has helped to improve the percent of missing assessment items. Additional training has also increased the collection of data.

**2) Access to Services**

Goal: Decrease the percent of provider "No Shows" reported by waiver agents and statewide. Increase the percentage of planned services actually delivered through the decrease of provider "No Shows."

- According to the figures provided by Waiver Agencies, 0.91% of services were a provider "No Show". This statewide figure is a decrease from last year's percentage of 1.09%.
- Waiver Agents continue to ensure back-up providers are in place for participants so that if workers are unavailable, services are still provided. Waiver Agents continue to encourage providers and participants to keep constant communication in an effort to reduce "no shows".

**3) Timeliness of Service Delivery**

Goal: Improve the timeliness of service delivery following the assessment and enrollment of each participant to less than 5 days from the date of enrollment into the MI Choice program.

- According to the figures provided by Waiver Agencies, there was an average of 4.14 days before the first day of service delivery. This statewide figure is an improvement from last year's average of 4.71 days and meets the goal in the Quality Management Plans.
- Waiver Agencies continue to monitor delays and provide training to staff which has helped to reduce this average. Familiarity with the Self Determination program has also helped to make Support Coordinators

more efficient with paperwork and has helped to get services in place faster.

- Common reasons for continued delays include issues with Medicaid eligibility, Self Determination paperwork not being completed by participant and/or their caregiver and delays with participants accepting their plans of care.

#### **4) No Waiver Services**

Goal: Decrease the number of enrolled MI Choice participants who did not receive MI Choice services for 30 or more continuous days to “0”.

- According to the figures provided by Waiver Agencies, there was an average of 4 participants who did not receive any waiver services for longer than 30 days. This statewide figure is a decrease from last year’s average of 6 participants.
- Waiver Agencies continue to monitor delays and provide training to staff which has helped to reduce this average. Informal services are often provided during the absence of waiver services and are documented in the participant’s record.
- Common reasons for continued delays in waiver services include issues with Medicaid eligibility and delays with participants accepting their plans of care.

#### **5) Participant Outcomes**

Goal: Decrease the percent of participants with a prevalence of disruptive or intense daily pain. MDCH defines “disruptive or intense daily pain” as daily pain, severe or excruciating pain, or pain that disrupts usual activities.

- According to the figures provided by Waiver Agencies, there was an average of 22.61% of participants reporting daily intense and/or disruptive pain. This statewide figure is an increase from last year’s average of 16.95%.
- Waiver Agencies continue to provide enhanced education and coordination around pain management.

#### ***b. New Quality Improvement Goals for 2010 – 2011***

1) **Quality Indicators:** Add clinical quality indicators once interRAI develops the methodology for the new iHC assessment tool (formerly MDS-HC).

2011 Goal: Implement, measure, and report selected Quality Indicators.

- The developers of the i-HC recently provided the algorithms for quality indicators. Baseline data will be collected in 2011 and priority quality indicators will be selected. Full implementation will be delayed until 2012.

## 2) **Self Determination Option**

2011 Goal: Each waiver agent enrolls at least 10% of total MI Choice participants in the self-determination option.

- 16 of 18 Waiver Agents on the statewide system met or exceeded this goal.
- 10 of 18 Waiver Agents on the statewide system exceeded 15% enrollment of Self Determination participants.
- 20% of all MI Choice enrollees across the state were enrolled in Self Determination in FY 2011.
- Note: Two Waiver Agents currently do not have their data accessible in the statewide system, therefore their information has been omitted in these percentages.

## 3) **Nursing Facility Transition (NFT)**

2011 Goal: Each waiver agent must meet the NFT benchmarks provided to them by MDCH.

- Eight of Waiver Agents met this goal.
- The statewide benchmark for FY 2011 was 1,347. The FY 2011 total transitions were 1,281 with 1,098 enrolling in MI Choice and 89 enrolling in Adult Home Help. Eight Waiver Agents exceeded their agency benchmarks for transitions.

