Quality Improvement

Program Evaluation

2013
INTRODUCTION

Care Wisconsin’s Quality Management Program uses the Home and Community-Based Quality Framework of Discovery, Remediation, and Continuous Improvement; and incorporates the Institute of Medicine’s six aims for healthcare—safety, effectiveness, member-centeredness, timeliness, efficiency, and equitability. This document provides an evaluation of the 2013 Quality Management Program; identifying both strengths and opportunities.

There are four sections in this report:

Executive Summary - The accomplishments, a brief analysis, and challenges or next steps are identified for each area of focus in the 2013 Quality Improvement Work Plan.

Quality Improvement Work Plan - Analysis of previous and on-going initiatives and how they shape the plan ahead. These are the seven areas of focus or domains that Care Wisconsin categorizes quality into:

- Member access
- Member-centered planning
- Member safeguards
- Member rights and responsibilities
- Provider access and capabilities
- Member outcomes
- System performance

Annual Quality Review - The results of the 2013 Annual Quality Review completed by MetaStar to ensure our compliance with the Department of Health Services standards.

EXECUTIVE SUMMARY

Member Access

2013 Analysis
Both the Family Care and Partnership programs experienced census growth in 2013. Both programs exceeded budgeted census goals.

![2013 Care Wisconsin Total Census](chart)

Four initiatives took place in 2013 to support the strategic goal of assuring high performance in order to be the managed care organization of choice. These were (1) remain below 3 percent of the census permanently residing in a nursing home, (2) increase the use of self-directed supports, (3) reduce incidents during care transitions, and (4) reducing critical falls.

2014 Challenges or Next Steps
The organizational strategic goal through 2018 is to achieve and maintain outstanding customer/member service and quality outcomes by (1) achieving and maintaining a 5 STAR rating for Medicare plan, (2) achieve high member/customer satisfaction, (3) achieve high quality member services through the development of programs that empower and support members, and (4) achieve care management excellence.

Member-Centered Planning and Service Delivery

Internal File Reviews
The Internal File Review (IFR) Committee consists of senior management, front line providers and program management in both programs. A monthly score card is published to show findings from the previous month. Results are reviewed and focus is put on the indicators with low scores. Individual chart
reviews are shared with Program Managers who then discuss results with teams. In addition, scores are compared with AQR scores.

2013 Analysis
MetaStar tended to score Care Wisconsin higher across all of the indicators except for Notices of Action sent when indicated and IDT follow up to ensure services are effective. Reasons for this are likely to be that Care Wisconsin reviews a much higher sample of charts than MetaStar.

2014 Challenges or Next Steps
The 2014 DHS Corrective Action Plan will monitor notices of action sent when indicated and IDT follow up to ensure services are effective. Targeted training and intervention will be implemented to increase compliance.

Member Centered Plan Timeliness
The Member Centered Plan (MCP) is completed every six months with the member, and whomever they wish to include, and is focused on 12 quality of life domains. The team must review, revise, and obtain member signatures on MCPs every six months. Care Wisconsin monitors MCP timeliness on a monthly basis.

2013 Analysis
Both Family Care and Partnership scored over 90 percent consistently in 2013 according to internal reports. However, results from the Annual Quality Review show that the timeliness of the most recent plan is much lower. This may be due to a much smaller sample size being reviewed for the quality review as opposed to Care Wisconsin’s report, which pulls results for all members.

2014 Challenges or Next Step
Continue to monitor MCP signature dates to ensure contractual compliance with care plan timeliness.

Member Safeguards
The primary responsibility of the care team is to assure member safety. This is a routine part of their work in assessing, planning, and monitoring supports to meet member needs and outcomes. When risks are identified plans are developed to reduce them as much as possible, or in some cases, to develop risk agreements with members who exhibit particularly risky behavior and are unwilling to change.

Incident Reporting
A robust incident reporting system is used to monitor critical incidents and adverse events. Critical incidents are reported in detail to the Department of Health Services each quarter. In-depth root cause analyses are completed for significant events.

