

REPORT ON QUALITY ASSURANCE INDICATORS, QUALITY IMPROVEMENT PLANS, AND DATA COLLECTED ON CRITICAL INCIDENTS FOR THE HOME-AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

(FY2009 Appropriation Bill - Public Act 246 of 2008)

April 1, 2009

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.

*Michigan Department
of Community Health*



Jennifer M. Granholm, Governor
Janet Olszewski, Director

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1. Introduction

STATUS REPORT ON MI CHOICE WAIVER PROGRAM

Report of Quality Assurances, Improvements and Critical Incidents for FY 08

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) 2008. 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 Senate Bill No. 1094. Reports provided include a summation of aggregated data collected for quality assurance indicators, quality management plans, critical incidents, and the resolution data for critical incidents.

Michigan developed its strategy to address quality management with meaningful contributions from consumers, advocates and caregivers who participate in the Quality Collaboration Group created in 2003. Meeting minutes from the FY 2008 are available upon request.

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 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. A Summary of the Statewide MDS-HC Quality Indicators for July 2008 through September 2008 and Statewide Quarterly Quality Indicator Summary Reports for the period of 10/1/2007 to 9/30/2008 are attached.
- 2) **Waiver Agent's Plan:** Each waiver agent provided a Quality Management summary to the state on January 15, 2009. The requested information included; reporting of all required assurances and improvements, and quality indicators. Quality Management Summary Data from the waiver agent plans for the year 2008 is attached.

C. Clinical Quality Assurance Reviews (CQAR)

MDCH continued to contract with the University of Michigan, School of Nursing for review of care plan authorizations and case record reviews utilizing Registered Nurses. In September, 2008 the University of Michigan review team completed a two-year review for FY 06 and FY 07.

The University of Michigan, School of Nursing, chose not to continue to contract with the state for this process. MDCH has developed its own review process and expects full implementation of this process to occur in FY 2010. A statewide Clinical Quality Assurance Review data for the Year 2006 and Year 2007 and a statewide Home Visit Review Data for Year 2007 are attached.

D. Critical Incident Management

MDCH continued to require the reporting of Critical Incidents for FY 08. Adjustments to reporting requirements including the monitoring and reporting of self-neglect. MDCH requires waiver agents to report Critical Incidents twice a year on January 15 and July 15. A Statewide Critical Incident and Resolution Report Data for Year 2008 is attached.

2. Summary of the Statewide MDS-HC Quality Indicators
For
July 2008 to September 2008

MDS-HC Quality Indicators	State Average	DAA	AAA 1B	MORC	TSA	TIC	R2 AAA 3B	Senior Services AAA	RVV	VAAA	TCAA	RVII AAA A & D	AAA NM	NEMCSA	NIMRHS	AAA NM	NLCMH	UPCAP	Senior Resources	
NUTRITION																				
Prevalence of inadequate meals	1.8%	2.5%	1.5%	1.5%	2.0%	2.6%	2.2%	3.4%	2.5%	3.2%	3.6%	2.2%	0.3%	3.7%	4.8%	2.6%	5.4%	1.0%	0.9%	
Prevalence of weight loss	4.1%	4.4%	6.4%	2.7%	6.2%	6.9%	3.5%	5.2%	4.5%	5.2%	4.8%	3.2%	1.4%	8.8%	2.2%	1.3%	1.6%	5.5%	4.7%	
Prevalence of dehydration	0.9%	1.3%	1.1%	1.9%	N/R	1.7%	0.6%	1.7%	0.6%	0.3%	2.6%	1.6%		0.5%	2.7%	0.6%		1.2%	0.4%	
MEDICATION																				
Prevalence of not receiving a medication by a physician	1.1%	2.7%	0.9%	0.8%	1.1%	0.8%	0.6%	0.3%	0.6%	0.7%	1.3%	1.0%	1.7%	0.6%	1.3%	1.3%		1.7%	0.2%	
INCONTINENCE																				
Failure to improve/incidence of bladder incontinence	56.6%	56.5%	56.5%	62.8%	59.9%	61.4%	57.0%	62.4%	58.6%	59.1%	50.9%	54.7%	57.0%	45.3%	57.7%	56.7%		58.0%	59.2%	
ULCERS																				
Failure to improve/incidence of skin ulcers	7.7%	7.2%	7.6%	5.6%	5.9%	9.6%	11.2%	8.9%	10.3%	10.1%	9.8%	15.3%	10.0%	7.2%	5.1%	11.3%	7.5%	9.1%	6.2%	
PHYSICAL FUNCTION																				
among clients with difficulty in locomotion	5.2%	4.4%	6.4%	3.6%	1.3%	4.0%	5.0%	3.8%	4.0%	0.9%	6.9%	7.0%	7.1%	1.8%	18.2%	4.4%	12.3%	4.4%	1.2%	
Prevalence of ADL/rehabilitation potential and no therapies	72.1%	66.9%	68.0%	82.7%	77.8%	68.6%	83.2%	76.9%	68.4%	78.0%	71.4%	56.7%	69.6%	84.3%	84.6%	56.6%	80.0%	70.7%	72.3%	
Failure to improve/incidence of decline on ADL form	69.7%	63.1%	63.5%	93.5%	68.1%	78.1%	78.4%	79.2%	73.4%	64.9%	60.3%	87.5%	70.5%	86.9%	82.7%	75.2%	63.2%	76.0%	81.0%	
Failure to improve/incidence of impaired locomotion in the home	43.1%	63.4%	44.0%	85.4%	38.8%	44.7%	46.2%	48.8%	46.8%	40.1%	43.6%	55.3%	47.7%	57.4%	25.0%	44.3%	44.1%	45.9%	55.0%	
Prevalence of falls	27.7%	23.2%	23.1%	32.8%	21.4%	22.9%	28.1%	36.3%	30.6%	29.6%	27.8%	31.6%	31.0%	27.2%	28.4%	34.2%	32.0%	36.4%	34.8%	
COGNITIVE FUNCTION																				
Prevalence of social isolation with cognitive decline	18.7%	15.9%	21.6%	29.0%	17.9%	25.4%	24.8%	16.1%	17.3%	26.1%	15.3%	23.9%	3.4%	7.1%	18.1%	22.9%	22.5%	18.9%	26.9%	
Prevalence of delirium	61.4%	61.6%	61.7%	69.9%	69.9%	75.2%	79.0%	62.2%	85.6%	67.3%	65.3%	67.2%	51.0%	55.6%	60.9%	61.9%	82.2%	62.5%	64.7%	
Prevalence of negative mood	3.9%	4.0%	5.0%	1.2%	3.6%	9.3%	6.8%	5.1%	1.8%	3.8%	3.6%	3.2%	4.4%	2.2%	1.2%	2.6%	5.4%	4.2%	3.3%	
Failure to improve/incidence of difficulty in communication	11.4%	5.5%	12.4%	28.6%	10.2%	16.1%	19.5%	13.0%	11.1%	14.0%	12.9%	11.2%	6.0%	5.7%	9.6%	14.6%	26.4%	13.0%	19.3%	
PAIN																				
Prevalence of disruptive or intense daily pain	34.5%	32.3%	37.1%	26.0%	26.7%	36.8%	55.4%	43.4%	60.0%	25.4%	33.3%	37.8%	28.2%	19.3%	15.4%	35.3%	60.0%	38.1%	32.2%	
SAFETY ENVIRONMENT																				
Prevalence of neglect/abuse	38.1%	32.1%	43.2%	56.6%	37.3%	49.4%	46.0%	49.3%	47.8%	52.4%	22.4%	33.0%	33.8%	7.9%	62.3%	40.0%	38.9%	48.4%	42.8%	
Prevalence of any injuries	3.0%	1.8%	8.5%	1.2%	2.0%	4.2%	3.1%	0.8%	3.7%	1.0%	1.8%	6.4%	1.0%	0.3%	3.6%	0.6%	2.3%	2.5%	5.9%	
OTHER																				
Prevalence of hospitalization	12.8%	8.3%	12.5%	6.9%	16.3%	18.6%	17.1%	11.3%	8.0%	17.2%	15.9%	20.1%	7.4%	9.2%	8.4%	10.8%	13.2%	11.3%	19.8%	
	27.7%	29.2%	30.5%	17.2%	31.6%	27.1%	28.9%	31.9%	34.0%	29.9%	36.2%	26.8%	31.2%	24.5%	27.7%	25.0%	22.5%	27.2%	29.8%	

3. Statewide Quarterly Quality Indicators Summary Reports
For
October 2007 to September 2008

WISP - Quality Indicators

QI Summary Report

Agent: STATEWIDE
 Reporting Period (required): OCT-2007 through DEC-2007
 Current Client Type: All
 Current Waiver Eligibility: All
 Current County: All
 Current CMI Initials: All
 Current CM2 Initials: All

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
NUTRITION				
<i>Prevalence of inadequate meals</i>				
N: Clients who ate 1 or fewer meals in 4 of the last 7 days	170	8314	2.0 %	1.8 %
D: All clients				
<i>Prevalence of weight loss</i>				
N: Clients with unintended weight loss	311	8148	3.8 %	4.1 %
D: All clients, excluding clients with end-stage disease on initial assessment				
<i>Prevalence of dehydration</i>				
N: Insufficient fluid intake	81	8289	1.0 %	0.9 %
D: All clients				
MEDICATION				
<i>Prevalence of not receiving a medication review by a physician</i>				
N: Number of clients whose medications have not been reviewed by a physician within the last 180 days	83	8131	1.0 %	1.1 %
D: Clients who are taking at least two medications				
INCONTINENCE				
<i>Failure to improve/Incidence of bladder incontinence</i>				
N: Clients who have experienced a decline in bladder continence between previous and most recent assessment	4402	7814	56.3 %	56.5 %
-OR- Clients who have developed a new bladder continence problem				
D: All clients with at least one reassessment				
ULCERS				
<i>Failure to improve/Incidence of skin ulcers</i>				
N: Clients with an ulcer on previous assessment who did not improve -OR- Clients with a new ulcer on follow-up	612	7776	7.9 %	7.7 %
D: All clients with at least one reassessment				
PHYSICAL FUNCTION				
<i>Prevalence of no assistive device among clients with difficulty in locomotion</i>				
N: Clients with impaired locomotion who are not using an assistive device	160	3523	4.5 %	5.2 %
D: All clients with impaired locomotion on most recent assessment (excludes clients for whom indoor locomotion did not occur)				
<i>Prevalence of ADL/rehabilitation potential and no therapies</i>				
N: Clients are not receiving OT, PT or exercise therapy	2689	3666	73.4 %	72.1 %
D: Clients who trigger the CAP for ADL/rehab potential				
<i>Failure to improve/Incidence of decline on ADL long form</i>				
N: Clients with some impairment on ADL long form who failed to improve between previous and most recent	5371	7682	69.9 %	69.7 %

*(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 clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
assessment -OR- Clients who have a new ADL impairment based on ADL long form D: All clients with at least one reassessment who are not palliative on initial assessment				
Failure to improve/Incidence of impaired locomotion in the home				
N: Clients who fail to improve in locomotion in the home -OR- Clients who have a new impairment in locomotion in the home D: All clients with at least one reassessment who are not palliative on initial assessment	3380	7738	43.7 %	43.1 %
Prevalence of falls				
N: The number of clients who record a fall on follow-up assessment D: All clients not completely dependent in bed mobility on previous assessment	1980	7778	25.5 %	27.7 %
COGNITIVE FUNCTION				
Prevalence of social isolation with distress				
N: Clients who are alone for long periods of time or always AND they also report feeling lonely -OR- Clients who are distressed by declining social activity D: All clients	1572	8341	18.8 %	18.7 %
Failure to improve/Incidence of cognitive decline				
N: Clients who have experienced a decline in cognitive performance between previous and most recent assessment -OR- Clients who experience new cognitive impairment D: All clients with at least one reassessment	4281	6992	61.2 %	61.4 %
Prevalence of delirium				
N: Clients with sudden or new onset/change in mental function -OR- Clients who have become agitated or disoriented such that his or her safety is endangered or client requires protection by others D: All clients	311	8309	3.7 %	3.9 %
Prevalence of negative mood				
N: Any client with sad mood on most recent assessment - AND- At least 2 symptoms of functional depression are exhibited up to five days a week or daily or almost daily D: All clients	891	8335	10.7 %	11.4 %
Failure to improve/Incidence of difficulty in communication				
N: Clients with both failure to improve in communication/making self understood and failure to improve in ability to understand others -OR- Clients with new difficulties in making self understood or understanding others D: All clients with at least one reassessment	2769	7850	35.3 %	34.5 %
PAIN				
Prevalence of disruptive or intense daily pain				
N: Clients who experience pain at least daily and pain is unusually intense -OR- pain intensity disrupts usual activities D: All clients	2242	6081	36.9 %	38.1 %
SAFETY/ENVIRONMENT				

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** Statewide% = All clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
<i>Prevalence of neglect/abuse</i>				
N: Clients who have unexplained injuries, have been abused or neglected	248	8277	3.0 %	3.0 %
D: All clients				
<i>Prevalence of any injuries</i>				
N: Clients with fractures or unexplained injuries	1155	8345	13.8 %	12.8 %
D: All clients				
OTHER				
<i>Prevalence of hospitalization</i>				
N: Clients who have been hospitalized, visited hospital emergency department or received emergent care since last assessment	2126	8242	25.8 %	27.7 %
D: All clients				

**(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 clients, all eligibilities for the last quarter of the FY.*

WISP - Quality Indicators

QI Summary Report

Agent: STATEWIDE
 Reporting Period (required): JAN-2008 through MAR-2008
 Current Client Type: All
 Current Waiver Eligibility: All
 Current County: All
 Current CM1 Initials: All
 Current CM2 Initials: All

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
NUTRITION				
<i>Prevalence of inadequate meals</i>				
N: Clients who ate 1 or fewer meals in 4 of the last 7 days	154	8063	1.9 %	1.8 %
D: All clients				
<i>Prevalence of weight loss</i>				
N: Clients with unintended weight loss	285	7898	3.6 %	4.1 %
D: All clients, excluding clients with end-stage disease on initial assessment				
<i>Prevalence of dehydration</i>				
N: Insufficient fluid intake	76	8040	1.0 %	0.9 %
D: All clients				
MEDICATION				
<i>Prevalence of not receiving a medication review by a physician</i>				
N: Number of clients whose medications have not been reviewed by a physician within the last 180 days	89	7922	1.1 %	1.1 %
D: Clients who are taking at least two medications				
INCONTINENCE				
<i>Failure to improve/Incidence of bladder incontinence</i>				
N: Clients who have experienced a decline in bladder continence between previous and most recent assessment	4223	7600	55.6 %	56.5 %
-OR- Clients who have developed a new bladder continence problem				
D: All clients with at least one reassessment				
ULCERS				
<i>Failure to improve/Incidence of skin ulcers</i>				
N: Clients with an ulcer on previous assessment who did not improve -OR- Clients with a new ulcer on follow-up	599	7541	7.9 %	7.7 %
D: All clients with at least one reassessment				
PHYSICAL FUNCTION				
<i>Prevalence of no assistive device among clients with difficulty in locomotion</i>				
N: Clients with impaired locomotion who are not using an assistive device	164	3345	4.9 %	5.2 %
D: All clients with impaired locomotion on most recent assessment (excludes clients for whom indoor locomotion did not occur)				
<i>Prevalence of ADL/rehabilitation potential and no therapies</i>				
N: Clients are not receiving OT, PT or exercise therapy	2637	3590	73.4 %	72.1 %
D: Clients who trigger the CAP for ADL/rehab potential				
<i>Failure to improve/Incidence of decline on ADL long form</i>				
N: Clients with some impairment on ADL long form who failed to improve between previous and most recent	5200	7464	69.7 %	69.7 %