## 4) **Consumer Survey**

2011 Goal: MDCH will work with waiver agents and the Quality Management Collaboration Committee to develop a statewide consumer satisfaction and quality of life survey for MI Choice participants. This will include the development of a methodology for administering survey

- The Quality Management Collaboration Committee formed a Statewide Survey Workgroup who has created surveys for four separate events: Monthly Call, Quarterly Home Visit, Mail-in Survey and an Annual Survey. These surveys are currently being piloted by two waiver agencies. The local quality group for those agencies are working with the statewide QMC to enhance the questions on the surveys. Once the survey questions are complete, the electronic reporting system will be updated and the survey will be implemented statewide.

## 4) **Local Consumer, Provider, Waiver Agent Quality Collaborative Committees**

2011 Goal: Each Waiver Agent will establish a local Quality Collaborative Committee during 2010 or develop the Quality Collaborative role within an existing group.

- The Waiver Agencies have established their local Quality Collaborative Committees and have started meetings with them. Waiver Agencies are

conducting outreach to ensure they have strong consumer participation. The statewide Quality Collaborative Committees are exploring the possibilities of having one representative from each local committee sit on the statewide committee.

**MI Choice Waiver  
Quality Improvement Goals  
Summary Data  
FY 2011**

This table provides data on the first five quality improvement goals described in the MI Choice Quality Management Plan.

**MI Choice Waiver  
Quality Improvement Goals Summary Data  
from Waiver Agencies  
FY 2011**

<b>AGENCY</b>	<b>Average Days for First Service Delivery</b>	<b>Count of participants with no waiver services for &gt; 30 days</b>	<b>Percent of Provider No Shows</b>	<b>Percent of persons reporting daily intense and/or disruptive pain</b>	<b>Percent of missing assessment items on iHC</b>
A & D Home Health Care, Inc.	0.73	0	0.10%	24.92%	0.08%
Area Agency on Aging 1B	8.00	0	0.04%	20.70%	N/A
Area Agency on Aging of Northwest Michigan	2.39	3	0.01%	23.50%	0.14%
Area Agency on Aging of Western Michigan	1.06	2	0.01%	21.52%	0.09%
Detroit Area Agency on Aging	5.00	18	0.03%	22.48%	0.27%
HHS, Health Options	6.72	0	4.76%	23.00%	N/A
MORC Home Care, Inc.	2.15	3	2.50%	21.00%	0.04%
Northeast Mich Community Service Agency	3.44	1	0.09%	24.63%	0.11%
Northern Lakes Community Mental Health	1.56	0	0.27%	19.90%	0.01%
Region II Area Agency on Aging	6.02	11	1.00%	27.70%	0.12%
Region 3B Area Agency on Aging	3.69	4	0.30%	31.50%	0.00%
Region IV Area Agency on Aging	4.78	3	0.40%	21.00%	0.11%
Region VII Area Agency on Aging	2.03	0	0.10%	28.73%	0.01%
Senior Resources	8.78	25	6.50%	29.30%	0.11%
Senior Services	4.37	2	0.20%	17.70%	0.12%
The Information Center	0.62	0	0.09%	20.61%	0.04%
Tri-County Office on Aging	3.43	0	0.52%	23.42%	0.03%
The Senior Alliance	3.95	5	0.30%	15.03%	0.37%
UPCAP Care Management	4.75	0	0.70%	17.60%	0.20%
Valley Area Agency on Aging	3.22	0	0.20%	17.96%	2.00%
<b>STATEWIDE AVERAGE</b>	<b>3.83</b>	<b>4</b>	<b>0.91%</b>	<b>22.61%</b>	<b>0.12%</b>

N/A - Figures Not Available

**Critical Incident Summary Data  
FY 2011**

This table shows the number of critical incidents in each category for each waiver agent. The second column under each category represents the number of unresolved critical incidents. MDCH follows up on all critical incidents until they are resolved.