2013 Analysis
Almost eighty percent of the 686 incidents reported in 2013 were critical incidents. This is an increase in the rate per 50 members from the average in 2012, a continuing trend believed to be a result of better
reporting based on education provided in 2012. In both programs for 2013 there was a slight decline in the second quarter, a rise in the third, and a decline again in the fourth.

Critical falls (with a fracture or head injury) were reported 232 times. Of the 78 incidents reported which occurred within 30 days of a care transition, the most common critical incident type was a fall. A care transition performance improvement project, started in 2012, is still ongoing and addressing this. In 2013 Care Wisconsin began monitoring fall assessment completion rates for critical falls.

2014 Challenges or Next Steps

- Modify the Program Manager’s section on critical falls (used to help increase awareness of critical falls and falls assessment completion rate)
- Begin discussions on changing the process of collecting data to incorporate the transition to the new intranet and SharePoint.

Use of Restrictive Measures

The use of restraints or restrictive measures is only allowed when all other measures to keep members safe from themselves or to protect others have failed. The Restrictive Measures Committee approves the use of restrictive measures for members in the developmentally disabled target group before submitting the plan to the Department of Health Services for approval. In 2012 the committee began tracking data on renewal applications to determine how many were approved on the first submission to the State. In 2013 the committee began reviewing all upcoming renewals that were previously approved by the State.

2013 Analysis

The restrictive measures database tracks and monitors the various categories of restraints and restrictive measures. Care Wisconsin has 20 members with medical restraints and 21 with restrictive measures. One restrictive measure was discontinued in 2013 due to non-use.

2014 Challenges or Next Step

The Restrictive Measures Committee Team Lead will continue to track restrictive measures and will evaluate more standardized oversight over medical restraints and restrictive measures in the physically disabled and frail elderly target groups.

Member Rights and Responsibilities

Grievances and Appeals

The Member Rights Specialist works as a resource for members and teams in order to protect member rights and to preserve and develop relationships. Mediation skills are used to resolve member concerns whenever possible. When mediation fails grievances and appeals are encouraged.

2013 Analysis

Appeals fell by about half from those reported the previous year, which made 2013 appeal numbers more consistent with those in 2011. The number of Notice of Actions (NOA) decreased by 36 percent from
those issued in 2012. Overall, about 6 percent of NOAs were appealed, which is fairly consistent with the
8 percent appealed in 2012. Partnership experienced an increase in the percentage of NOAs appealed,
from 7 percent in 2012 to 18 percent in 2013. However, this 11 percent increase is caused by a significant
drop in NOAs issued in 2013 (211) versus 2012 (977). The Partnership program restructured and
reviewed care plans in 2012, which contributed to the higher number of NOAs issued that year. In
Family Care the percentage of NOAs appealed decreased from 9 percent in 2012 to 4 percent in 2013. In
contrast to Partnership, the number of NOAs issued in Family Care increased from 800 in 2012 to 923 in
2013.

In 2013 the Quality Improvement Department continued to streamline processes, put data validation
checks into place, and create process maps. Process maps were created for internal Medicaid appeals,
expedited Medicaid appeals, appeals though the Division of Hearings and Appeals, level of care appeals,
cost share appeals, room and board appeals, medication appeals, Medicare Part C and D appeals, and
MetaStar investigations. Most of these appeal processes differ, so these maps will help Member Rights
Specialists clearly explain the appeals process to members and teams.

2014 Challenges or Next Steps
- Continue efforts to increase the use of mediation in appeals
- Consistently and efficiently work through appeals and meet data reporting requirements
- Update Medicare Part C and D gap analysis and policies

Member Advisory Committee
Care Wisconsin met the goal, established in 2012, of having a Member Advisory Committee in each of
the represented counties holding quarterly meetings. In one of those committees two counties (Sauk and
Columbia) are both represented, bringing feedback from members in all ten original represented counties
back to Care Wisconsin leadership.