*(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 clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
assessment -OR- Clients who have a new ADL impairment based on ADL long form D: All clients with at least one reassessment who are not palliative on initial assessment				
Failure to improve/Incidence of impaired locomotion in the home N: Clients who fail to improve in locomotion in the home -OR- Clients who have a new impairment in locomotion in the home D: All clients with at least one reassessment who are not palliative on initial assessment	3210	7516	42.7 %	43.1 %
Prevalence of falls N: The number of clients who record a fall on follow-up assessment D: All clients not completely dependent in bed mobility on previous assessment	1995	7563	26.4 %	27.7 %
COGNITIVE FUNCTION				
Prevalence of social isolation with distress N: Clients who are alone for long periods of time or always AND they also report feeling lonely -OR- Clients who are distressed by declining social activity D: All clients	1530	8104	18.9 %	18.7 %
Failure to improve/Incidence of cognitive decline N: Clients who have experienced a decline in cognitive performance between previous and most recent assessment -OR- Clients who experience new cognitive impairment D: All clients with at least one reassessment	4238	6895	61.5 %	61.4 %
Prevalence of delirium N: Clients with sudden or new onset/change in mental function -OR- Clients who have become agitated or disoriented such that his or her safety is endangered or client requires protection by others D: All clients	295	8062	3.7 %	3.9 %
Prevalence of negative mood N: Any client with sad mood on most recent assessment - AND- At least 2 symptoms of functional depression are exhibited up to five days a week or daily or almost daily D: All clients.	859	8090	10.6 %	11.4 %
Failure to improve/Incidence of difficulty in communication N: Clients with both failure to improve in communication/making self understood and failure to improve in ability to understand others -OR- Clients with new difficulties in making self understood or understanding others D: All clients with at least one reassessment	2688	7629	35.2 %	34.5 %
PAIN				
Prevalence of disruptive or intense daily pain N: Clients who experience pain at least daily and pain is unusually intense -OR- pain intensity disrupts usual activities D: All clients	2239	6014	37.2 %	38.1 %
SAFETY/ENVIRONMENT				

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** Statewide% = All clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
<i>Prevalence of neglect/abuse</i>				
N: Clients who have unexplained injuries, have been abused or neglected	239	8044	3.0 %	3.0 %
D: All clients				
<i>Prevalence of any injuries</i>				
N: Clients with fractures or unexplained injuries	1095	8104	13.5 %	12.8 %
D: All clients				
OTHER				
<i>Prevalence of hospitalization</i>				
N: Clients who have been hospitalized, visited hospital emergency department or received emergent care since last assessment	2163	8030	26.9 %	27.7 %
D: All clients				

*(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 clients, all eligibilities for the last quarter of the FY.

WISP - Quality Indicators

QI Summary Report

Agent: STATEWIDE
 Reporting Period (required): APR-2008 through JUN-2008
 Current Client Type: All
 Current Waiver Eligibility: All
 Current County: All
 Current CM1 Initials: All
 Current CM2 Initials: All

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
NUTRITION				
<i>Prevalence of inadequate meals</i>				
N: Clients who ate 1 or fewer meals in 4 of the last 7 days	147	8046	1.8 %	1.8 %
D: All clients				
<i>Prevalence of weight loss</i>				
N: Clients with unintended weight loss	300	7869	3.8 %	4.1 %
D: All clients, excluding clients with end-stage disease on initial assessment				
<i>Prevalence of dehydration</i>				
N: Insufficient fluid intake	73	8023	0.9 %	0.9 %
D: All clients				
MEDICATION				
<i>Prevalence of not receiving a medication review by a physician</i>				
N: Number of clients whose medications have not been reviewed by a physician within the last 180 days	100	7890	1.3 %	1.1 %
D: Clients who are taking at least two medications				
INCONTINENCE				
<i>Failure to improve/Incidence of bladder incontinence</i>				
N: Clients who have experienced a decline in bladder continence between previous and most recent assessment	4294	7564	56.8 %	56.5 %
-OR- Clients who have developed a new bladder continence problem				
D: All clients with at least one reassessment				
ULCERS				
<i>Failure to improve/Incidence of skin ulcers</i>				
N: Clients with an ulcer on previous assessment who did not improve -OR- Clients with a new ulcer on follow-up	585	7474	7.8 %	7.7 %
D: All clients with at least one reassessment				
PHYSICAL FUNCTION				
<i>Prevalence of no assistive device among clients with difficulty in locomotion</i>				
N: Clients with impaired locomotion who are not using an assistive device	180	3446	5.2 %	5.2 %
D: All clients with impaired locomotion on most recent assessment (excludes clients for whom indoor locomotion did not occur)				
<i>Prevalence of ADL/rehabilitation potential and no therapies</i>				
N: Clients are not receiving OT, PT or exercise therapy	2599	3606	72.1 %	72.1 %
D: Clients who trigger the CAP for ADL/rehab potential				
<i>Failure to improve/Incidence of decline on ADL long form</i>				
N: Clients with some impairment on ADL long form who failed to improve between previous and most recent	5197	7443	69.8 %	69.7 %

*(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 clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
assessment -OR- Clients who have a new ADL impairment based on ADL long form D: All clients with at least one reassessment who are not palliative on initial assessment				
Failure to improve/Incidence of impaired locomotion in the home				
N: Clients who fail to improve in locomotion in the home -OR- Clients who have a new impairment in locomotion in the home D: All clients with at least one reassessment who are not palliative on initial assessment	3264	7496	43.5 %	43.1 %
Prevalence of falls				
N: The number of clients who record a fall on follow-up assessment D: All clients not completely dependent in bed mobility on previous assessment	1987	7546	26.3 %	27.7 %
COGNITIVE FUNCTION				
Prevalence of social isolation with distress				
N: Clients who are alone for long periods of time or always AND they also report feeling lonely -OR- Clients who are distressed by declining social activity D: All clients	1483	8075	18.4 %	18.7 %
Failure to improve/Incidence of cognitive decline				
N: Clients who have experienced a decline in cognitive performance between previous and most recent assessment -OR- Clients who experience new cognitive impairment D: All clients with at least one reassessment	4173	6718	62.1 %	61.4 %
Prevalence of delirium				
N: Clients with sudden or new onset/change in mental function -OR- Clients who have become agitated or disoriented such that his or her safety is endangered or client requires protection by others D: All clients	294	8047	3.6 %	3.9 %
Prevalence of negative mood				
N: Any client with sad mood on most recent assessment - AND- At least 2 symptoms of functional depression are exhibited up to five days a week or daily or almost daily D: All clients	903	8072	11.2 %	11.4 %
Failure to improve/Incidence of difficulty in communication				
N: Clients with both failure to improve in communication/making self understood and failure to improve in ability to understand others -OR- Clients with new difficulties in making self understood or understanding others D: All clients with at least one reassessment	2711	7602	35.7 %	34.5 %
PAIN				
Prevalence of disruptive or intense daily pain				
N: Clients who experience pain at least daily and pain is unusually intense -OR- pain intensity disrupts usual activities D: All clients	2283	5965	38.3 %	38.1 %
SAFETY/ENVIRONMENT				

*(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 clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
<i>Prevalence of neglect/abuse</i>				
N: Clients who have unexplained injuries, have been abused or neglected	259	8039	3.2 %	3.0 %
D: All clients				
<i>Prevalence of any injuries</i>				
N: Clients with fractures or unexplained injuries	1066	8074	13.2 %	12.8 %
D: All clients				
OTHER				
<i>Prevalence of hospitalization</i>				
N: Clients who have been hospitalized, visited hospital emergency department or received emergent care since last assessment	2230	7999	27.9 %	27.7 %
D: All clients				

**(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 clients, all eligibilities for the last quarter of the FY.*

WISP - Quality Indicators

QI Summary Report

Agent: STATEWIDE
 Reporting Period (required): JUL-2008 through SEP-2008
 Current Client Type: All
 Current Waiver Eligibility: All
 Current County: All
 Current CM1 Initials: All
 Current CM2 Initials: All

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
NUTRITION				
<i>Prevalence of inadequate meals</i>				
N: Clients who ate 1 or fewer meals in 4 of the last 7 days	144	7748	1.9 %	1.8 %
D: All clients				
<i>Prevalence of weight loss</i>				
N: Clients with unintended weight loss	313	7604	4.1 %	4.1 %
D: All clients, excluding clients with end-stage disease on initial assessment				
<i>Prevalence of dehydration</i>				
N: Insufficient fluid intake	70	7729	0.9 %	0.9 %
D: All clients				
MEDICATION				
<i>Prevalence of not receiving a medication review by a physician</i>				
N: Number of clients whose medications have not been reviewed by a physician within the last 180 days	85	7606	1.1 %	1.1 %
D: Clients who are taking at least two medications				
INCONTINENCE				
<i>Failure to improve/Incidence of bladder incontinence</i>				
N: Clients who have experienced a decline in bladder continence between previous and most recent assessment	4181	7394	56.6 %	56.5 %
-OR- Clients who have developed a new bladder continence problem				
D: All clients with at least one reassessment				
ULCERS				
<i>Failure to improve/Incidence of skin ulcers</i>				
N: Clients with an ulcer on previous assessment who did not improve -OR- Clients with a new ulcer on follow-up	564	7289	7.7 %	7.7 %
D: All clients with at least one reassessment				
PHYSICAL FUNCTION				
<i>Prevalence of no assistive device among clients with difficulty in locomotion</i>				
N: Clients with impaired locomotion who are not using an assistive device	168	3254	5.2 %	5.2 %
D: All clients with impaired locomotion on most recent assessment (excludes clients for whom indoor locomotion did not occur)				
<i>Prevalence of ADL/rehabilitation potential and no therapies</i>				
N: Clients are not receiving OT, PT or exercise therapy	2512	3480	72.2 %	72.1 %
D: Clients who trigger the CAP for ADL/rehab potential				
<i>Failure to improve/Incidence of decline on ADL long form</i>				
N: Clients with some impairment on ADL long form who failed to improve between previous and most recent	5088	7303	69.7 %	69.7 %

*(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 clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
assessment -OR- Clients who have a new ADL impairment based on ADL long form D: All clients with at least one reassessment who are not palliative on initial assessment				
<i>Failure to improve/Incidence of impaired locomotion in the home</i>				
N: Clients who fail to improve in locomotion in the home -OR- Clients who have a new impairment in locomotion in the home D: All clients with at least one reassessment who are not palliative on initial assessment	3162	7339	43.1 %	43.1 %
<i>Prevalence of falls</i>				
N: The number of clients who record a fall on follow-up assessment D: All clients not completely dependent in bed mobility on previous assessment	1999	7233	27.6 %	27.7 %
COGNITIVE FUNCTION				
<i>Prevalence of social isolation with distress</i>				
N: Clients who are alone for long periods of time or always AND they also report feeling lonely -OR- Clients who are distressed by declining social activity D: All clients	1461	7794	18.8 %	18.7 %
<i>Failure to improve/Incidence of cognitive decline</i>				
N: Clients who have experienced a decline in cognitive performance between previous and most recent assessment -OR- Clients who experience new cognitive impairment D: All clients with at least one reassessment	3976	6483	61.3 %	61.4 %
<i>Prevalence of delirium</i>				
N: Clients with sudden or new onset/change in mental function -OR- Clients who have become agitated or disoriented such that his or her safety is endangered or client requires protection by others D: All clients	300	7744	3.9 %	3.9 %
<i>Prevalence of negative mood</i>				
N: Any client with sad mood on most recent assessment - AND- At least 2 symptoms of functional depression are exhibited up to five days a week or daily or almost daily D: All clients	889	7777	11.4 %	11.4 %
<i>Failure to improve/Incidence of difficulty in communication</i>				
N: Clients with both failure to improve in communication/making self understood and failure to improve in ability to understand others -OR- Clients with new difficulties in making self understood or understanding others D: All clients with at least one reassessment	2566	7442	34.5 %	34.5 %
PAIN				
<i>Prevalence of disruptive or intense daily pain</i>				
N: Clients who experience pain at least daily and pain is unusually intense -OR- pain intensity disrupts usual activities D: All clients	2194	5763	38.1 %	38.1 %
SAFETY/ENVIRONMENT				

*(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 clients, all eligibilities for the last quarter of the FY.

Clients included N = Numerator D - Denominator	(N)um.	*(D)enom.	Agency % of clients	**Statewide % of clients(FY08)
<i>Prevalence of neglect/abuse</i>				
N: Clients who have unexplained injuries, have been abused or neglected D: All clients	235	7732	3.0 %	3.0 %
<i>Prevalence of any injuries</i>				
N: Clients with fractures or unexplained injuries D: All clients	992	7793	12.7 %	12.8 %
OTHER				
<i>Prevalence of hospitalization</i>				
N: Clients who have been hospitalized, visited hospital emergency department or received emergent care since last assessment D: All clients	2132	7708	27.7 %	27.7 %

**(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 clients, all eligibilities for the last quarter of the FY.*

4. Quality Management Summary Data
From
Waiver Agent Plans for the Year 2008

Quality Management Summary Data
from Waiver Agent plans
for the Year 2008

Quality Indicators	DAAA	AAA-1E	MGRC	ISA	ITC	R2AAA	3B	Senior Services	AAA	RIV	VAAA	ICOA	RVI/AAA	A & D	AAA/WM	HHS	HEMCSA	NMRHS	AAA-NM	NLCMH	UPCAP	Senior Resources
Days for First Service Delivery																						
Average	30.15	4.00	2.66	4.36	5.38	6.49	8.74	4.13	7.87	10.74	7.35	2.71	2.53	3.50	39.00	2.81	1.85	7.90	3.00	4.99	9.80	
Shortest	N.P.	0	N.P.	0	N.P.	N.P.	0	N.P.	N.P.	N.P.	0	0	N.P.	N.P.	N.P.	N.P.	0	0	N.P.	0	0	0
Longest	N.P.	60	N.P.	29	N.P.	37	106	N.P.	N.P.	84	84	38	N.P.	N.P.	67	N.P.	14	N.P.	27	65	102	
No Waiver Services for > 30 days																						
Participant Number	115	6	2	0	10	10	15	0	2	7	0	3	0	0	0	N.P.	0	0	3	0	N.P.	19
Provider No Shows																						
Percentage of Planned Services versus Actual Services	N.P.	0.6%	3.0%	2.7%	1.0%	1.4%	2.0%	0.4%	0.75%	0.6%	0.5%	0.2%	0.3%	1.2%	1.0%	0.5%	0.5%	1.6%	2.0%	1.2%	0.84%	
Prevalence of Pain																						
Percentage of persons reporting daily intense and/or disruptive pain	38.1%	43.8%	55.0%	37.3%	38.1%	41.4%	49.3%	47.0%	19.2%	41.0%	38.1%	33.5%	33.8%	39.6	43.7%	7.90%	61.8%	40%	38.6	48.40%	42.5%	
Missing Data																						
Percentage of missing assessment items on MDS-HC	N.P.	*R.G.	*R.G.	2.9%	1.1%	2.3%	0.06%	*R.G.	*R.G.	56.0%	N.P.	*R.G.	*R.G.	*R.G.	10%	5.42%	<1.0%	N.P.	<1.0%	*R.G.	N.P.	