**MI CHOICE CRITICAL INCIDENTS  
FY 2011**

Agency	Illegal Activity in Home			Verbal Abuse			Theft			Worker Drugs /Alcohol			Exploitation			Physical Abuse			Neglect			No Show			Sexual Abuse			Suspicious Death			Total			APS Referral
	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %	Resolved	Unresolved	Unresolved %				
A & D Home Health Care, Inc.	2	3	60%	3	2	40%	22	4	18%	0	0	0%	3	2	40%	4	1	20%	1	1	50%	5	0	0%	1	1	50%	0	0	0%	41	14	25%	20
Area Agency on Aging 1B	3	0	0%	3	0	0%	12	0	0%	0	0	0%	3	0	0%	4	0	0%	4	1	20%	0	0	0%	1	0	0%	1	0	0%	31	1	3%	14
Area Agency on Aging of Northwest Michigan	1	0	0%	1	0	0%	8	0	0%	0	0	0%	1	0	0%	1	0	0%	1	0	0%	4	0	0%	0	0	0%	0	0	0%	17	0	0%	3
Area Agency on Aging of Western Michigan	0	0	0%	1	0	0%	5	1	17%	1	0	0%	4	0	0%	0	0	0%	2	0	0%	1	0	0%	0	0	0%	0	0	0%	14	1	7%	3
Detroit Area Agency on Aging	0	0	0%	0	0	0%	3	0	0%	0	0	0%	0	0	0%	1	0	0%	3	0	0%	2	0	0%	1	0	0%	0	0	0%	10	0	0%	3
HHS, Health Options	0	0	0%	0	0	0%	3	2	40%	0	0	0%	1	0	0%	0	0	0%	1	1	50%	6	0	0%	0	0	0%	0	0	0%	11	3	21%	1
MORC Home Care, Inc.	0	0	0%	0	0	0%	1	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%	1	0	0%	1
Northeast Mich Community Service Agency	0	0	0%	1	0	0%	3	0	0%	0	0	0%	0	0	0%	0	0	0%	1	0	0%	7	0	0%	0	0	0%	0	0	0%	12	0	0%	2
Northern Lakes Community Mental Health	0	0	0%	1	0	0%	7	2	22%	1	0	0%	0	0	0%	0	0	0%	1	0	0%	1	0	0%	0	0	0%	0	0	0%	11	2	15%	4
Region II Area Agency on Aging	1	0	0%	1	1	50%	6	0	0%	2	0	0%	3	2	40%	4	1	20%	2	0	0%	2	0	0%	0	0	0%	0	0	0%	21	4	19%	13
Region 3B Area Agency on Aging	2	0	0%	6	0	0%	4	0	0%	0	0	0%	5	0	0%	2	0	0%	20	1	5%	5	1	17%	0	0	0%	2	0	0%	46	2	4%	31
Region IV Area Agency on Aging	0	0	0%	3	0	0%	13	2	13%	1	0	0%	3	1	25%	3	0	0%	5	1	17%	3	0	0%	0	0	0%	0	0	0%	31	4	11%	20
Region VII Area Agency on Aging	5	0	0%	3	0	0%	18	1	5%	0	0	0%	3	0	0%	5	0	0%	4	0	0%	7	0	0%	1	0	0%	0	1	100%	46	2	4%	18
Senior Resources	0	0	0%	0	0	0%	0	0	0%	0	0	0%	1	1	0%	0	0	0%	1	0	0%	1	0	0%	0	0	0%	0	0	0%	3	1	25%	1
Senior Services	2	0	0%	0	0	0%	4	3	43%	0	0	0%	2	0	0%	0	0	0%	1	0	0%	1	0	0%	0	0	0%	1	0	0%	11	3	21%	3
The Information Center	0	0	0%	4	2	33%	3	1	25%	0	0	0%	4	1	20%	1	1	50%	12	3	20%	1	0	0%	0	0	0%	0	0	0%	25	8	24%	22
Tri-County Office on Aging	1	0	0%	2	0	0%	10	0	0%	0	0	0%	3	0	0%	0	0	0%	1	0	0%	0	0	0%	0	0	0%	0	0	0%	18	0	0%	4
The Senior Alliance	0	0	0%	0	0	0%	11	0	0%	0	0	0%	0	0	0%	1	0	0%	3	0	0%	5	0	0%	0	0	0%	2	0	0%	22	0	0%	5
UPCAP Care Management	0	0	0%	0	1	100%	2	0	0%	1	0	0%	0	0	0%	0	0	0%	1	0	0%	4	0	0%	0	0	0%	0	0	0%	8	1	11%	2
Valley Area Agency on Aging	0	0	0%	0	0	0%	3	1	25%	0	0	0%	0	0	0%	0	0	0%	0	0	0%	4	0	0%	0	0	0%	0	0	0%	7	1	13%	0
<b>Statewide Total</b>	<b>17</b>	<b>3</b>	<b>23%</b>	<b>29</b>	<b>6</b>	<b>5%</b>	<b>138</b>	<b>17</b>	<b>10%</b>	<b>6</b>	<b>0</b>	<b>20%</b>	<b>36</b>	<b>7</b>	<b>10%</b>	<b>26</b>	<b>3</b>	<b>11%</b>	<b>64</b>	<b>8</b>	<b>7%</b>	<b>59</b>	<b>1</b>	<b>0%</b>	<b>4</b>	<b>1</b>	<b>33%</b>	<b>7</b>	<b>1</b>	<b>33%</b>	<b>386</b>	<b>47</b>	<b>9%</b>	<b>37</b>