2013 Analysis
In 2013 the Member Advisory Committee meeting format became more focused and started discussing
the same topics in the same quarter across all county committees. This enabled Care Wisconsin to obtain
feedback from all of the counties at the same time on key agency issues to aid in decision-making and
program and process improvements.

2014 Challenges or Next Steps
Key topics for discussion based on organization strategic goals and initiatives were developed and will be
discussed in 2014, including: strategic goals, member satisfaction, SDS (self directed services/supports),
integrated employment, performance improvement projects, and member care plans.

Following each quarter, the Member Rights Specialist will compile a report using the information from
all the committee meetings summarizing the discussion on the key topics and providing recommendations
from members to executive leadership staff.
Executive leadership staff will review the report and make recommendations and decisions about ongoing projects and processes related to that topic. Member Advisory Committee members will receive written feedback each quarter indicating how their input was used in order to close the loop and continually show them the importance of their feedback.

**Provider Access and Capabilities**

**Provider Quality Committee**  
The Provider Quality Committee (PQC) charter is to assure that members receive high-quality care from providers and that care teams are supported in resolving quality of care issues that arise. This is accomplished by monitoring and discussing concerns initiated by care teams, the State, or the federal government regarding providers that currently serve members, or may potentially serve members, in order to assure that care is safe and appropriate.

**2013 Analysis**  
The Provider Quality Committee reviewed 33 providers (mostly residential) and there were eight site visits completed in 2013. All holds on admissions were at the same time as the state except for one where the committee kept the hold for an additional two weeks to ensure the Corrective Action Plan was implemented. The committee requested four Corrective Action Plans from residential providers and reviewed 22 Statement of Deficiencies during the year.

A new policy and procedure was drafted for placing members in a residential facility with a ‘No New Admit Order’ or in a Skilled Nursing Facility with a ‘Discretionary Denial of Payments.’

A process for having the Provider Services Department follow up directly with providers to obtain State Rescind orders was developed.

**2014 Challenges or Next Steps**  
- Continue to streamline PQC’s review process  
- Plan for expansion in Family Care and the addition of Medicaid SSI

**Member Outcomes**

**Member Satisfaction**  
The survey methodology was changed in 2013 to enable more timely and actionable data from a larger number of members. All members were given the opportunity to complete a satisfaction survey using the standard mail-in survey instrument for all managed care organizations. The surveys were mailed to members in the month following their MCP review so that members had a recent experience with the care team to rate their satisfaction on. Returned surveys were scanned into survey software and the results were analyzed on a monthly and annual basis.
2013 Analysis
Member satisfaction data for 2013 shows improvement in satisfaction scores with both programs meeting or exceeding established goals. Changing the process for surveying member satisfaction increased both the number of surveys sent and those returned. In 2013 three times the number of surveys were returned than in 2012. With an increase in member satisfaction data and a continued focus on improving member satisfaction, Care Wisconsin was able to use the information gathered to develop new baselines and determine how best to move forward.

A challenge for 2013 was to develop a strategic workgroup to focus on satisfaction results and implement a plan to make a positive impact on the results. The Member Satisfaction Strategic Team was formed, consisting of staff across the organization interested in improving member satisfaction. Customer service standards were created, reviewed by the Member Advisory Committee, and implemented.

2014 Challenges or Next Steps
The Department of Health Services updated the annual 2014 member satisfaction survey resulting in changes that present a challenge in comparing satisfaction data year to year. Five key questions have been identified that can continue to be compared to past survey data to indicate how member satisfaction changes in 2014. Each program has a goal to achieve overall improved member satisfaction in the top box scores for these five key questions in 2014, which will be reviewed and re-evaluated midyear.

HEDIS
Partnership is a specific type of Medicare Advantage HMO called a Special Needs Plan (SNP) with two contracts – one for Dane County and one for expansion counties. One of the requirements as a SNP is to report Health Effectiveness Data and Information Set (HEDIS) data to the Centers for Medicare and Medicaid.