*R.G. = Replacement Goal
N.P. = Not Provided by Agency

5. Statewide Clinical Quality Assurance Review Data
For
Year 2006

MI Choice Quality Assurance Reporting Agency Result Report

Statewide

Clinical Quality Assurance Review Data for the Year: 2006
Number of Participant in Review Year: 335

Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	C/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
I.B.2.a. Waiver agent provided an individual evaluation to determine that applicant meets the NF LOC criteria.	329	0	6	0	335	1.96	A	98.21%	0.00%	1.79%
I.B.2.b. Waiver agent serves the appropriate target population: Participant is aged (over 65) or is over 18 years of age and disabled (i.e. receive SST, Social Security Disability, or have a disability determination through DHS).	334	0	1	0	335	1.99	A	99.70%	0.00%	0.30%
I.B.2.c. Waiver agent transitioned participant from the nursing facility to the community with MI Choice services.	13	0	0	322	335	2.00	D	100.00%	0.00%	0.00%
I.B.2.f. Waiver agent followed standard of promptness procedures for completing assessment after initial screening.	32	0	1	302	335	1.94	B	96.97%	0.00%	3.03%
I.B.2.g. Waiver agent offered a choice of either institutional or home and community-based services to participant.	331	0	4	0	335	1.98	A	98.81%	0.00%	1.19%
I.B.2.h. Waiver agent uses correct waiver eligibility dates.	332	0	3	0	335	1.98	A	99.10%	0.00%	0.90%
I.B.2.i. Waiver agent promptly notified DHS of waiver eligible and ineligible dates.	34	0	8	293	335	1.62	A	80.95%	0.00%	19.05%
I.B.2.j. Waiver agent followed standard of promptness for initiating services.	328	0	7	0	335	1.96	B	97.91%	0.00%	2.09%
I.B.2.k. Waiver agent minimally provides an annual reevaluation of the nursing facility level of care for the participant.	239	0	87	9	335	1.47	A	73.31%	0.00%	26.69%
I.B.2.l. The participant record appropriately reflects the participant's LOC.	313	0	22	0	335	1.87	A	93.43%	0.00%	6.57%
Sub-Total Section I (10 standards):	2285	0	139	926	3350	1.89	B	94.27%	0.00%	5.73%
II.A.2.a. Waiver agent ensured participant had access to other community-based services if a need for non-waiver services was present.	268	0	14	53	335	1.90	B	95.04%	0.00%	4.96%
II.A.2.b. Waiver agent assured all appropriate waiver services were available and offered to participant.	320	0	15	0	335	1.91	A	95.52%	0.00%	4.48%
II.A.2.c. Waiver agent supports the participant's use of personal resources.	307	0	1	27	335	1.99	B	99.68%	0.00%	0.32%

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Agency Result Report**

Statewide

Clinical Quality Assurance Review Data for the Year: 2006
Number of Participant in Review Year: 335

II.A.2.d. Waiver agent completed a comprehensive evaluation including an assessment of the individual's: a) Physical status; b) Medications; c) Physical environment; d) Informal support potential; e) Financial status; f) Social & emotional functioning	317	0	18	0	335	1.89	A	94.63%	0.00%	5.37%
II.A.2.e. Waiver agent supports the participant in achieving and maintaining independence and self-direction.	327	4	3	1	335	1.97	A	97.90%	1.20%	0.90%
II.A.2.f. CM helped participant access resources to address participant's needs and accomplish the participant's goals.	308	0	9	18	335	1.94	A	97.16%	0.00%	2.84%
II.A.2.g. CM provides social/emotional support and advocacy to participant, as needed.	235	0	7	93	335	1.94	D	97.11%	0.00%	2.89%
II.A.2.h. CM identified and made note of participant preferences and goals.	295	0	8	32	335	1.95	B	97.36%	0.00%	2.64%
II.A.2.i. CM gave participant opportunities to choose services and service providers. <input type="checkbox"/> Services <input type="checkbox"/> Service Providers <input type="checkbox"/> Other: Specify	332	0	3	0	335	1.98	A	99.10%	0.00%	0.90%
II.A.2.j. CM honors participant choices and preferences, even if CM did not grant the choices and preferences.	273	0	8	54	335	1.94	C	97.15%	0.00%	2.85%
II.A.2.k. CM encouraged participant to revisit issues and consider other options.	212	0	12	111	335	1.89	D	94.64%	0.00%	5.36%
II.A.2.l. CM provided participant a copy of their plan of care or service plan.	266	0	69	0	335	1.59	D	79.40%	0.00%	20.60%
II.A.2.m. CM shares information with participant to support the persons' right to make informed choices regarding setting, services, and providers.	325	5	5	0	335	1.96	C	97.01%	1.49%	1.49%
II.A.2.n. CM seeks input from the participant (and/or family members, legal guardians or caregivers, if acceptable to participant) to identify health issues and support service needs.	330	0	5	0	335	1.97	C	98.51%	0.00%	1.49%
II.A.2.o. CM makes accommodations for sensory and communication limitations when necessary for the planning process.	131	0	0	204	335	2.00	D	100.00%	0.00%	0.00%

**MI Choice Quality Assurance Reporting
Agency Result Report**

Statewide

Clinical Quality Assurance Review Data for the Year: 2006
Number of Participant in Review Year: 335

II.A.2.p. Waiver agent uses RN and SW team approach for completing assessments.	334	0	1	0	335	1.99	A	99.70%	0.00%	0.30%
II.A.2.q. Waiver agent uses RN and SW team approach for completing reassessments, POC, and other participant reviews or changes.	311	0	24	0	335	1.86	A	92.84%	0.00%	7.16%
II.A.2.r.i. POC contains (regardless of payer source): <input type="checkbox"/> The type of service furnished; <input type="checkbox"/> The amount of service; <input type="checkbox"/> The frequency and duration of each service; <input type="checkbox"/> The type of provider to furnish each service;	260	0	75	0	335	1.55	A	77.61%	0.00%	22.39%
II.A.2.r.ii. POC contains (regardless of payer source): <input type="checkbox"/> Goals; <input type="checkbox"/> Outcomes; and <input type="checkbox"/> Participant approval of care plan	268	0	67	0	335	1.60	A	80.00%	0.00%	20.00%
II.B.2.a. CM ensures participant receives the services identified in the POC.	322	5	8	0	335	1.94	A	96.12%	1.49%	2.39%
II.B.2.c. CM links and coordinates the delivery of services and supports to participant, as preferred by the participant.	296	0	10	29	335	1.93	B	96.73%	0.00%	3.27%
II.B.2.d. Waiver agent takes actions when they identify problems with access to program services to ensure that participant receives the services identified on the POC.	68	0	5	262	335	1.86	A	93.15%	0.00%	6.85%
II.B.2.e. Waiver agent makes changes to the person-centered plan in response to participant commentary.	236	0	12	87	335	1.90	C	95.16%	0.00%	4.84%
II.B.2.f. Waiver agent links participants to needed services that are not available through the waiver.	231	0	9	95	335	1.93	D	96.25%	0.00%	3.75%
II.B.2.g. Waiver agent addresses discrepancies found between the POC, assessment, and the participant's identified needs.	32	0	62	241	335	0.68	A	34.04%	0.00%	65.96%
II.B.2.h. Waiver agent ensures that services are consistent with the nature and severity of the individual's disability.	323	0	12	0	335	1.93	A	96.42%	0.00%	3.58%
II.B.2.i. Participant has access to a reevaluation of the plan of care and services received as needs change, but at least every 90 days.	267	0	68	0	335	1.59	B	79.70%	0.00%	20.30%

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Statewide

Clinical Quality Assurance Review Data for the Year: 2006
Number of Participant in Review Year: 335

II.B.2.j. CM monitors goals and updates progress made toward outcomes identified in the POC at least every 90 days.	253	0	82	0	335	1.51	B	75.52%	0.00%	24.48%
II.B.2.k. CM completes a reassessment of the individual as needs indicate, but at least every 90 (180) days.	210	0	125	0	335	1.25	B	62.69%	0.00%	37.31%
II.B.2.l. Participant has a continuous opportunity to provide feedback about services and supports to waiver agent.	258	0	77	0	335	1.54	C	77.01%	0.00%	22.99%
II.B.2.m. Participant (and family members or legal guardians, if participant prefers) can access their CM.	324	0	9	2	335	1.95	C	97.30%	0.00%	2.70%
Sub-Total Section II (31 standards):	8239	14	823	1309	10385	1.82	B	90.78%	0.15%	9.07%
III.B.2.a. Qualified professionals, as specified in the waiver application and MDCH policy, perform NF LOC evaluations, assessments and reassessments.	334	0	1	0	335	1.99	A	99.70%	0.00%	0.30%
Sub-Total Section III (1 standard):	334	0	1	0	335	1.99	A	99.70%	0.00%	0.30%
IV.A.2.a. Participant has an opportunity to explore, discuss, and make choices regarding their health care needs and safety considerations during the planning process.	290	0	7	38	335	1.95	D	97.64%	0.00%	2.36%
IV.A.2.b. CM considers health & welfare during the assessment, re-assessment, development of care plans, and throughout service delivery.	300	0	35	0	335	1.79	A	89.55%	0.00%	10.45%
IV.A.2.c. CM identifies health and welfare risks related to the participants' personal choices. (This standard applies only to the health and welfare risks related to the participant's choices.)	132	0	8	195	335	1.89	A	94.29%	0.00%	5.71%
IV.A.2.d. CM assists participant in creating safeguards and support mechanisms to honor the participant's choices and provide assistance when choices may cause risk to the participant's health and welfare.	132	0	7	196	335	1.90	A	94.96%	0.00%	5.04%
IV.A.2.e. Participant, family members/legal guardians have an opportunity to discuss health and welfare preferences during planning and throughout service delivery.	326	0	9	0	335	1.95	A	97.31%	0.00%	2.69%
IV.A.2.f. Waiver agent informs service providers of risks related to health and welfare decisions made by participant and assists service providers in supporting those choices.	209	0	11	115	335	1.90	B	95.00%	0.00%	5.00%

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Agency Result Report**

Statewide

Clinical Quality Assurance Review Data for the Year: 2006
Number of Participant in Review Year: 335

IV.A.2.g. Service providers honor participant's health and welfare preferences.	111	0	5	219	335	1.91	B	95.69%	0.00%	4.31%
IV.A.2.h. Service providers adequately address the health and welfare needs of participants.	123	0	10	202	335	1.85	B	92.48%	0.00%	7.52%
IV.B.2.a. CM identifies incidents of neglect, abuse and/or exploitation of participants and when present takes steps to prevent additional neglect, abuse and/or exploitation from occurring.	29	0	1	305	335	1.93	A	96.67%	0.00%	3.33%
IV.B.2.b. Waiver agent takes appropriate action upon the determination of incidents of abuse, neglect and/or exploitation.	23	0	3	309	335	1.77	A	88.46%	0.00%	11.54%
IV.B.2.c. Service providers take appropriate action upon the determination of incidents of abuse, neglect and/or exploitation.	26	0	1	308	335	1.93	B	96.30%	0.00%	3.70%
IV.B.2.d. Waiver agent monitors providers to confirm that they identify and prevent incidents of neglect, abuse and/or exploitation of participants.	23	0	2	310	335	1.84	B	92.00%	0.00%	8.00%
IV.C.2.a. Care managers assess the safety and security of the living arrangement, identify risk factors, and offer modifications to promote independence and safety in the home.	215	0	7	113	335	1.94	B	96.85%	0.00%	3.15%
IV.D.2.a. Care managers identify and address the use of restraints and seclusion for participations.	1	0	0	334	335	2.00	B	100.00%	0.00%	0.00%
IV.E.2.a. The CM evaluation of participant's medication regimen was comprehensive. A comprehensive evaluation of the medication regimen includes the components described in IV.E.2.b.i through IV.E.2.b.vi below.	205	114	13	3	335	1.58	B	61.75%	34.34%	3.92%
IV.E.2.b. CM evaluated participant on multiple medications or behavior modifying medications for safe medication management and made appropriate referrals for assistance, including education on duplication of medications and side effects, assistive devices and/or technology, professional medication management, etc.	216	0	15	104	335	1.87	B	93.51%	0.00%	6.49%
IV.F.2.a. CM assists participant in establishing contingency plans for emergencies (e.g., severe weather or unscheduled absence of a caregiver).	201	70	63	1	335	1.41	D	60.18%	20.96%	18.86%
IV.F.2.b. When needed, participant, service provider, and waiver agent implemented the contingency plan.	34	0	3	298	335	1.84	D	91.89%	0.00%	8.11%

**MI Choice Quality Assurance Reporting
Agency Result Report**

Statewide

Clinical Quality Assurance Review Data for the Year: 2006
Number of Participant in Review Year: 335

Sub-Total Section IV (18 standards):	2596	184	200	3050	6030	1.80	B	87.11%	6.17%	6.71%
V.A.2.a. CM informed participant of their rights and responsibilities and how to access those rights.	334	0	1	0	335	1.99	C	99.70%	0.00%	0.30%
V.B.2.a. CM gives participant opportunity to make decisions about the planning process, i.e. who to include, when/where to meet, service providers, POC development, etc.	324	0	11	0	335	1.93	D	96.72%	0.00%	3.28%
V.B.2.b. CM gives participant opportunity to evaluate and comment upon the planning process and its outcomes.	330	0	5	0	335	1.97	D	98.51%	0.00%	1.49%
V.B.2.c. Participant exercised their right to refuse services.	101	0	0	234	335	2.00	D	100.00%	0.00%	0.00%
V.C.2.a. CM follows waiver agent procedures before pursuing guardianship or other mechanisms that take authority away from participants.	13	0	0	322	335	2.00	A	100.00%	0.00%	0.00%
V.D.2.a. Waiver agent informed participant and family/legal guardians of their right to appeal.	335	0	0	0	335	2.00	C	100.00%	0.00%	0.00%
V.D.2.b. Waiver agent informed participant and family/legal guardians in writing by a Notice of Advanced Action when Waiver agent planned to terminate, reduce or suspend services.	46	0	48	241	335	0.98	C	48.94%	0.00%	51.06%
V.D.2.c. Waiver agent informed participant and family/legal guardians in writing by a Notice of Adequate Action when Waiver agent denied services or access to services.	25	0	28	282	335	0.94	C	47.17%	0.00%	52.83%
V.E.2.a. CM notified participant of Waiver agent's agency specific complaint process, and explained this process to participant.	335	0	0	0	335	2.00	C	100.00%	0.00%	0.00%
Sub-Total Section V (9 standards):	1843	0	93	1079	3015	1.90	C	95.20%	0.00%	4.80%
VI.A.2.a. Case record indicates that participant is satisfied with all of the following: <input type="checkbox"/> Current Services <input type="checkbox"/> Amount of services, and <input type="checkbox"/> Quality of services	212	0	123	0	335	1.27	C	63.28%	0.00%	36.72%
VI.B.2.a. Participant identifies and addresses strategies and supports, services and/or treatment needs to achieve desired outcomes.	327	0	7	1	335	1.96	D	97.90%	0.00%	2.10%

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VI.B.2.b. The case record reflects that the participant has achieved or made progress toward achieving desired outcomes or identifies barriers to achieving desired outcomes.	322	0	13	0	335	1.92	D	96.12%	0.00%	3.88%
Sub-Total Section VI (3 standards):	861	0	143	1	1005	1.72	D	85.76%	0.00%	14.24%
VII.A.2.f. Waiver agent ensures proper and cost-effective utilization of resources.	323	0	12	0	335	1.93	A	96.42%	0.00%	3.58%
VII.B.2.a. Waiver agent addresses inappropriate LOC determinations when it finds inappropriate determinations have been made.	12	0	8	315	335	1.20	A	60.00%	0.00%	40.00%
VII.C.2.a. Waiver agent considers and respects participant's cultural background.	15	0	0	320	335	2.00	D	100.00%	0.00%	0.00%
Sub-Total Section VII (3 standards):	350	0	20	635	1005	1.89	B	94.59%	0.00%	5.41%
VIII.A.2.a. Waiver agent only releases personal and confidential information to other parties with written consent from participant.	310	0	25	335	1.85	C	92.54%	0.00%	7.46%	
Sub-Total Section VIII (1 standard):	310	0	25	0	335	1.85	C	92.54%	0.00%	7.46%
IX.A.2.a. Participants receiving Adult Day Health paid for through the MI Choice program:	18	0	0	317	335	2.00	B	100.00%	0.00%	0.00%
IX.A.2.b. Participants receiving Chore Services paid for through the MI Choice program:	49	0	1	285	335	1.96	C	98.00%	0.00%	2.00%
IX.A.2.c. Participants receiving Counseling services paid for through the MI Choice program:	19	0	0	316	335	2.00	B	100.00%	0.00%	0.00%
IX.A.2.d. Participants receiving Environmental Accessibility Adaptations (Home Modifications) paid for through the MI Choice program:	26	0	0	309	335	2.00	B	100.00%	0.00%	0.00%
IX.A.2.e. Participants receiving Home Delivered Meals paid for through the MI Choice program:	179	0	1	155	335	1.99	C	99.44%	0.00%	0.56%
IX.A.2.f. Participants receiving Homemaking paid for through the MI Choice program, have indicated that the individual usually responsible for these activities is temporarily absent or unable to manage the home.	241	0	0	94	335	2.00	B	100.00%	0.00%	0.00%
IX.A.2.g. Participants receiving respite care (at home or outside of the home) paid for through the MI Choice program:	61	0	0	274	335	2.00	B	100.00%	0.00%	0.00%