## **Administrative Quality Assurance Review FY 2010-2011**

The MI Choice Waiver Agents receive an Administrative Quality Assurance Review (AQAR) on a *bi-annual* schedule. The review involves a team of MDCH employees working on-site at the waiver agency reviewing policies, procedures, billing records and other documents in order to evaluate the agency infrastructure needed to administer the program and meet the performance standards defined in the Clinical Quality Assurance Reviews and other documents. The AQAR is based upon the nine focus areas identified in the Quality Management Plan:

- 1) Participant Access – Participants have ready access to home and community based care and supports in their community.
- 2) Participant-Centered Service Planning & Delivery – Services and supports are planned and implemented in accordance with participant needs, preferences and decisions.
- 3) Provider Capacity and Capabilities – There are sufficient qualified agency and individual providers.
- 4) Participant Safeguards – Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- 5) Participant Rights and Responsibilities – Participants receive support to exercise their rights and accept personal responsibilities.
- 6) Participant Outcomes and Satisfaction – Participants are satisfied with their services and achieve desired outcomes.
- 7) System Performance – The system supports participants effectively and efficiently and strives to improve quality.
- 8) Administration – The MI Choice program is administered efficiently and effectively to maximize Medicaid buying power while giving precedence to the participant's best interests.
- 9) Services - Participants receive the MI Choice waiver services most appropriate for their needs.

**ADMINISTRATIVE QUALITY ASSURANCE REVIEW  
FISCAL YEAR 2010-2011  
AVERAGE COMPLIANCE LEVEL**

<b>AGENCY</b>	<b>FOCUS I: Participant Access</b>	<b>FOCUS II: Participant- Centered Service Planning &amp; Delivery</b>	<b>FOCUS III: Provider Capacity and Capabilities</b>	<b>FOCUS IV: Participant Safeguards</b>	<b>FOCUS V: Participant Rights &amp; Responsibilities</b>	<b>FOCUS VI: Participant Outcomes &amp; Satisfaction</b>	<b>FOCUS VII: System Performance</b>	<b>FOCUS VIII: Administration</b>	<b>FOCUS IX: Services</b>	<b>OVERALL COMPLIANCE</b>
A & D Home Health Care, Inc.	4.00	4.00	4.00	3.25	4.00	4.00	2.52	4.00	4.00	<b>3.70</b>
Area Agency on Aging 1B	4.00	4.00	4.00	4.00	4.00	4.00	4.00	3.04	4.00	<b>3.76</b>
Area Agency on Aging of Northwest Michigan	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	<b>4.00</b>
Area Agency on Aging of Western Michigan	4.00	4.00	4.00	3.25	4.00	4.00	4.00	3.52	4.00	<b>3.80</b>
Detroit Area Agency on Aging	2.00	2.80	4.00	1.00	2.23	4.00	1.00	4.00	4.00	<b>2.74</b>
HHS, Health Options	4.00	4.00	4.00	4.00	3.23	4.00	4.00	4.00	1.00	<b>3.93</b>
MORC Home Care, Inc.	3.29	4.00	2.28	3.25	4.00	4.00	2.03	4.00	1.00	<b>3.19</b>
Northeast Mich Community Service Agency	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	<b>4.00</b>
Northern Lakes Community Mental Health	4.00	3.60	4.00	4.00	4.00	4.00	4.00	3.52	4.00	<b>3.85</b>
Region II Area Agency on Aging	2.71	2.40	4.00	1.75	4.00	4.00	2.45	4.00	4.00	<b>3.23</b>
Region 3B Area Agency on Aging	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	<b>4.00</b>
Region IV Area Agency on Aging	4.00	2.93	1.72	1.75	2.15	1.00	1.48	4.00	1.00	<b>2.69</b>
Region VII Area Agency on Aging	3.36	3.60	4.00	4.00	4.00	4.00	4.00	4.00	4.00	<b>3.88</b>
Senior Resources	4.00	3.60	4.00	3.25	3.38	4.00	3.48	3.00	4.00	<b>3.53</b>
Senior Services	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	<b>4.00</b>
The Information Center	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	<b>4.00</b>
Tri-County Office on Aging	4.00	4.00	4.00	3.25	4.00	4.00	4.00	4.00	4.00	<b>3.92</b>
The Senior Alliance	4.00	4.00	2.78	1.50	3.23	4.00	2.03	4.00	1.00	<b>3.15</b>
UPCAP Care Management	3.36	4.00	4.00	2.50	3.23	3.00	4.00	4.00	1.00	<b>3.66</b>
Valley Area Agency on Aging	4.00	4.00	4.00	2.50	4.00	4.00	1.00	4.00	4.00	<b>3.40</b>
<b>STATEWIDE AVERAGE</b>	<b>3.74</b>	<b>3.75</b>	<b>3.74</b>	<b>3.16</b>	<b>3.67</b>	<b>3.80</b>	<b>3.20</b>	<b>3.85</b>	<b>3.25</b>	<b>3.62</b>

**Rating Scale For Clinical Quality Assurance Review Compliance Level:**

<b>SUBSTANTIAL COMPLIANCE:</b>	3.26 to 4.00
<b>SOME COMPLIANCE, NEEDS IMPROVEMENT:</b>	2.51 to 3.25
<b>NOT FULL OR SUBSTANTIAL COMPLIANCE:</b>	1.76 to 2.50
<b>COMPLIANCE NOT DEMONSTRATED:</b>	1.00 to 1.75

**Clinical Quality Assurance Review  
FY 2010**

The Clinical Quality Assurance Reviews (CQARs) are conducted by a team of reviewers, most of whom have previously worked in the MI Choice program.

The CQAR Data in this report include results from record reviews and in-home visits.

**CLINICAL QUALITY ASSURANCE REVIEW  
FISCAL YEAR 2010  
AVERAGE COMPLIANCE LEVEL**

AGENCY	FOCUS I: Participant Access	FOCUS II A: Participant- Centered Service Planning	FOCUS II B: Participant- Centered Service Delivery	FOCUS III: Provider Capacity and Capabilities	FOCUS IV: Participant Safeguards	FOCUS V: Participant Rights & Responsibilities	FOCUS VI: Participant Outcomes & Satisfaction	FOCUS VII: System Performance	FOCUS VIII: Administration	FOCUS IX: Services	OVERALL COMPLIANCE
Detroit Area Agency on Aging	3.20	1.61	1.61	4.00	2.41	1.61	4.00	1.41	1.61	3.20	<b>2.69</b>
Area Agency on Aging 1B	3.15	3.15	1.50	4.00	2.31	3.15	4.00	1.46	2.31	4.00	<b>3.15</b>
The Senior Alliance	3.33	4.00	2.67	4.00	4.00	4.00	4.00	1.67	2.00	3.33	<b>3.51</b>
Region II Area Agency on Aging	2.45	3.23	1.68	4.00	2.45	1.68	4.00	1.45	2.45	3.23	<b>2.82</b>
Region 3B Area Agency on Aging	4.00	4.00	2.37	4.00	4.00	4.00	4.00	3.81	1.56	4.00	<b>3.79</b>
Region IV Area Agency on Aging	4.00	3.17	2.34	4.00	4.00	4.00	4.00	1.52	4.00	4.00	<b>3.69</b>
Valley Area Agency on Aging	4.00	4.00	1.79	4.00	4.00	4.00	4.00	1.00	4.00	4.00	<b>3.66</b>
Tri-County Office on Aging	1.60	2.40	1.60	4.00	2.40	4.00	4.00	1.60	3.20	3.20	<b>2.84</b>
Region VII Area Agency on Aging	4.00	4.00	1.60	4.00	4.00	3.20	4.00	1.40	1.60	4.00	<b>3.59</b>
Area Agency on Aging of Western Michigan	4.00	4.00	2.38	4.00	4.00	4.00	4.00	2.38	4.00	4.00	<b>3.80</b>
Northeast Michigan Community Service Agency, Inc.	4.00	4.00	1.83	4.00	4.00	4.00	4.00	1.83	1.83	4.00	<b>3.66</b>
Area Agency on Aging of Northwest Michigan	4.00	4.00	2.00	4.00	4.00	4.00	4.00	2.00	4.00	4.00	<b>3.70</b>
UPCAP	4.00	3.20	1.60	4.00	2.40	3.20	4.00	1.40	1.60	4.00	<b>3.19</b>
Senior Resources	3.21	3.21	1.63	4.00	4.00	3.21	4.00	2.42	1.63	3.21	<b>3.33</b>
HHS, Health Options	2.38	3.19	1.58	4.00	3.19	3.19	4.00	1.38	1.58	4.00	<b>3.19</b>
The Information Center	4.00	3.33	2.00	4.00	3.33	3.33	4.00	1.67	2.00	4.00	<b>3.34</b>
MORC Home Care, Inc.	1.79	2.53	1.53	4.00	1.53	1.79	4.00	1.00	4.00	2.53	<b>2.26</b>
Senior Services	4.00	3.33	2.00	4.00	4.00	4.00	4.00	2.33	4.00	3.33	<b>3.48</b>
A & D Home Health Care, Inc.	4.00	4.00	2.42	4.00	4.00	4.00	4.00	1.42	4.00	3.21	<b>3.63</b>
Northern Lakes Community Mental Health	4.00	2.67	2.00	4.00	4.00	2.00	4.00	2.00	2.00	2.67	<b>3.05</b>
<b>STATEWIDE AVERAGE</b>	<b>3.46</b>	<b>3.35</b>	<b>1.91</b>	<b>4.00</b>	<b>3.40</b>	<b>3.32</b>	<b>4.00</b>	<b>1.76</b>	<b>2.67</b>	<b>3.60</b>	<b>3.32</b>

**Rating Scale For Clinical Quality Assurance Review Compliance Level:**

<b>SUBSTANTIAL COMPLIANCE:</b>	3.5 or higher
<b>SOME COMPLIANCE, NEEDS IMPROVEMENT:</b>	2.5 to 3.4
<b>NOT FULL OR SUBSTANTIAL COMPLIANCE:</b>	1.5 to 2.4
<b>COMPLIANCE NOT DEMONSTRATED:</b>	0 to 1.4