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IX.A.2.h. Participants receiving a PERS unit paid for through the MI Choice program:	219	0	1	115	335	1.99	B	99.55%	0.00%	0.45%
IX.A.2.i. Participants receiving personal care paid for through the MI Choice program require assistance with ADLs or reminding, prompting, cuing, and frequent direction to perform ADLs.	271	0	0	64	335	2.00	B	100.00%	0.00%	0.00%
IX.A.2.j. Participants receiving Private Duty Nursing paid for through the MI Choice program are not eligible to receive identical nursing services through another funding source.	103	0	0	232	335	2.00	B	100.00%	0.00%	0.00%
IX.A.2.k. Participants receiving Specialized Medical Equipment and Supplies paid for through the MI Choice program:	50	0	0	285	335	2.00	C	100.00%	0.00%	0.00%
IX.A.2.l. Participants receiving Training services paid for through the MI Choice program learn independent living skills required to maintain the individual at home.	3	0	0	332	335	2.00	C	100.00%	0.00%	0.00%
IX.A.2.m. Participants receiving Transportation services paid for through the MI Choice program:	108	0	0	227	335	2.00	C	100.00%	0.00%	0.00%
IX.A.2.n. Participants receiving Nursing Facility Transition Services resided in a nursing facility at the time of assessment and expressed a desire to return to the community with the assistance of the waiver agent.	4	0	0	331	335	2.00	B	100.00%	0.00%	0.00%
IX.A.2.o. Participant receives at least one waiver service on a continual basis to maintain eligibility	333	0	2	0	335	1.99	A	99.40%	0.00%	0.60%
Sub-Total Section IX (15 standards):	1684	0	5	3336	5025	1.99	B	99.70%	0.00%	0.30%
Totals:	18502	198	1449	10336	30485	1.85		91.83%	0.98%	7.19%

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I.B.2.a. Waiver agent provided an individual evaluation to determine that applicant meets the NF LOC criteria.	340	0	6	0	346	1.97	A	98.27%	0.00%	1.73%
I.B.2.b. Waiver agent serves the appropriate target population: Participant is aged (over 65) or is over 18 years of age and disabled (i.e. receive SSI, Social Security Disability, or have a disability determination through DHS).	346	0	0	0	346	2.00	A	100.00%	0.00%	0.00%
I.B.2.c. Waiver agent transitioned participant from the nursing facility to the community with MI Choice services.	19	0	0	327	346	2.00	D	100.00%	0.00%	0.00%
I.B.2.f. Waiver agent followed standard of promptness procedures for completing assessment after initial screening.	9	0	7	330	346	1.13	B	56.25%	0.00%	43.75%
I.B.2.g. Waiver agent offered a choice of either institutional or home and community-based services to participant.	331	0	15	0	346	1.91	A	95.66%	0.00%	4.34%
I.B.2.h. Waiver agent uses correct waiver eligibility dates.	344	0	2	0	346	1.99	A	99.42%	0.00%	0.58%
I.B.2.i. Waiver agent promptly notified DHS of waiver eligible and ineligible dates.	39	0	4	303	346	1.81	A	90.70%	0.00%	9.30%
I.B.2.j. Waiver agent followed standard of promptness for initiating services.	338	0	8	0	346	1.95	B	97.69%	0.00%	2.31%
I.B.2.k. Waiver agent minimally provides an annual reevaluation of the nursing facility level of care for the participant	319	0	24	3	346	1.86	A	93.00%	0.00%	7.00%
I.B.2.l. The participant record appropriately reflects the participant's LOC.	315	0	31	0	346	1.82	A	91.04%	0.00%	8.96%
Sub-Total Section I (10 standards):	2400	0	97	963	3460	1.92	B	96.12%	0.00%	3.88%
II.A.2.a. Waiver agent ensured participant had access to other community-based services if a need for non-waiver services was present	291	0	17	38	346	1.89	B	94.48%	0.00%	5.52%
II.A.2.b. Waiver agent assured all appropriate waiver services were available and offered to participant.	323	0	23	0	346	1.87	A	93.35%	0.00%	6.65%

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II.A.2.c. Waiver agent supports the participant's use of personal resources.	319	0	0	27	346	2.00	B	100.00%	0.00%	0.00%
II.A.2.d. Waiver agent completed a comprehensive evaluation including an assessment of the individual's: a) Physical status; b) Medications; c) Physical environment; d) Informal support potential; e) Financial status;	329	0	17	0	346	1.90	A	95.09%	0.00%	4.91%
II.A.2.e. Waiver agent supports the participant in achieving and maintaining independence and self-direction.	339	5	0	2	346	1.99	A	98.55%	1.45%	0.00%
II.A.2.f. CM helped participant access resources to address participant's needs and accomplish the participant's goals.	314	0	18	14	346	1.89	A	94.58%	0.00%	5.42%
II.A.2.g. CM provides social/emotional support and advocacy to participant, as needed.	248	0	18	80	346	1.86	D	93.23%	0.00%	6.77%
II.A.2.h. CM identified and made note of participant preferences and goals.	316	0	5	25	346	1.97	B	98.44%	0.00%	1.56%
II.A.2.i. CM gave participant opportunities to choose services and service providers. <input type="checkbox"/> Services <input type="checkbox"/> Service Providers <input type="checkbox"/> Other: Specify	344	0	2	0	346	1.99	A	99.42%	0.00%	0.58%
II.A.2.j. CM honors participant choices and preferences, even if CM did not grant the choices and preferences.	311	0	7	28	346	1.96	C	97.80%	0.00%	2.20%
II.A.2.k. CM encouraged participant to revisit issues and consider other options.	231	0	21	94	346	1.83	D	91.67%	0.00%	8.33%
II.A.2.l. CM provided participant a copy of their plan of care or service plan.	286	0	60	0	346	1.65	D	82.66%	0.00%	17.34%

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II.A.2.m. CM shares information with participant to support the persons' right to make informed choices regarding setting, services, and providers.	333	6	7	0	346	1.94	C	96.24%	1.73%	2.02%
II.A.2.n. CM seeks input from the participant (and/or family members, legal guardians or caregivers, if acceptable to participant) to identify health issues and support service needs.	338	0	8	0	346	1.95	C	97.69%	0.00%	2.31%
II.A.2.o. CM makes accommodations for sensory and communication limitations when necessary for the planning process.	164	0	6	176	346	1.93	D	96.47%	0.00%	3.53%
II.A.2.p. Waiver agent uses RN and SW team approach for completing assessments.	346	0	0	0	346	2.00	A	100.00%	0.00%	0.00%
II.A.2.q. Waiver agent uses RN and SW team approach for completing reassessments, POC, and other participant reviews or changes.	274	0	72	0	346	1.58	A	79.19%	0.00%	20.81%
II.A.2.r.i. POC contains (regardless of payer source): <input type="checkbox"/> The type of service furnished; <input type="checkbox"/> The amount of service; <input type="checkbox"/> The frequency and duration of each service; <input type="checkbox"/> The type of provider to furnish each service;	253	0	93	0	346	1.46	A	73.12%	0.00%	26.88%
II.A.2.r.ii. POC contains (regardless of payer source): <input type="checkbox"/> Goals; <input type="checkbox"/> Outcomes; and <input type="checkbox"/> Participant approval of care plan	287	0	59	0	346	1.66	A	82.95%	0.00%	17.05%
II.B.2.a. CM ensures participant receives the services identified in the POC.	340	2	4	0	346	1.97	A	98.27%	0.58%	1.16%
II.B.2.c. CM links and coordinates the delivery of services and supports to participant, as preferred by the participant.	319	0	8	19	346	1.95	B	97.55%	0.00%	2.45%
II.B.2.d. Waiver agent takes actions when they identify problems with access to program services to ensure that participant receives the services identified on the POC.	56	0	6	284	346	1.81	A	90.32%	0.00%	9.68%

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Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	G/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
II.B.2.e. Waiver agent makes changes to the person-centered plan in response to participant commentary.	227	0	10	109	346	1.92	C	95.78%	0.00%	4.22%
II.B.2.f. Waiver agent links participants to needed services that are not available through the waiver.	245	0	12	89	346	1.91	D	95.33%	0.00%	4.67%
II.B.2.g. Waiver agent addresses discrepancies found between the POC, assessment, and the participant's identified needs.	11	0	54	281	346	0.34	A	16.92%	0.00%	83.08%
II.B.2.h. Waiver agent ensures that services are consistent with the nature and severity of the individual's disability.	321	0	25	0	346	1.86	A	92.77%	0.00%	7.23%
II.B.2.i. Participant has access to a reevaluation of the plan of care and services received as needs change, but at least every 90 days.	327	0	19	0	346	1.89	B	94.51%	0.00%	5.49%
II.B.2.j. CM monitors goals and updates progress made toward outcomes identified in the POC at least every 90 days.	317	0	29	0	346	1.83	B	91.62%	0.00%	8.38%
II.B.2.k. CM completes a reassessment of the individual as needs indicate, but at least every 90 (180) days.	221	0	124	1	346	1.28	B	64.06%	0.00%	35.94%
II.B.2.l. Participant has a continuous opportunity to provide feedback about services and supports to waiver agent.	247	0	99	0	346	1.43	C	71.39%	0.00%	28.61%
II.B.2.m. Participant (and family members or legal guardians, if participant prefers) can access their CM.	341	0	5	0	346	1.97	C	98.55%	0.00%	1.45%
Sub-Total Section II (31 standards):	8618	13	828	1267	10726	1.82	B	91.11%	0.14%	8.75%
III.B.2.a. Qualified professionals, as specified in the waiver application and MDCH policy, perform NF LOC evaluations, assessments and reassessments.	345	0	1	0	346	1.99	A	99.71%	0.00%	0.29%
Sub-Total Section III (1 standard):	345	0	1	0	346	1.99	A	99.71%	0.00%	0.29%

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Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	C/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
IV.A.2.a. Participant has an opportunity to explore, discuss, and make choices regarding their health care needs and safety considerations during the planning process.	322	0	9	15	346	1.95	D	97.28%	0.00%	2.72%
IV.A.2.b. CM considers health & welfare during the assessment, re-assessment, development of care plans, and throughout service delivery.	298	0	48	0	346	1.72	A	86.13%	0.00%	13.87%
IV.A.2.c. CM identifies health and welfare risks related to the participants' personal choices. (This standard applies only to the health and welfare risks related to the participant's choices.)	137	0	14	195	346	1.81	A	90.73%	0.00%	9.27%
IV.A.2.d. CM assists participant in creating safeguards and support mechanisms to honor the participant's choices and provide assistance when choices may cause risk to the participant's health and welfare.	143	0	13	190	346	1.83	A	91.67%	0.00%	8.33%
IV.A.2.e. Participant, family members/legal guardians have an opportunity to discuss health and welfare preferences during planning and throughout service delivery.	340	0	6	0	346	1.97	A	98.27%	0.00%	1.73%
IV.A.2.f. Waiver agent informs service providers of risks related to health and welfare decisions made by participant and assists service providers in supporting those choices.	277	0	15	54	346	1.90	B	94.86%	0.00%	5.14%
IV.A.2.g. Service providers honor participant's health and welfare preferences.	121	0	2	223	346	1.97	B	98.37%	0.00%	1.63%
IV.A.2.h. Service providers adequately address the health and welfare needs of participants.	148	0	14	184	346	1.83	B	91.36%	0.00%	8.64%
IV.B.2.a. CM identifies incidents of neglect, abuse and/or exploitation of participants and when present takes steps to prevent additional neglect, abuse and/or exploitation from occurring.	15	0	0	331	346	2.00	A	100.00%	0.00%	0.00%
IV.B.2.b. Waiver agent takes appropriate action upon the determination of incidents of abuse, neglect and/or exploitation.	14	0	0	332	346	2.00	A	100.00%	0.00%	0.00%

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Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	C/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
IV.B.2.c. Service providers take appropriate action upon the determination of incidents of abuse, neglect and/or exploitation.	12	0	0	334	346	2.00	B	100.00%	0.00%	0.00%
IV.B.2.d. Waiver agent monitors providers to confirm that they identify and prevent incidents of neglect, abuse and/or exploitation of participants.	9	0	1	336	346	1.80	B	90.00%	0.00%	10.00%
IV.C.2.a. Care managers assess the safety and security of the living arrangement, identify risk factors, and offer modifications to promote independence and safety in the home.	308	0	17	21	346	1.90	B	94.77%	0.00%	5.23%
IV.D.2.a. Care managers identify and address the use of restraints and seclusion for participants.	1	0	0	345	346	2.00	B	100.00%	0.00%	0.00%
IV.E.2.a. The CM evaluation of participant's medication regimen was comprehensive. A comprehensive evaluation of the medication regimen includes the components described in IV.E.2.b.i through IV.E.2.b.vi below.	297	34	14	1	346	1.82	B	86.09%	9.86%	4.06%
IV.E.2.b. CM evaluated participant on multiple medications or behavior modifying medications for safe medication management and made appropriate referrals for assistance, including education on duplication of medications and side effects, assistive devices and/or technology, professional medication assessment etc.	278	0	16	52	346	1.89	B	94.56%	0.00%	5.44%
IV.F.2.a. CM assists participant in establishing contingency plans for emergencies (e.g., severe weather or unscheduled absence of a caregiver).	122	180	43	1	346	1.23	D	35.36%	52.17%	12.46%
IV.F.2.b. When needed, participant, service provider, and waiver agent implemented the contingency plan.	47	0	5	294	346	1.81	D	90.38%	0.00%	9.62%
Sub-Total Section IV (18 standards):	2889	214	217	2908	6228	1.80	B	87.02%	6.45%	6.54%
V.A.2.a. CM informed participant of their rights and responsibilities and how to access those rights.	346	0	0	0	346	2.00	C	100.00%	0.00%	0.00%

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Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	G/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
V.B.2.a. CM gives participant opportunity to make decisions about the planning process, i.e. who to include, when/where to meet, service providers, POC development, etc.	334	0	12	0	346	1.93	D	96.53%	0.00%	3.47%
V.B.2.b. CM gives participant opportunity to evaluate and comment upon the planning process and its outcomes.	338	0	8	0	346	1.95	D	97.69%	0.00%	2.31%
V.B.2.c. Participant exercised their right to refuse services.	111	0	0	235	346	2.00	D	100.00%	0.00%	0.00%
V.C.2.a. CM follows waiver agent procedures before pursuing guardianship or other mechanisms that take authority away from participants.	9	0	0	337	346	2.00	A	100.00%	0.00%	0.00%
V.D.2.a. Waiver agent informed participant and family/legal guardians of their right to appeal.	346	0	0	0	346	2.00	C	100.00%	0.00%	0.00%
V.D.2.b. Waiver agent informed participant and family/legal guardians in writing by a Notice of Advanced Action when Waiver agent planned to terminate, reduce or suspend services.	29	0	26	291	346	1.05	C	52.73%	0.00%	47.27%
V.D.2.c. Waiver agent informed participant and family/legal guardians in writing by a Notice of Adequate Action when Waiver agent denied services or access to services.	36	0	80	230	346	0.62	C	31.03%	0.00%	68.97%
V.E.2.a. CM notified participant of Waiver agent's agency specific complaint process, and explained this process to participant.	346	0	0	0	346	2.00	C	100.00%	0.00%	0.00%
Sub-Total Section V (9 standards):	1895	0	126	1093	3114	1.88	C	93.77%	0.00%	6.23%
VI.A.2.a. Case record indicates that participant is satisfied with all of the following: <input type="checkbox"/> Current Services <input type="checkbox"/> Amount of services, and <input type="checkbox"/> Quality of services	282	0	64	0	346	1.63	C	81.50%	0.00%	18.50%