**Acronyms for the Statewide Waiver Agencies**

## Acronyms for the Statewide Waiver Agencies

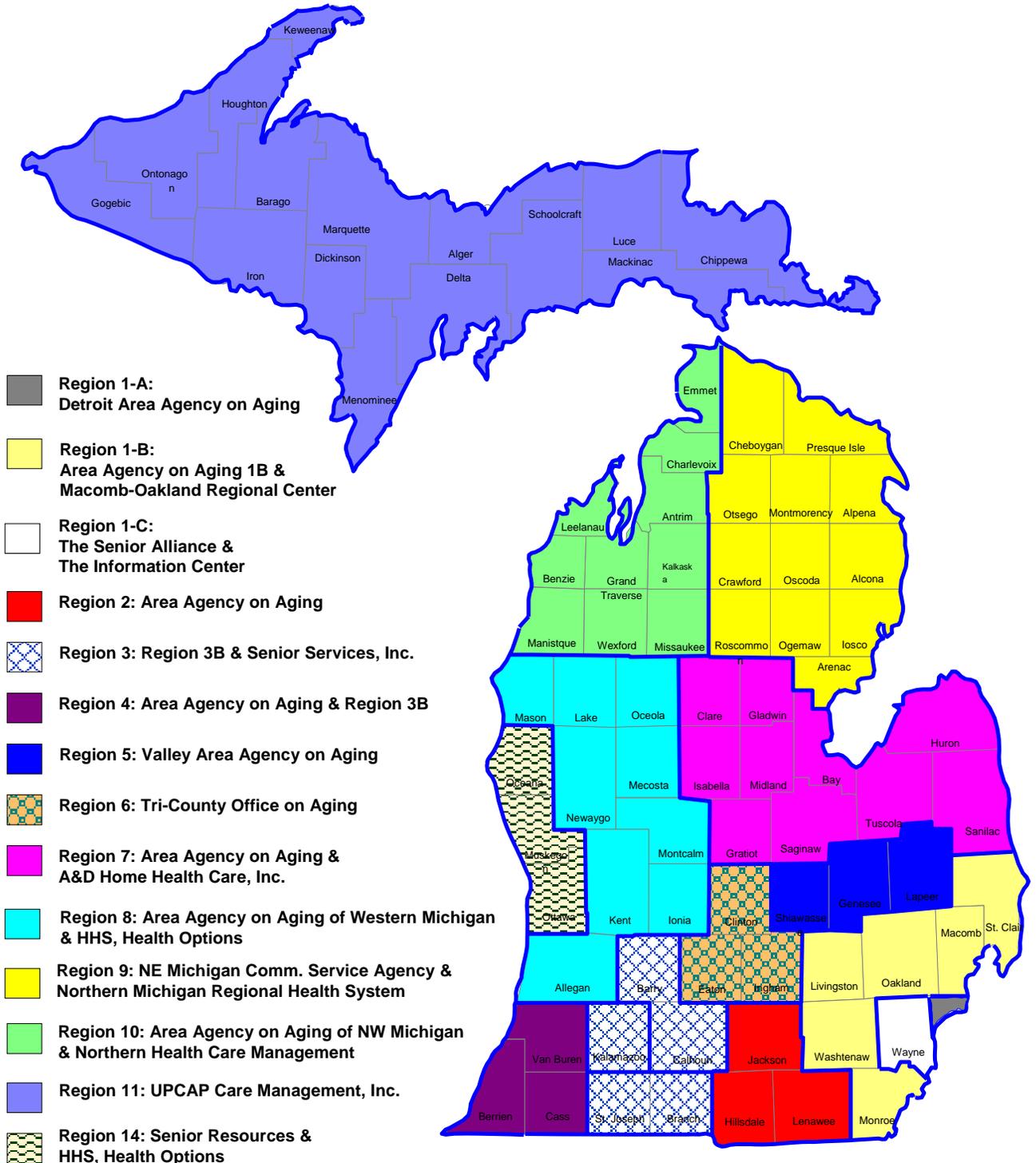
<b>Agency</b>	<b>Full Name</b>	<b>Location</b>
DAAA	Detroit Area Agency on Aging	Detroit
AAA1B	Area Agency on Aging 1B	Southfield
MORC	MORC Home Care, Inc	Clinton Township
TSA	The Senior Alliance	Wayne
TIC	The Information Center	Taylor
R2AAA	Region 2 Area Agency on Aging	Brooklyn
3B	Burnham Brook Center	Battle Creek
S. Services	Senior Services, Inc	Kalamazoo
R IV AAA	Region IV Area Agency on Aging	Saint Joseph
VAAA	Valley Area Agency on Aging	Flint
TCOA	Tri-County Office on Aging	Lansing
R VII AAA	Region VII Area Agency on Aging	Bay City
A & D	A&D Home Health Care, Inc.	Saginaw
AAAWM	Area Agency on Aging of Western Michigan	Grand Rapids
HHS	HHS, Health Options	Grand Rapids
NEMCSA	Northeast MI Community Service Agency	Alpena
NMRHS	Northern Michigan Regional Health System	Petoskey
AAANM	Area Agency on Aging of Northwest Michigan	Traverse City
NLCMH	Northern Lakes Community Mental Health	Traverse City
UPCAP	UP Area Agency on Aging	Escanaba
S. Resources	Senior Resources	Muskegon Heights

**MI Choice Home & Community-Based Services Waiver  
for the Elderly & Disabled  
Regional Service Area Map**

# Michigan Department of Community Health

## Home & Community-Based Services Waiver for the Elderly & Disabled

### Regional Service Areas



## **Glossary of Acronyms and Terms**

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**AAAs** – Area Agencies on aging. Planning, advocacy, and administrative agencies that plan and provide needed services to seniors in specified geographic regions of the state.

**Administrative Quality Assurance Review (AQAR)** – Focuses on assuring that each Waiver agent has policies and procedures consistent with waiver requirements. MDCH staff review waiver policy and procedures manuals, peer review reports, client satisfaction survey results, critical incident reports, quality management plans, waiver agent provider monitoring reports, waiver agent provider contract templates, and required provider licenses to verify that requirements are met.

**Clinical Quality Assurance Review (CQAR)** – This review include interviews with waiver agent staff and MI Choice participants in their homes. The overall purpose of this review is to determine, based on written case record documentation and discussion with supports coordinators, whether or not each participant’s health and welfare are being protected during the implementation and delivery of services and supports.

**CMS** – Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

**Consumer/Participant** – Individual receiving services through the Waiver, also called beneficiary, client, participant.

**Critical Incidents** – CMS requires a formal plan, developed and implemented by the state, to define, identify, investigate, and resolve incidents, events, or occurrences that jeopardize the health and welfare of a participant.

**FY** – Fiscal Year

**HCBS** – Home and Community-Based Services

**HIPAA** – Health Insurance Portability and Accountability Act of 1996 – Federal rules regarding health care transactions, code sets and protection of confidential data.

**InterRAI** – International organization of researchers and clinicians who developed the Resident Assessment Instrument that includes the minimum data set (MDS) that CMS mandates be used to assess residents in every nursing facility in the United States.

**MDCH** – Michigan Department of Community Health

**MDRC** – Michigan Disability Rights Coalition

**MDS-HC** – Minimum Data Set for Home Care

**MDS-NF** – Minimum Data Set for Nursing Facilities

**Money Follows Person (MFP)** - A grant from the Centers for Medicare and Medicaid Services (CMS) to provide seniors and adults with disabilities the opportunity to transition from a nursing facility (NF) into their own home or apartment.

**Nursing Facility Transition** – This service is a non-recurring expense for a person who is transitioning from a nursing facility to another living arrangement in a private residence where a person is responsible for his or her own living arrangement.

**OHCDS** - Organized Health Care Delivery Systems – Organizations that perform waiver activities directly function as organized health care delivery systems and carry out their responsibilities in compliance with MDCH approved requirements for operation of an OHCDS.

**Participant** – A person enrolled in the MI Choice Home and Community Based Medicaid Waiver Program for Elderly and Younger Persons with Disabilities.

**Person Centered Planning** – means a process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honors the individual’s preferences, choices and abilities.

**Quality Assurance (QA)** - Quality assurance is a planned effort designed to organize and operate the program to meet contractual obligations in accordance with federal, state, local laws, regulations, and standards.

**Quality Management Collaboration** – Waiver agents, consumers/advocates and MDCH seek solutions together with guidance from researchers and subject area experts in the MI Choice Person Focused QM Collaboration as a way to identify effective strategies and interventions to improve quality of care in Michigan.

**Quality Improvement (QI)** - Quality improvement goes beyond compliance activities to measure the impact that services and supports have on participant outcomes. The focus of quality improvement is desired outcomes for Participant.

**Quality Indicators (QIs)** – Performance measures that gauge quality by examining the structure, process and participant outcomes of services and supports.

**Quality Management (QM)**- Quality management is a planned effort designed to improve and maximize the degree to which services and supports achieve desired participant outcomes while meeting state and federal government assurances, requirements and laws.

## GLOSSARY OF ACRONYMS AND TERMS

**Self Determination** – It is a consumer directed care that integrates and maximizes consumer choice and control into all aspects of home and community-based care.

**Special Memorandum of Understanding (SMOU)** - A Special Memorandum of Understanding between MDCH and the Contractor for participants with complex medical acuity who require extensive MI Choice services.

**Support Coordination (SC)** - The method that facilitates access to and arrangement of services and other forms of support needed and wanted by MI Choice participants.

**Support Coordinators (SCs)** - SCs work with participants to determine how and who will meet the participant's long term care needs. SCs assist participants in arranging for services and supports and monitor the quality of services received.

**Waiver** – Federal Government allows or grants States permission to waive certain Federal requirements in order to operate a specific kind of program. (Example: MI Choice Home and Community Based Services Waiver for the Elderly and Disabled).

**Waiver Agent** – An administrative local agency that contracts directly with MDCH for the purpose of organizing a network of long term care services and supports to deliver MI Choice Waiver services.