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Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	C/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
VI.B.2.a. Participant identifies and addresses strategies and supports, services and/or treatment needs to achieve desired outcomes.	340	0	4	2	346	1.98	D	98.84%	0.00%	1.16%
VI.B.2.b. The case record reflects that the participant has achieved or made progress toward achieving desired outcomes or identifies barriers to achieving desired outcomes.	336	0	10	0	346	1.94	D	97.11%	0.00%	2.89%
Sub-Total Section VI (3 standards):	958	0	78	2	1038	1.85	D	92.47%	0.00%	7.53%
VII.A.2.f. Waiver agent ensures proper and cost-effective utilization of resources.	324	0	22	0	346	1.87	A	93.64%	0.00%	6.36%
VII.B.2.a. Waiver agent addresses inappropriate LOC determinations when it finds inappropriate determinations have been made.	6	0	11	329	346	0.71	A	35.29%	0.00%	64.71%
VII.C.2.a. Waiver agent considers and respects participant's cultural background.	14	0	0	332	346	2.00	D	100.00%	0.00%	0.00%
Sub-Total Section VII (3 standards):	344	0	33	661	1038	1.82	B	91.25%	0.00%	8.75%
VIII.A.2.a. Waiver agent only releases personal and confidential information to other parties with written consent from participant	273	0	73	0	346	1.58	C	78.90%	0.00%	21.10%
Sub-Total Section VIII (1 standard):	273	0	73	0	346	1.58	C	78.90%	0.00%	21.10%
IX.A.2.a. Participants receiving Adult Day Health paid for through the MI Choice program:	9	0	0	337	346	2.00	B	100.00%	0.00%	0.00%
IX.A.2.b. Participants receiving Chore Services paid for through the MI Choice program:	48	0	0	298	346	2.00	C	100.00%	0.00%	0.00%
IX.A.2.c. Participants receiving Counseling services paid for through the MI Choice program:	16	0	0	330	346	2.00	B	100.00%	0.00%	0.00%

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Number of Participants in Review Year: 346

Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	C/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
IX.A.2.d. Participants receiving Environmental Accessibility Adaptations (Home Modifications) paid for through the MI Choice program:	19	0	0	327	346	2.00	B	100.00%	0.00%	0.00%
IX.A.2.e. Participants receiving Home Delivered Meals paid for through the MI Choice program:	184	0	0	162	346	2.00	C	100.00%	0.00%	0.00%
IX.A.2.f. Participants receiving Homemaking paid for through the MI Choice program, have indicated that the individual usually responsible for these activities is temporarily absent or unable to manage the home.	257	0	0	89	346	2.00	B	100.00%	0.00%	0.00%
IX.A.2.g. Participants receiving respite care (at home or outside of the home) paid for through the MI Choice program:	67	0	1	278	346	1.97	B	98.53%	0.00%	1.47%
IX.A.2.h. Participants receiving a PERS unit paid for through the MI Choice program:	228	0	1	117	346	1.99	B	99.56%	0.00%	0.44%
IX.A.2.i. Participants receiving personal care paid for through the MI Choice program require assistance with ADLs or reminding, prompting, cuing, and frequent direction to perform ADLs	285	0	1	60	346	1.99	B	99.65%	0.00%	0.35%
IX.A.2.j. Participants receiving Private Duty Nursing paid for through the MI Choice program are not eligible to receive identical nursing services through another funding source.	78	0	0	268	346	2.00	B	100.00%	0.00%	0.00%
IX.A.2.k. Participants receiving Specialized Medical Equipment and Supplies paid for through the MI Choice program:	41	0	0	305	346	2.00	C	100.00%	0.00%	0.00%
IX.A.2.l. Participants receiving Training services paid for through the MI Choice program learn independent living skills required to maintain the individual at home.	4	0	0	342	346	2.00	C	100.00%	0.00%	0.00%

MI Choice Quality Assurance Reporting
Agency Result Report

Statewide

Clinical Quality assurance Review Data for Year: 2007
Number of Participants in Review Year: 346

Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	C/R Level	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
IX.A.2.m. Participants receiving Transportation services paid for through the MI Choice program:	119	0	0	227	346	2.00	C	100.00%	0.00%	0.00%
IX.A.2.n. Participants receiving Nursing Facility Transition Services resided in a nursing facility at the time of assessment and expressed a desire to return to the community with the assistance of the waiver agent.	14	0	0	332	346	2.00	B	100.00%	0.00%	0.00%
IX.A.2.o. Participant receives at least one waiver service on a continual basis to maintain eligibility	346	0	0	0	346	2.00	A	100.00%	0.00%	0.00%
Sub-Total Section IX (15 standards):	1715	0	3	3472	5190	2.00	B	99.83%	0.00%	0.17%
Totals:	19,437	227	1,456	10,366	31,486	2		92.03%	1.07%	6.89%

MI Choice Quality Assurance Reporting
Home Visit Results Report

STATEWIDE HOME VISIT REVIEW DATA
FOR Year 2007

Number of Participants in Review Year: 208

Standard	Evident	Partially Evident	Non-Evident	N/A	Total	Mean	% Evident Applicable Answers	% Partially Evident Applicable Answers	% Non-Evident Applicable Answers
II.A.2.a. Waiver agent ensured participant had access to other community-based services if a need for non-waiver services was present.	153	0	16	39	208	1.81	90.53%	0.00%	9.47%
II.A.2.b. Waiver agent assured all appropriate waiver services were available and offered to participant.	188	0	20	0	208	1.81	90.38%	0.00%	9.62%
II.A.2.c. Waiver agent supports the participant's use of personal resources.	185	0	0	23	208	2.00	100.00%	0.00%	0.00%
II.A.2.e. Waiver agent supports the participant in achieving and maintaining independence and self-direction.	201	0	7	0	208	1.93	96.63%	0.00%	3.37%
II.A.2.f. CM helped participant access resources to address participant's needs and accomplish the participant's goals.	180	0	12	16	208	1.88	93.75%	0.00%	6.25%
II.A.2.g. CM provides social/emotional support and advocacy to participant, as needed.	145	0	12	51	208	1.85	92.36%	0.00%	7.64%
II.A.2.i. CM gave participant opportunities to choose services and service providers.									
c Service Providers	200	0	8	0	208	1.92	96.15%	0.00%	3.85%
c. Other Services	109	0	8	91	208	1.86	93.16%	0.00%	6.84%
II.A.2.k. CM encouraged participant to revisit issues and consider other options.	164	0	44	0	208	1.58	78.85%	0.00%	21.15%
II.A.2.l. CM provided participant a copy of their plan of care or service plan.									
II.A.2.m. CM shares information with participant to support the persons' right to make informed choices regarding setting,	197	8	3	0	208	1.93	94.71%	3.85%	1.44%
II.A.2.o. CM makes accommodations for sensory and communication limitations when necessary for the planning	84	0	2	122	208	1.95	97.67%	0.00%	2.33%
II.B.2.a. CM ensures participant receives the services identified	201	0	7	0	208	1.93	96.63%	0.00%	3.37%
II.B.2.d. Waiver agent takes actions when they identify problems with access to program services to ensure that participant receives the services identified on the POC.									
II.B.2.e. Waiver agent makes changes to the person-centered plan in response to participant commentary.	64	0	6	138	208	1.83	91.43%	0.00%	8.57%
	141	0	10	57	208	1.87	93.38%	0.00%	6.62%

MI Choice Quality Assurance Reporting
Home Visit Results Report

STATEWIDE HOME VISIT REVIEW DATA
FOR Year 2007

Number of Participants in Review Year: 208

II.B.2.h. Waiver agent ensures that services are consistent with the nature and severity of the individual's disability.	191	0	17	0	208	1.84	91.83%	0.00%	8.17%
II.B.2.i. Participant has a continuous opportunity to provide feedback about services and supports to waiver agent.	200	0	8	0	208	1.92	96.15%	0.00%	3.85%
II.B.2.m. Participant (and family members or legal guardians, if participant prefers) can access their CM.	203	0	5	0	208	1.95	97.60%	0.00%	2.40%
Sub-Total Section II (17 standards):	2806	8	185	537	3536	1.87	93.56%	0.27%	6.17%
IV.A.2.a. Participant has an opportunity to explore, discuss, and make choices regarding their health care needs and safety considerations during the planning process.	184	0	7	17	208	1.93	96.34%	0.00%	3.66%
IV.A.2.d. CM assists participant in creating safeguards and support mechanisms to honor the participant's choices and provide assistance when choices may cause risk to the	189	0	19	0	208	1.82	90.87%	0.00%	9.13%
IV.B.2.a. CM identifies incidents of neglect, abuse and/or exploitation of participants and when present takes steps to prevent additional neglect, abuse and/or exploitation from	10	0	0	198	208	2.00	100.00%	0.00%	0.00%
IV.C.2.a. Care managers assess the safety and security of the living arrangement, identify risk factors, and offer modifications to promote independence and safety in the home.	155	0	19	34	208	1.78	89.08%	0.00%	10.92%
IV.E.2.b. CM evaluated participant on multiple medications or behavior modifying medications for safe medication management and made appropriate referrals for assistance, including education on duplication of medications and side effects. assistive devic	184	0	18	6	208	1.82	91.09%	0.00%	8.91%
IV.F.2.a. CM assists participant in establishing contingency plans for emergencies (e.g., severe weather or unscheduled absence of	140	33	34	1	208	1.51	67.63%	15.94%	16.43%
IV.F.2.b. When needed, participant, service provider, and waiver agent implemented the contingency plan.	39	0	4	165	208	1.81	90.70%	0.00%	9.30%
Sub-Total Section IV (7 standards):	901	33	101	421	1456	1.77	87.05%	3.19%	9.76%
V.B.2.a. CM gives participant opportunity to make decisions about the planning process, i.e. who to include, when/where to meet, service providers, POC development, etc.	199	0	9	0	208	1.91	95.67%	0.00%	4.33%
V.D.2.a. Waiver agent informed participant and family/legal guardians of their right to appeal.	201	0	7	0	208	1.93	96.63%	0.00%	3.37%

MI Choice Quality Assurance Reporting
Home Visit Results Report

STATEWIDE HOME VISIT REVIEW DATA
FOR Year 2007

Number of Participants in Review Year: 208

	205	0	3	0	208	1.97	98.56%	0.00%	1.44%
V.E.2.a. CM notified participant of Waiver agent's agency specific complaint process, and explained this process to participant.	205	0	3	0	208	1.97	98.56%	0.00%	1.44%
Sub-Total Section V (3 standards):	605	0	19	0	624	1.94	96.96%	0.00%	3.04%
VI.A.2.a. Case record indicates that participant is satisfied with all of the following:									
c Current Services									
c Amount of services, and	187	0	21	0	208	1.80	89.90%	0.00%	10.10%
c Quality of services									
VI.B.2.a. Participant identifies and addresses strategies and supports, services and/or treatment needs to achieve desired outcomes.	202	0	3	3	208	1.97	98.54%	0.00%	1.46%
Sub-Total Section VI (2 standards):	389	0	24	3	416	1.88	94.19%	0.00%	5.81%
VII.A.2.f. Waiver agent ensures proper and cost-effective utilization of resources.	191	0	17	0	208	1.84	91.83%	0.00%	8.17%
VII.C.2.a. Waiver agent considers and respects participant's cultural background.	18	0	1	189	208	1.89	94.74%	0.00%	5.26%
Sub-Total Section VII (2 standards):	209	0	18	189	416	1.84	92.07%	0.00%	7.93%
IX.A.2.a. Participants receiving Adult Day Health paid for through the MI Choice program:	6	0	0	202	208	2.00	100.00%	0.00%	0.00%
IX.A.2.b. Participants receiving Chore Services paid for through the MI Choice program:	36	0	0	172	208	2.00	100.00%	0.00%	0.00%
IX.A.2.c. Participants receiving Counseling services paid for through the MI Choice program:	15	0	0	193	208	2.00	100.00%	0.00%	0.00%
IX.A.2.d. Participants receiving Environmental Accessibility Adaptations (Home Modifications) paid for through the MI Choice program:	17	0	0	191	208	2.00	100.00%	0.00%	0.00%
IX.A.2.e. Participants receiving Home Delivered Meals paid for through the MI Choice program:	98	0	1	109	208	1.98	98.99%	0.00%	1.01%

MI Choice Quality Assurance Reporting
Home Visit Results Report

STATEWIDE HOME VISIT REVIEW DATA
FOR Year 2007

Number of Participants in Review Year: 208

IX.A.2.f. Participants receiving Homemaking paid for through the MI Choice program, have indicated that the individual usually responsible for these activities is temporarily absent or unable to manage the home.	166	0	3	39	208	1.96	98.22%	0.00%	1.78%
IX.A.2.g. Participants receiving respite care (at home or outside of the home) paid for through the MI Choice program:	26	0	0	182	208	2.00	100.00%	0.00%	0.00%
IX.A.2.h. Participants receiving a PERS unit paid for through the MI Choice program:	134	0	2	72	208	1.97	98.53%	0.00%	1.47%
IX.A.2.i. Participants receiving personal care paid for through the MI Choice program require assistance with ADLs or reminding, prompting, cuing, and frequent direction to perform ADLs.	165	0	2	41	208	1.98	98.80%	0.00%	1.20%
IX.A.2.j. Participants receiving Private Duty Nursing paid for through the MI Choice program are not eligible to receive identical nursing services through another funding source.	57	0	0	151	208	2.00	100.00%	0.00%	0.00%
IX.A.2.k. Participants receiving Specialized Medical Equipment and Supplies paid for through the MI Choice program:	36	0	0	172	208	2.00	100.00%	0.00%	0.00%
IX.A.2.l. Participants receiving Training services paid for through the MI Choice program learn independent living skills required to maintain the individual at home.	4	0	0	204	208	2.00	100.00%	0.00%	0.00%
IX.A.2.m. Participants receiving Transportation services paid for through the MI Choice program:	72	0	0	136	208	2.00	100.00%	0.00%	0.00%
IX.A.2.n. Participants receiving Nursing Facility Transition Services resided in a nursing facility at the time of assessment and expressed a desire to return to the community with the assistance of the waiver agent.	6	0	0	202	208	2.00	100.00%	0.00%	0.00%
IX.A.2.o. Participant receives at least one waiver service on a continual basis to maintain eligibility	208	0	0	0	208	2.00	100.00%	0.00%	0.00%
Sub-Total Section IX (15 standards):	1046	0	8	2066	3120	1.98	99.24%	0.00%	0.76%
Totals:	5956	41	355	3216	9568	1.88	93.77%	0.65%	5.59%

8. Statewide Critical Incident and Resolution Report Data
Year 2008

STATEWIDE CRITICAL INCIDENT AND RESOLUTION REPORT DATA FOR YEAR 2008

Jan--2008 total waiver population 7,133		July--2008 total waiver population 7,581	
Totals	Percentage statewide	Totals	Percentage statewide
4	0.056	7	0.092
12	0.168	14	0.185
34	0.477	43	0.567
0	0.000	1	0.013
8	0.112	14	0.185
6	0.084	8	0.106
26	0.365	20	0.264
2	0.028	3	0.040
0	0.000	23	0.303
1	0.014	0	0.000
33	1.304	0	0.000
		133	1.754
32	0.449		
22	0.308	40	0.528
0	0.000	27	0.356
2	0.028	0	0.000
56	0.785	0	0.000
13	0.182	67	0.884
5	0.070	12	0.158
0	0.000	5	0.066
18	0.252	0	0.000
82	1.150	12	0.158
8	0.112	98	1.293
		14	0.185

Jan--2008 total waiver population 7,133		July--2008 total waiver population 7,581	
Totals	Thefts reported	Totals	Thefts reported
	Percentage statewide		Percentage statewide
16	0.224	24	0.317
			RESOLVED of the 133 cases
80	86.022	122	91.729
			NOT RESOLVED of the 133 cases
13	13.978	11	8.271
	*2 exploitations reported to law enforcement		

9. MI Choice Waiver Services and Supports
Quality Management Plan
2005-2007

**STRATEGY FOR ASSESSING AND IMPROVING
THE QUALITY OF MI CHOICE WAIVER SERVICES AND SUPPORTS
Finalized 8/23/2005**

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

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

Michigan developed its quality strategy with meaningful contributions from consumers, advocates and a caregiver who participated in monthly meetings with staff from DCH, MSA and waiver agent representatives. A leadership group composed of 7 consumers/advocates and 7 waiver agent representatives organized formally into the MI Choice Person Focused Quality Management Collaboration. Collaboration activities are supported by a 2001 Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services (CMS) and are co-facilitated by DCH and the Michigan Disability Rights Coalition (MDRC).

The purpose of the QM Collaboration is to include consumers/advocates in the development and review of MI Choice quality management activities. The Collaboration provides a venue where providers and consumers/advocates together can review a variety of quality outcomes (measured provider performance and participant survey outcomes), identify problem/issue areas that need improvement, develop strategies for remediation of service delivery problems/issues and recommend improvements that need to be made in the Michigan Medicaid service delivery system. The Collaboration also allows consumers/advocates to provide meaningful input during the implementation of person centered planning and self-directed care options that have been found to increase participant satisfaction with services and supports. First year achievements of the Collaboration:

- The QM Collaboration adopted a quality outcome review methodology that examined performance outcomes (data) drawn from the Michigan Minimum Data Set for Home Care (MDS-HC) Assessment System and tools sets (data reports) including 22 Quality Indicators (QIs). MDS-HC QIs are used to monitor individual participant outcomes. During any given QM planning cycle, one or more MDS-HC QIs are selected for planned interventions to improve on a specific participant outcome.

Interventions or strategies that are found to improve outcomes are shared with other waiver agents and documented as best practices.

- MDRC managed a project that involved consumers and their peers as interviewers of MI Choice Participants in their homes to test the CMS Participant Experience Survey (PES). This includes testing the 33 Quality Indicators in the PES methodology. The PES survey focuses on how participants perceive their services are being delivered along the four CMS Quality Framework domains of 1) Access to Care 2) Choice and Control 3) Respect and Dignity and 4) Community Integration.
- The chosen quality strategy includes updating service standards and contract requirements as routinely needed for assuring the health and welfare of the 1915 (c) waiver participant. The strategy incorporates the overall quality assurance compliance review system that Michigan conducts to monitor its providers, to meet CMS assurances and requirements.
- Collaboration members are also involved in the development of new measurement protocols to ascertain Quality of Life along dimensions deemed most significant to participant consumers with research guidance from Dr. Jim Conroy, Center for Outcome Analysis, Philadelphia and Dr. Brant Fries, University of Michigan, Institute of Gerontology, Ann Arbor. These new participant outcome measures are another product of Michigan's 2001 CMS Real Choice Systems Change Quality Grant to improve quality and will be the basis for add-on components administered in tandem with the MDS-HC assessment instrument. The package will be used to measure quality of life by looking at participant experiences with service delivery and personal outcomes.
- Michigan is implementing person centered planning and a self-directed care option in the MI Choice Waiver Program. Consumers/advocates are currently involved in policy and program development meetings for these options, as well as in significant LTC systems change planning through the Governor's Long Term Care Medicaid Task Force. The Chair of the Governor's task force is co-facilitator of the MI Choice QM Collaboration. Consumers/advocates provide direct feedback about the implementation of self-directed care options through the MI Choice QM Collaboration.

In its second year of operation, the Collaboration is evaluating its progress, goals, values, and structure with plans to expand QM Collaborations locally during 2005 and 2006, in conjunction with the implementation of the self-directed care option. Members believe that the strength of their endeavor is the interaction and growing mutual respect among members (providers, consumers, advocates and caregivers). Their efforts are centered on making quality improvements in the MI Choice Waiver Program for the benefit of all participants.

Consumers/advocates took an active role in developing waiver agent quality management goals contained in this plan. Michigan intends to continue to include consumers/advocates in the review of quality management activities, program and policy development and improvement changes we are making in the MI Choice program.

2. QUALITY VALUES AND FRAMEWORK

The MI Choice quality plan is built on a philosophy, a definition of quality and the CMS Quality Framework. The philosophy comes from the independent living movement, and affirms that those who best know what services and supports persons with disabilities need are the persons with disabilities themselves. This is valid for persons of any age, race, gender or sexual orientation.

The definition of quality comes from the Michigan Governor's Medicaid Long Term Care Task Force: **Quality** - A quality long-term care experience is an individual evaluation. Quality is defined and measured by the person receiving supports and not through surrogates (payers, regulators, caregivers, families, professionals, advocates). The elements of quality are meaningful relationships, continuing of community involvement in a person's life, personal well being, performance based customer satisfaction measures, the dignity of risk taking and the freedom to choose or refuse. The Governor's LTC Medicaid Task Force is convinced that a high quality LTC system of services and supports must recognize the primacy of the consumer.

The CMS Quality 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.

3. QUALITY MANAGEMENT PLANS

a. DCH Plan - The State establishes a quality management plan every two years which includes statewide goals and strategies. The State plan is focused on meeting CMS Assurances and Requirements for protecting the health and welfare of waiver participants, DCH contract requirements and targeted Participant outcome improvement goals. DCH also reviews each waiver agent's quality management plan annually. DCH guides, prompts and assists waiver agents in preparing and updating quality management plans based on individual agency results from compliance reviews, participant outcomes, consumer survey results, complaint history and other performance measured outcomes.

b. Waiver Agent Plans - Each waiver agent establishes a quality management plan that includes a quality assurance plan and a quality improvement plan. DCH requires that waiver agents update quality management plans formally at least every two years. However, good quality management plans are updated as frequently as each waiver agent deems it necessary to accomplish its goals.

The quality assurance plan addresses how the waiver agent intends to meet State and Federal assurances and requirements stipulated in the waiver agent contract with DCH, the CMS approved waiver plan, CMS protocols and Medicaid requirements for assuring the health and welfare of the participants in the waiver program. Waiver Agents include the DCH QM plan's required goals in their plans and add their own unique quality improvement goals. Waiver Agent plans are focused on meeting waiver requirements and any DCH or self-targeted quality improvement strategies, including service provider performance requirements and administrative improvements

4. QUALITY ASSURANCE: DCH COMPLIANCE REVIEWS

DCH, MSA, Administrative Support and Contract Development Section staff updated its compliance review methodology based on requirements defined in the December 20, 2000, CMS Regional Office "Protocols for Conducting Full Reviews of State Medicaid Home and Community Based Services Waiver Programs," and assurances that the State must meet in operating the MI Choice Medicaid Waiver Program for Elderly and Younger Adults with Disabilities. DCH, MSA staff and their monitoring contractors review program, clinical and administrative activities annually to assure that CMS Protocol Requirements and DCH Contract and Operating Standards are met, thereby assuring the health and welfare of participants enrolled in the MI Choice Waiver Program. These reviews include RN Care Plan and Case Record Reviews (process reviews) and Administrative, Financial and Program Reviews (structure reviews). DCH

contracts with the University of Michigan School of Nursing (UoM-SoN) to work with DCH to conduct the required RN Care Plan and Case Record Reviews. Administrative, Program and Financial Reviews are conducted by contract management staff. Prior to each review, DCH, MSA contract managers and monitoring contractors share all review tools/forms with Waiver Agents.

Note: It is the view of the MI Choice Waiver Person Centered Quality Management Collaboration that existing protocols are overly clinical/medical in orientation. Given the shift to a philosophy of person centered service and supports delivery at the federal and state levels, the Collaboration urges the redrafting of the Review Protocols to allow participant choice to override clinical/medical suggestions for care plans and service/supports. Until the protocols are redrafted, the Collaboration respects the need to conduct assurance reviews, but wishes to see recognition, properly documented, of participant choice in the care plans and records.

a. RN Care Plan and Case Record Reviews

To meet CMS requirements for RN review of care plan authorizations and case record reviews, DCH contracts with the University of Michigan, School of Nursing. Four M.S. RN reviewers sample 30 care plans and case records from each of 21 waiver agents. These reviews are conducted on-site and 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. DCH randomly selects the sample of thirty participant records for case record review. If significant issues, concerns or questions are found in the first 30 case records reviewed, the RN reviewer may opt to review additional records to make determinations.

RNs review and evaluate enrollment, assessment, level of care evaluations of eligibility, care planning and reassessment procedures. Both qualitative and objective data is collected and reviewed by the contract RN reviewers, who evaluate the waiver agent's assessment and the actions of supports coordinators, to assure that every item in the assessment is covered in the care plan. The RN reviewer determines:

- 1) Are all issues, concerns, conditions identified in assessment and reassessments addressed in the participant care plan, consistent with participant preferences and choice? If not, is there written documentation in the case record explaining why an intervention or service is not planned?
- 2) Have the participant, his/her family and natural supports been provided with choices in developing the care plan, including the right to refuse services? Is there evidence that participant preferences are honored in the care planning process?

- 3) If services were refused, is there documentation that the risk associated with refusing a service was addressed and followed up by supports coordinators? Were participants provided with choices between waiver service and institutional care, or among needed waiver services and providers?
- 4) Is each planned service and/or intervention chosen by the participant implemented in a timely manner and as specified in the participant-approved care plan or is there a reasonable explanation provided in the case record explaining why not?
- 5) Do services and interventions authorized in the care plan correspond to the participant's care needs and choices, are they adequate and appropriate based on assessment findings; do supports coordinators document delivery of waiver services and/or interventions consistent with care plans and/or service plans?
- 6) Are reassessments performed by the supports coordinators within every 90 days for Open Active participants, every 180 days for Open Maintenance participants and more frequently, as necessary, if the participant experiences significant status change? Is a determination made whether a participant needs a reassessment upon discharge from a hospital? Following any reassessment, are care plans updated with needed interventions and/or service changes? If there are changes in the participant's status, are these changes documented in the case record?
- 7) Does each participant meet the DCH eligibility criteria for a nursing facility level of care? Is suspected abuse, neglect or exploitation of a participant documented in a case record? Was a referral made to the State's mandatory reporting system, Adult Protective Services, and/or other organizations (including legal) to protect the participant from further abuse, neglect or exploitation and if not, what is the documented reason in the case record? (The case record must contain documentation that any interventions or services provided to protect the participant from further harmful occurrences are working.) The reviewer must determine whether adequate actions were taken by supports coordinators to reasonably prevent reoccurrence.
- 8) Did services accomplish their goals, and if not, were adjustments made in the plan of care?
- 9) Were natural supports used and bolstered by paid services? Were all required forms present and signed? Is there evidence that the participant understood all forms, including hearings and appeals, care plans, complaints, notices to suspend services, releases of information, participant choice for home care instead of institutional care and enrollment in the program and/or did a proxy understand the forms and provide signature? Is there evidence that the participant received services throughout the service year on an on-going basis?

The RN Reviewer documents written verification (evidence) for each of the items reviewed; discusses findings and recommendations with supports coordinators

when there are significant findings; prepares a written report of findings and recommendations that includes a request for written corrective action plan from the waiver agent to address significant concerns, issues or problems. The waiver agent responds to the request for corrective action within 30 days of receipt of the report. The RN reviewer is available to answer waiver agent questions or discuss concerns regarding the documented report of findings.

A final summary report to the waiver agent is DCH's official document in meeting the obligation to conduct care plan, service authorization and case record reviews for each waiver agent annually. The waiver agent may submit a written response to DCH regarding the final report within 30 days of receipt and this written response is attached to the official final summary report.

b. Administrative and Program Reviews

DCH, MSA contract management staff review waiver policy and procedures manuals, peer review reports, client satisfaction survey results, waiver agent provider monitoring reports, waiver agent provider contract templates, and required provider licenses to verify that requirements are met. If required items are not evident, DCH staff discuss the missing requirements with waiver agent staff prior to issuing the final review report. The final report verifies findings that 1) there was evidence that required item(s) were met as required, 2) no such evidence was found, or 3) incomplete evidence was found.

Contract managers conduct on site visits to verify that administrative and program policy and procedural requirements such as: program records must be maintained for six years; program records are locked and controlled access is maintained according to the Health Insurance Portability and Accountability Act (HIPAA) requirements; program policies and procedures are accessible to waiver agent employees. They also review waiver agent agreements with providers; perform provider reviews and conduct interviews with both supports coordinators and participants.

The MI Choice Review Protocol is structured according to the CMS Protocol and the CMS Quality Framework. Each review area in the MI Choice Site Review Protocol is separated into three parts, designated by numerical suffixes on the charts. Structure (.1 items) refers to policies and procedures that waiver agents are required to have in place. Process (.2 items) refers to evidence that the waiver agent is actually performing activities according to their policy and procedures. Outcomes (.3 items) refer to service results for participants.

The review form also contains proposed requirements for Person Centered Planning that DCH is working towards implementing. These items are not required by CMS, but will be required by DCH for MI Choice, after the policy is implemented and waiver agents are trained in PCP.

During compliance reviews, contract managers thoroughly read 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. The reviewer may inquire about a missing item during the review. If after a second or third inquiry, the reviewer cannot find language that addresses the topic, the reviewer will check “not evident.” Following review of the entire compliance document, a preliminary administrative report is prepared. This report includes the key findings of the clinical review summary from the RN’s care plan and case review. This preliminary report points out problem areas and instances where required documentation was not evident/not found. The report is sent to the waiver agent, which has thirty days to respond to the preliminary findings. After receiving the waiver agent’s written response and engaging in any necessary clarifying discussion, DCH prepares the final report. The waiver agent is provided 30 additional days to correct any deficiencies noted in its final reports.

c. Financial and Program Reviews

DCH contract management staff conducts program and financial reviews annually.

5. QUALITY IMPROVEMENT ELEMENTS OF THE QM PLAN

- a. **Consumer Surveys** – Effective consumer interviewing is a powerful tool that Michigan will use to identify weaknesses and problems so that improvements in the quality of services and supports can be made. MDRC is currently testing the CMS-developed consumer survey instrument, Participant Experience Survey (PES), for use in the MI Choice Waiver Program. Consumers are interviewed in their homes regarding what they think about access to service delivery, choice and control, respect and dignity and community integration while participating in the MI Choice program. We anticipate positive outcomes using the PES, which may be adopted by the state. Regardless of the choice of survey tool, all Waiver Agents must do consumer interviewing.
- b. **Consumer Complaints** – Michigan is considering development of a 1-800 number to manage complaints in the MI Choice Program.
- c. **Critical incidents management** – CMS requires a formal plan, developed and implemented by the state, to define, identify, investigate and resolve incidents, events or occurrences which jeopardize the health and welfare of a consumer. In the HCBS waiver application template for self directed care, states must address management of “critical events or incidents (e.g., abuse, neglect and exploitation) that bring harm, or create potential harm to a waiver participant.”

There are two critical incident management systems currently in place in Michigan: Adult Protective Services (APS) and Child Protective Services (CPS), both administered by the Michigan Department of Human Services (DHS). Both systems were designed for services provided by agencies or institutions. They do not meet fully the needs of participants in consumer directed programs for at least two reasons:

- First, they focus on extreme situations such as abuse, neglect and exploitation. Participants typically identify a wider variety of situations as critical incidents, such as being threatened or coerced by a service worker, left in an uncomfortable or unsafe situation or cared for by a worker who behaves inappropriately.
- Secondly, professionals such as supports coordinators and state staff use these systems. Participants do not have an active role in these systems, they have not been trained or required to identify and report incidents and they do not control the outcome of critical incident reports.

For these reasons, the current critical incident management systems are not fully compatible with consumer direction. The State will ask Waiver Agents to create local reporting and response systems for critical incidents, with regular reports provided to the State regarding the number of incidents recorded and the responses made. Until this new system is in place, the MI Choice Waiver Program will continue to use Adult Protective Services (APS) as mandated by Michigan law for reporting all suspected incidents of abuse, neglect and exploitation.

d. System Performance Issues/Problems – During FY 2004, the MI Choice Person Focused Quality Management Collaboration identified two systemic Medicaid service delivery problem areas that impact directly on the delivery of waiver and other Medicaid services. The CMS domain of Access to services is affected by either 1) a systemic delay of financial eligibility determinations that are not being conducted in a timely manner by DHS, (primarily in Wayne County, but other counties were also affected during 2004); or 2) difficulties in obtaining approvals for non-emergency medical transportation reimbursements to medical services from DHS due to a multitude of nonstandardized and unclear (or in some cases non-workable) procedures across the state. The DHS local offices are responsible for assuring the approval and dissemination of payments for non-emergency transportation to medical services to meet the requirements in the Medicaid State Plan. Additionally, the Collaboration identified a problem with transportation to and from emergency service, hospital emergency rooms or urgent care, when ambulance providers are not fully cognizant of Medicaid emergency transportation policy.

1. Transportation Issues

Medical Transportation To Medical Services - In order for the MI Choice Home and Community Based Services Medicaid Waiver Program participant to be successful in remaining at home and in the community, access (transportation) to medical services, i.e., doctor appointments, outpatient surgery, outpatient therapies, is critical.

Non-Emergency Medical Transportation to Medical Services

Medicaid non-emergency medical transportation to medical services is one method that is used to provide transport for beneficiaries when no other transportation to medical services is available. Per DHS policy, PAM 825, "non-emergency medical transportation to medical services is ensured."

Strategy - The waiver agent will develop a matrix based on local practice between the waiver program and each DHS office that describes the waiver agent's understanding of: 1) DHS (previously FIA) local policy and procedures and under what circumstances each DHS office approves and reimburses for non-emergency medical transportation to medical services in each Michigan county; 2) a description of county, DHS office headquarters and contact information for submitting request for approvals and reimbursements, including contact person, if available; 3) advance notice requirements for submitting requests for approval of medical transportation reimbursements 4) medical transportation reimbursement rates for each type of non-emergency medical transport available; 5) ability to retroactively secure approval of reimbursements for non-emergency medical transportation to medical services in unforeseen circumstances that do not meet local DHS office policy precisely; and 6) barriers and gaps in securing and obtaining non-emergency medical transportation to medical services in each Michigan county.

Information contained on the matrix will be sent to each DHS County Office with a request from DCH, Medical Services Administration (MSA) to verify local practices and policy and provide feedback on the clarity of the waiver agent account of local policy and procedures. Absent feedback from local DHS County Offices, MSA will submit matrix information to the DHS central office requesting verification of policy and practices in each Michigan county. Consumers and advocates in the MI Choice Person Focused QM Collaboration will review the matrix and provide feedback about the clarity and utility of the document. A wider distribution among advocates groups regarding non-emergency medical transportation to medical services will be requested through Collaboration members for the purpose of obtaining additional feedback on local practices. Following these reviews and subsequent amendments to the matrix based on feedback received from all sources, the matrix information regarding each county in the waiver region will be published on each available waiver agent website, the DCH MSA website and advocate organization websites to inform Michigan Medicaid recipients

how best to access non-emergency medical transportation to medical services in each Michigan county.

If, following review and clarification of DHS local policy and procedures for the assurance that non-emergency medical transportation to medical services is provided to Medicaid recipients, local DHS approval for non-emergency medical transportation remains elusive in some counties, DCH will form a medical transportation work group among DHS local offices, local waiver agents, DCH MSA, local consumers/advocates and the Michigan Department of Transportation to develop a strategic plan for improving non emergency medical transportation for Medicaid beneficiaries.

Emergency Medical Transportation to and from Emergency Medical Centers

Following a problem with emergency medical transportation from a hospital emergency room during 2004, MSA emergency medical transportation policy was distributed, discussed and policy issues clarified with waiver agents and QM Collaboration members. As the problem with emergency medical transportation from an emergency room was the misinterpretation of Medicaid policy by one ambulance provider in one region of the State, our plan is monitor providers and participant during 2006 and 2007 to identify whether or not there are pervasive problems with emergency medical transportation. Waiver agents must report participant problems/issues with emergency medical transportation to DCH contract managers as they occur.

2. Financial Eligibility Determination Delay Issues

In August 2004, the QM Collaboration discovered that Medicaid financial eligibility was not being determined by DHS in a timely manner in various counties in the State, primarily Genesee and Wayne Counties. The average number of days between waiver assessment/enrollment and the time participants received their first waiver service revealed large outlier averages in these counties for all waiver agents. Subsequent discussions in the Collaboration with Wayne and Genesee waiver agents revealed that backlogs of DHS eligibility determinations had reached an all-time high in Wayne County from November, 2003 – March 2004 when Medicaid application processing took over one year. The standard of promptness for financial eligibility is 45 days. By August 2004, DHS financial eligibility determinations for new Medicaid applicants were down to an average of 9 months pending in Wayne County and over the standard of promptness in Genesee County.

The extended application processing delay has severely hampered waiver agents' ability to provide services in these two counties. Waiver agents

are at considerable financial risk as a result of this delay. To explain, although Michigan has a procedure in place to reimburse waiver agents for waiver services provided to presumptively eligible participants for up to one year following date of service, the problem occurs when waiver agents who have presumed financial eligibility find out after one year pending at DHS that a presumed eligible person is not financially eligible, because he/she failed to disclose an asset. Under this circumstance, waiver agents have no way to get fully reimbursed for care management and administrative expenditures, which are calculated based on the total number of eligible days. Waiver agents are more than a little reluctant to enroll participants when there is a risk of not being reimbursed for care management services provided over an extended and lengthy period of time. According to federal requirements, waiver agents are not permitted to enroll waiver participants without providing the full complement of services that are needed based on assessment results and managing every case fully, which includes assessment, full service arrangement, follow-up, on-going monitoring and performing reassessments every 90 days, or more frequently when there is a participant status change.

Strategy - To address this problem, DCH began meeting with DHS staff to discuss remedies from several directions. DCH and DHS are developing strategies, process improvements and tracking/monitoring functions to reduce the delays in application processing in Wayne County. These monthly meetings are continuing. Additionally, DCH and DHS convened a Wayne County work group to meet with Stakeholders, including waiver agents, on a regular basis. Steps are being taken to address the issues of large caseloads, staff shortages and staff training. Additionally, some provider education/training is being planned, particularly with nursing facilities, so that provider applications are submitted to DHS with complete information that is needed to process applications.

By January 2005, Medicaid applications were being processed within the standard of promptness for Genesee County. Wayne County waiver agents reported that new application processing dropped to 50 days, however it was still taking up to 6 months to complete application processing on cases opened at one Wayne County district office transferring to a different Wayne County office. Currently, Wayne County waiver agents report that new applications are being processed within 60 days, generally. Some are quicker. Others are slower. However, transfer cases remain a problem. Since the creation of the Wayne County Community Task Force, waiver agents have implemented additional steps with transfer cases. Before waiver agents submit Medicaid applications to DHS, they check to see if these beneficiaries have an open enrollment in the Client Information System (CIS). If they do, the waiver agent indicates the district and prints out a copy of the Medi-fax screen and attaches this

information to the application that is sent to DHS for application processing.

It is too early to tell whether this additional step will reduce the application processing time with transfer cases. The groups will continue to meet until this problem is resolved. Wayne County waiver agents are doing presumptive eligibility with new waiver enrollments unless there is a red flag question regarding whether the person will be determined financially eligible by DHS. Waiver agents are providing the full array of appropriate waiver services following enrollment of presumptive eligible individuals into the waiver program. DCH will continue to monitor the problem and work on strategies with DHS to eliminate standard of promptness problems.

6. QUALITY IMPROVEMENT GOALS AND QUALITY INDICATORS

Use of the MDS-HC and related tools: In 1998-99, DCH adopted the Minimum Data Set for Home Care (MDS-HC) assessment system for a variety of reasons, one being the increased likelihood of improving quality in the MI Choice Medicaid Waiver Program. Rigorously studied by InterRAI researchers in 20 countries and tested to establish the reliability of each item, the MDS-HC Assessment System contains time-measured outcomes, assessment protocols, a case-mix algorithm and 22 clinical quality indicators. InterRAI's goal in developing the MDS assessment system is "to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data about the characteristics and outcomes of persons served across a variety of health and social services settings." The MDS-HC was designed specifically to highlight issues related to functioning and quality of life for individuals residing in communities.

The MDS-HC and its instruction manual provide a standardized approach to evaluating the health status and care needs of frail elderly and younger adults with disabilities living in the community. The comprehensive instruction manual contains item-by-item instructions for using the MDS-HC with suggested assessment processes and procedures.

All items in the MDS-HC assessment system are defined in the Instruction Manual and have been reviewed by home care clinicians, researchers and administrators. Inter-assessor reliability levels were established for each item. The MDS-HC provides specific measures of individual performance and health over time making it a good comparison to itself from assessment to reassessments in measuring and monitoring participant outcomes.

The MDS-HC was designed to be a usable, useful participant assessment system that informs and guides comprehensive care planning in the home environment. Particular MDS-HC items identify participants who could benefit from further evaluation of specific problems and risks for functional decline. These items, known as triggers, link the MDS-HC to a series of problem-oriented Client Assessment Protocols (CAPs). The protocols or "CAPs" contain general guidelines for conducting further assessment and individualized care planning for participants who have the problematic trigger conditions. Comparable Resident Assessment Protocols (RAPs) in nursing facilities were found to improve care planning and services provided. For this reason, waiver agents use the MI Choice CAPs and triggers report(s) following assessments to identify individuals who present any problems or risks that warrant additional examination. A final point of importance is that the MDS-HC can be reliably compared to the Minimum Dataset for Nursing Facility Residents (MDS RAI). This enables a view of long term care across care settings.

Additionally, 22 quality indicators (QIs) are defined in terms of clinical characteristics collected by the MDS. These QIs define individual characteristics and take on meaning when expressed as averages at the waiver agent and statewide program levels to produce summary measures reflecting presumed quality of care. Each QI has an explicit definition, inclusion/exclusion criteria and tested risk adjusters. An obvious advantage of using the MDS-based quality indicators in Michigan is that they are derived directly from our computerized assessment instrument, thus facilitating their calculation without the need for additional data collection. This is a rich dataset, since Michigan data has been collected statewide since 1998 in the current format.

The MDS-HC QIs are new tools providing a first step along the path of quality improvement for home care participants. These indicators can provide high-quality evidence on performance at the waiver agent level. At the state level, the MDS-HC QIs are good guides in revealing how the state is doing overall, as well as how each waiver agent is performing in protecting the health and welfare of MI Choice participants. As noted above, additional research comparing the MDS-HC QIs with other measures of quality, including quality of life outcomes and consumer survey experiences, is also being conducted in Michigan.

The ability to actually improve quality also depends on the successful communication of findings to appropriate target audiences, the capacity of home care professionals to make evidence-based decisions, the availability of effective solutions to address identified quality problems and the resources to implement those solutions. Waiver agents, consumers/advocates and DCH 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. Collaboration members recommend interventions to be targeted and tested that might lead to improvements in services and supports in selected target areas. Baseline data is

established on a selected target area prior to the implementation of an intervention. All waiver agents conduct interventions during the year for targeted statewide goals. Individual waiver agents may select improvement goals and interventions based on their unique circumstances. Follow-up data outcomes are then run a year later on target areas and analyzed to determine whether planned interventions were successful at improving service delivery and participant outcomes.

Michigan has established a two-year baseline line using the 22 quality indicators for each waiver agent, as well as a statewide average. An additional two years of data is available to add to this baseline. Michigan plans to monitor the 22 quality indicators over time, by waiver agent and by statewide average, then discuss participant outcomes and identify various interventions that can be tested to improve participant outcomes. During each quality planning cycle we intend to target priority outcomes for improvement. As we learn what improves various participant and performance outcomes, best practices among waiver agents is shared and written into best practices documents. DCH reinforces exemplary performance by highlighting waiver agent best practices.

MDS-HC QIs are subject to public review and discussion in the MI Choice Person Focused Quality Management Collaboration. After MI Choice gains some experience in using the MDS-HC QIs, identifies interventions that prove to be successful at improving targeted QIs, we will begin establishing acceptable ranges or benchmarks for each of the 22 QIs.

Statewide averages and waiver agent data are run on the twenty-two MDS-HC Quality Indicators annually to monitor participant outcomes. One quality indicator, the prevalence of intense daily pain, was selected for quality improvement purposes for this QM Plan. Time periods to run new data for 22 MDS-HC QIs: 10/1/2005 – 9/30/2006 and 10/1/2006 – 9/30/2007. Additionally, University of Michigan, Institute of Gerontology will conduct data analysis on these 22 MDS-HC Quality Indicators for baseline purposes from 2001 – 2004 by waiver agent and statewide average. Additional data was collected for informational purposes only: Number of waiver participants and average cost in each of seven RUGs categories by waiver agent and statewide. Time periods to run new data: 10/1/2005 – 9/30/2006 and 10/1/2006 – 9/30/2007

Data Sources

Compliance Reviews

Consumer Surveys

MDS-HC-Quality Indicators

Waiver Agent Reports

Analysis and Report Displays by University of Michigan, IOG

WaiverAgent and Statewide Reports by Center for Information Management

Other Quality Indicators from MI Choice Information System (MICIS)

Medical Services Administration's Data Warehouse, loaded from MICIS

Goals and Quality Indicators for FY 2006 and 2007

This State Quality Management Plan begins on 10/1/2005 and expires on 9/30/2007. Comparable data sets will be run annually during time periods noted for each quality indicator. Requirements are described further as follows for the statewide quality improvement goals.

Reports, which were distributed to all waiver agents in 2004, establish statewide and waiver agent baseline performance outcomes, using 2003 data sets primarily. Based on its performance outcomes for each measure, each waiver agent determines what goals it needs to include in its quality improvement plan for 2006 and 2007. The agent needs to consider including each goal in its plan where there is clearly opportunity to make improvements. For each goal, the waiver agent must describe why it has included a goal in its quality improvement plan or why it does not need to include the goal; for example, agent performance on a particular goal is currently stellar. DCH reviews and approves each waiver agent's quality improvement plan based on agent performance outcomes. DCH will either agree or disagree with the agent's evaluation of these goals based on agent performance outcomes.

For each of the goals included for quality improvement, the waiver agent must describe what its baseline performance outcome is in each measure and what the agent's improvement goal is. (How much does the agent plan on improving each goal?) The waiver agent must describe interventions and strategies that it will use to improve the outcome for each goal, including how it intends to drill down and investigate quality indicators further when this is necessary, for example, percentage of provider "No Shows".

For each goal an agent proposes not to include in their agency's quality improvement plan due to current stellar performance, the waiver agent must propose a replacement goal that is deemed useful and worthy of improvement to the waiver agent, with descriptions of interventions and quality indicators that the waiver agent intends to use for each unique quality improvement goal.

Integrity of Data

1. **Goal: To Decrease the percent of missing data items in the MI Choice Assessment System by Waiver Agents and in Statewide Reports**

Actions: Each waiver agent evaluates missing data and implements intervention(s) to decrease missing data items in its assessment system i.e., evaluate the system for cause(s) of missing data in the assessment system and plan intervention(s) to eliminate or reduce missing items.

The waiver agent defines planned intervention(s), documents barriers and successes in meeting quality objectives, monitors, reassesses and realigns the plan as necessary to achieve goal.

Quality Indicator: Completeness of items in the MI Choice Assessment System (as measured by the percentage of completeness of MDS-HC items contained in the MI Choice Assessment System by waiver agent and average statewide vs. percentage of “missing data”). DCH expects that each waiver agent will make improvements in this QI compared to their baseline. The University of Michigan, Institute of Gerontology, conducts data analysis annually on this QI. Time periods for data run for data completeness of data sets: 10/1/2005 – 9/30/2006 and 10/1/2006 – 9/30/2007.

Access to Services

2. **Goal: Decrease the percent of provider “No Shows” reported by waiver agent and Statewide. Increase the percentage of planned service actually delivered through the decrease of provider “No Shows.”**
 - a. Define the percent of provider no shows by waiver agent and Statewide

Actions: This quality indicator requires the waiver agent to first determine whether there is a provider “No Show” problem in the service delivery network. This can be accomplished by several different methods and each waiver agent must describe in its quality improvement plan how it proposes to drill down or investigate this issue. Waiver agents are required to compare the percent of authorized services in care plans that are not delivered because both the original provider and a back-up provider failed to show vs. the percent of family or participant service refusals or other mitigating events (i.e., hospitalization, conflicting appointment, etc.) as reasons for services not being rendered as authorized and planned.

Two examples of how a waiver agent might develop evidence of whether or not it has a No Show problem:

- 1) Conduct a one-month sample review of all participant case record documentation during the 2003 baseline time period. During the month, identify and document all incidents, total units, total expenditures and the reason why a service was not rendered as planned per the plan of care.
- 2) Select one month of data over a several year time period, record all incidents and reasons (including total units and total expenditures) that service is not rendered as planned per the plan of care. During the months selected, identify and document all incidents and the reasons (including total units and total expenditures) why a service was not rendered as planned per the plan of care.

In either example, organize the reasons into two categories: 1) no show of provider, with no back up provided; or 2) participant cancelled due to any reason. Conflicts with a participant appointment outside of the home should be included

in this category. Compare the total number of units and total expenditures of no show by providers (numerator) to the total number of units and total expenditures in all plans of care (denominator).

The percent that is calculated from either method of investigation is the waiver agent's outcome for "No Shows" by providers. The percent of total units and total expenditures in the care plan that are actually received by the participant is 100% minus the percent of Provider No Shows. The total units and total expenditures and the percentage from services actually provided in this sample must be submitted annually to DCH, MSA, Contract Managers by September 30th.

Waiver agents must define planned intervention(s), document barriers and successes in meeting quality objectives, monitor, reassess and realign plan as necessary to achieve goal.

Quality Indicator: The Percent of Actual Service Delivery to Planned Service Delivery. The Percent of total units and total expenditures in the care plan that are actually received by the participant

Time periods to run new data for percentage of planned vs. actual services received: 10/1/2005 – 9/30/2006 and 10/1/2006 – 9/30/2007.

3. **Goal: Improve the timeliness of service delivery following enrollment and assessment of each participant.**
 - a. Decrease the average number of days between enrollment in the waiver program and participant receipt of first waiver service.
 - b. Decrease the longest and next longest number of days between enrollment and first day of waiver service.

Action: When the average number of days between enrollment and first service is greater than 7, the waiver agent must include this indicator in its quality improvement plan for the year. Waiver agents with an average number of days between enrollment and first service equal to or less than 7 may select another goal and quality indicator to use in their quality improvement plans.

Waiver agents must define planned intervention(s), document barriers and successes in meeting quality objectives, monitor, reassess and realign plan as necessary to achieve goal.

Quality Indicator: Timeliness of first service delivery – The average number of days between enrollment in the waiver program and participant receiving the first waiver service.

- a. This outcome also includes shortest, longest and next longest number of days between enrollment in the waiver program and participant receiving the first waiver service.

Time period to run new data for this quality indicator: 10/1/2005 – 9/30/2006 and 10/1/2006 –9/30/200

- 4. Goal: Decrease the number of waiver participants who received no waiver services and were enrolled in the waiver for 30 or more continuous days.**

Action: Include this goal in the waiver agent quality improvement plan when the waiver agent has more than (for example) 3 participants enrolled in the waiver program for 30 or more continuous days and participants received no waiver services.

Waiver agents define planned intervention(s), document barriers and successes in meeting quality objectives, monitor, reassess and realign plan as necessary to achieve goal.

Annually report (on September 30) the number of participants who were enrolled in the waiver program 30 or more continuous days with no services and their respective number of continuous days for the year that is ending to DCH, MSA Contract Managers.

Quality Indicator: The total number of enrolled waiver participants who received no waiver services for 30 or more continuous days during the fiscal year that is ending: 10/1/2004 – 9/30/2005

- a. Time period to run new data for these quality indicators:
10/1/2005 – 9/30/2006 and 10/1/2006 – 9/30/2007

Participant Outcomes

- 5. Goal: Decrease the percent of participants with a prevalence of disruptive or intense daily pain. (Daily pain, severe or excruciating pain or pain that disrupts usual activities.)**

Actions: Waiver agents define planned intervention(s), document barriers and successes in meeting quality objectives, monitor, reassess and realign plan as necessary to achieve goal.

Quality Indicator: The percent of participants who have a prevalence of disruptive or intense daily pain. (Daily pain, severe or excruciating pain or pain that disrupts usual activities.)

Time periods to run new data for 22 MDS-HC quality indicators:
10/1/2005 – 9/30/2006 and 10/1/2006 – 9/30/2007

7. WAIVER AGENT QUALITY ASSURANCE PLANS

All waiver agents must include the following items in their quality assurance plans.

Data Integrity

1. Assure the accuracy of assessor evaluations of each item in the MI Choice Assessment System.

Actions:

- a. Evaluate on a regular basis whether supports coordinators are completing assessment items according to MDS-HC instructions.
- b. Describe interventions, strategies or actions that are designed to identify when assessors are not completing items according to assessment instructions.
- c. Describe how the waiver agent plans to correct, improve, increase and maintain the accuracy of assessor evaluation.

Care Planning – Choice and Control

1. Assure that all participants have service back-up plans to deal with situations when planned services fail.

Actions:

- a. When a back up plan is activated and doesn't work, supports coordinators assess why the back-up plan didn't work. Based on this evaluation, the supports coordinators reassess back-up plan for participant and may opt to develop a new back-up plan.
 - b. Waiver agent develops a method to track when back-up plans are activated, when the back-up provides services and when they didn't.
 - c. Waiver agent defines planned intervention(s), documents barriers and successes in meeting quality objectives, monitors, reassesses and realigns plan as necessary to meet the assurance.
2. Assure that all participants are provided with a meaningful and understandable copy of their care plan.

Definition: A meaningful and understandable copy of a care plan is one that clearly describes each arranged and purchased service, natural support or intervention that is planned for the participant to receive from a paid or non paid service worker or natural supports person.

Evidence: Evidence in the participant's care record that the person received a copy of a person focused or person centered care plan.

Actions:

- a. DCH assists waiver agents in developing the person centered planning option.
- b. Waiver agent implements person centered planning option

- c. DCH provides person centered planning training.
 - d. Waiver agent defines planned intervention(s), documents barriers and successes in meeting quality objectives, monitors, reassesses and realigns plan as necessary to meet the assurance.
3. Assure that all participants are provided with the right to refuse services or supports (participant choice is honored) and when there is risk associated with refusing services that this risk is addressed appropriately (explained) with the participant.

Definition: Risk is the potential for realization of unwanted, adverse consequences to human life, health, property or the environment. Depending on individual circumstances, people who receive services in the MI Choice Medicaid Waiver Program can be at risk of adverse outcomes.

Actions:

- a. Supports coordinators identify and document risks in participant case records.
 - b. Supports coordinators develop individualized plans for addressing (designed to reduce risk) identified participant risks.
 - c. Supports coordinators monitor identified risk and risk management strategies designed to reduce risk.
 - d. Evidence is entered in the participant case record that a risk(s) of refusing a service is explained.
 - e. Waiver agent defines planned intervention(s), documents barriers and successes in meeting quality objectives, monitors, reassesses and realigns plan as necessary to meet the assurance
4. Assure that all participants are provided the option to participate in person centered planning.

Actions:

- a. DCH assists waiver agents in developing the person centered planning option.
- b. DCH provides person centered planning training.
- c. Waiver agent implements person centered planning process option.
- d. Evidence is entered in the participant case record that person centered planning is offered to participant.
- e. Waiver agent defines planned intervention(s), documents barriers and successes in meeting quality objectives, monitors, reassesses and realigns plan as necessary to improve goal.

**Michigan Department of Community Health
Updating MI Choice Quality Management Plans
September 4, 2007**

The current quality management plans expire on September 30, 2007. The new quality management plan begins on October 1, 2007 and ends on September 30, 2009. MDCH and each waiver agent must update their quality management plan by September 30, 2007. Waiver agents must submit their updated quality management plans to MDCH contract manager, Elizabeth Gallagher or Pamela McNab in Larry Parker's absence by September 28, 2007.

How to Update the Waiver Agent Plans

The MI Choice Person Focused Quality Management Collaboration met on August 28, 2007 to recommend to the department updates and additions to the QM plans. MDCH accepted the following Collaboration recommendations:

- 1) Continue all required assurances and improvement projects contained in the FYs 06 & 07 plan. This includes waiver program assurances that waiver agents use to meet CMS and MDCH requirements, including the newer required assurances on page 20 of the current plan.
 - a) data integrity: assuring the accuracy of assessor evaluations;
 - b) care planning choice and control: assuring that participants
 - i) have service back up plans;
 - ii) are provided with a meaningful and understandable copy of their care plan;
 - iii) are provided with a person centered planning option; and
 - iv) are provided with the right to refuse services or supports and when there is risk associated with refusing services that risk is addressed appropriately (explained) with the participant.

- 2) Continue all required FY 06 and 07 quality improvement projects. Waiver agents that met the following goals in FY 2006 must write and implement strategies for maintaining and monitoring the goal. Waiver agents that have not met the following goals in FY 2006 must write and implement strategies for improving each goal.
 - a) FY 08 & 09 Overall provider no show rate: goal = 1% when the FY 2006 waiver agent rate reported a rate of $\leq 3\%$ overall. When the FY 06 overall no show rate for the waiver agent was $>$ than 3%, then the new goal is 3% for these agencies. Waiver agents with a FY 2006 overall provider no show rate of 1% or less should plan to monitor and maintain their provider no show rate.
 - b) FY 08 & 09 timeliness, overall average number of days between enrollment and first date of service delivery goal = 7 days when the FY 2006 waiver agent average is $>$ 7 days, 5 days when the FY 2006 waiver agent average is $<$ 7 days. Waiver agents with an overall average of $<$ 5 days during FY 2006 should plan to monitor and maintain or lower their average at or below 5 days.
 - c) FY 08 & 09 total number of participants enrolled in the waiver program not receiving waiver services for $>$ 30 days. When the FY 06 total number of participants is $>$ 3, the waiver agent goal is $<$ 3. When the FY 06 total number of participants is $<$ 3, the waiver agent goal is 0. Waiver agents reporting "0" as the number of

participants not receiving waiver services for > 30 days during FY 2006 should plan to monitor and maintain this number at 0.

Exceptions to be used in calculating the quality indicators for 2b and 2c:

Participants with the following situations should be excluded from the negative counts for both quality indicators.

- 1) Participant enters a hospital for what is intended to be less than 30 days. Services are discontinued, but participant stays longer than 30 days, then case is closed due to a hospitalization that exceeds 30 days. Do not include participants who stay unexpectedly in a hospital for longer than 30 days in these counts. These participants are receiving services in a hospital and should be closed to the waiver when the hospitalization extends beyond 30 days.
- 2) Participant is enrolled in the waiver, then discovers that they will be receiving skilled services for a while and chooses not to receive waiver services until the skilled services end. These participants may remain on the waiver and are monitored by the waiver agent supports coordinators. Do not include these participants in the negative QI counts.
- 3) Participant is enrolled in the waiver, informal caregivers are providing services, but have not started to be paid for their services for administrative reasons. These participants may remain on the waiver and are monitored by the waiver agent supports coordinators, because they are receiving services from informal caregivers who are working on getting paid by the waiver. Do not include these participants in the negative QI counts, because they are receiving services.
- 4) Participants may be enrolled in the waiver not receiving waiver services, but require monitoring. Do not include these participants in the QI, because they are receiving required monitoring. Be certain to document monitoring activities, reason for monitoring only while receiving no waiver services in the participant case record.

FY 08 & 09 New Assurance Plans

The FY 08 & 09 QM plans must contain an assurance to implement and provide person centered planning and self-determination options during FY 08. Waiver agents will report the number of participants who have initiated the person centered planning process and the number of participants enrolled in Self Determination in Long Term Care (SD in LTC) during each fiscal year in the annual quality management report, due to MDCH on January 15.

Waiver Renewal

CMS is currently reviewing the five year renewal waiver plan for approval. MDCH wrote this renewal plan into a new template (new format) with additional quality management requirements for both traditional and SD in LTC options. MDCH will provide the waiver agent with additional CMS requirements as soon as the state receives approval from CMS. Most of the new quality requirements are for the implementation of PCP and SD in LTC quality and monitoring. MDCH will also discuss these requirements in future SD in LTC trainings. Following CMS approval, MDCH will inform waiver agents of the requirements and request waiver agents to

submit an addendum to the waiver quality management plan to address the new requirements.

Final Comments

Waiver agent quality management plans, both elective assurances and elective improvement projects, can be rewritten and/or reduced as deemed necessary by each waiver agent. All required assurances and improvement projects contained in the current plan must be maintained although strategies can be changed and/or updated. Goals should be updated as needed per instructions above. Strategies that were found to be not helpful can be discontinued and new strategies can be planned.

Waiver agents submit the same type of updated quality management plan to MDCH by September 28, 2007 as submitted previously for 2006/2007. MDCH will continue to review all quality plans annually. MDCH will review implementation of the new QM plans during the summer of 2008 similar to the reviews conducted during the summer of 2006.

MDCH continues to require that waiver agents conduct consumer surveys. POSM surveys are required for all persons enrolled in SD in LTC, prior to PCP and then every 6 months. MDCH has not implemented a 1-800 number to manage complaints in the MI Choice Program. Complaint logging is still required for MDCH staff and waiver agents. Critical incident management continues as a requirement for waiver agents with submission of reports to MDCH semi annually on January 15th and July 15th.

No decisions have been made regarding non medical transportation and DHS financial eligibility determinations goals for the new quality plan. These two issues are suspended and are not required to be addressed in the new plan. Continued monitoring of these two systemic problems and reporting of such in the waiver agent quality summary reports on January 15th is greatly appreciated.

MI Choice waiver agents will continue to use the InterRAI Assessment System that contains the MDS-HC. Discussions have begun regarding the use of the updated MDS-HC version called the HC Suites. Information about this home care assessment tool and how it works can be found on the following website: InterRAI.org

10. Acronyms for the Statewide Waiver Agencies

Agency	Full Name	Location
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

11. State of Michigan Map
Home and Community Based Services Waiver for the Elderly and Disabled
Regional Service Areas

· 12. Glossary of Acronyms and Terms

Glossary of Acronyms and Terms

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 – 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 – 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.

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.