2013 Analysis
Care Wisconsin performed exceptionally well on HEDIS measures associated with Care of Older Adults and consistently above the Medicare mean for most other measures. One measure was not successfully reported: Call Center Timeliness– due to insufficient data. This measure is being successfully reported in RY2014.

2014 Challenges and Next Steps
Design performance improvement projects that impact HEDIS measures with a focus on Star measures.

Performance Improvement Projects
Care Wisconsin is required to conduct two Performance Improvement Projects for the DHS contract (one with a long term care focus and one with an acute care focus) and two projects for CMS for the Partnership program (one with a hospital readmissions focus and one with a cardiovascular focus). Care Wisconsin’s approach to these multiply projects is to align the topics with the contract requirements and organizational strategic goals. As a result, there are a total of three large-scale improvement projects that fulfill the requirements for both contracts and align with organizational goals. In 2013 Partnership
conducted a hospital readmissions project, a blood pressure project, and a care transitions project. Family Care conducted a care transitions project.

2013 Analysis
Reducing hospital readmissions within 30 days

Reducing critical incidents that occur within 30 days of a care transition= both programs are below their 2012 percentages which were Family Care=17% and Partnership=19%.

2014 Challenges or Next Steps
Projects will be conducted using required protocols as per DHS and CMS contracts.

Immunizations
The Quality Improvement Department tracks influenza immunizations and pneumococcal pneumonia immunizations. The results are reported and validated as per contract with the Department of Health Services. Results in this report are from 2012 because measures are not calculated and submitted until March of the following year.

2013 Analysis
Care Wisconsin immunization rates are in line with other Family Care and Partnership programs in Wisconsin and above the state average.

2014 Challenges or Next Steps
Continue to monitor and evaluate the immunization reporting process.

System Performance

Utilization Management
The purpose of the Utilization Management Program (a component of the Quality Management Program) is to monitor, evaluate, and manage resource allocation to:

- Avoid under- and over-utilization of services;
- Promote the provision of medically appropriate care;
- Monitor cost effectiveness and quality of services to ensure that services are appropriate, medically necessary and provided in a timely and resource efficient manner.

This work is accomplished through a Utilization Management Committee that meets monthly to review key areas of both long term care and acute and primary healthcare utilization. Key focus areas for long term care were home care, home health care (skilled nursing), residential services, adult day services and vocational services. The acute and primary healthcare focus areas included hospitalizations, drug costs and generic drug usage. Reports are published monthly for Family Care and Partnership and posted on Care Wisconsin’s intranet under ‘Organizational Metrics.’ Most of the available data at this point
continue to be claims data, but work is continuing on the development of real time data that would be actionable more quickly.

2013 Analysis
2013 was a year of stabilization in utilization of services. Sustainability initiatives had been addressed in 2012, and Care Wisconsin made significant changes in structure and careful review of services to assure members were receiving appropriate services in the right amount and in the most cost effective manner.

2014 Challenges or Next Steps
Utilization patterns in 2013 for long term care services were favorable to budget in both programs. Hospitalization rates continue to be challenging, often due to the complexity of the population served; new strategies are continually being tested to reduce readmissions, a piece of the overall hospitalization rate issue. Most recently, support RNs are being deployed to work closely with local hospitals to begin transition planning at admission and to streamline communication for the hospital. Generic drug use and medication costs per member per month are favorable to targets.

Annual Quality Review
Annually, the Department of Health Services contracts with an external quality review organization, MetaStar, to perform an audit of the managed care organizations. The review is composed of three sections: (1) quality compliance review of structures and processes, (2) a care management review, and (3) a performance improvement projects review. 2013 was a “targeted review year” which means that MetaStar only reviewed compliance standards that were not fully met in the 2012 review. Care Wisconsin changed three of five standards from “partially met” to “met” for an overall compliance rate of 96 percent.

2013 Analysis
Since last year, Care Wisconsin made progress in all two of the three review areas: Quality Compliance Review, Care Management Review, and Performance Improvement Projects.

- Fully met three of the five Quality Compliance Review (QCR) standards that were partially met in last year’s review. Overall rate of compliance was 96.2 percent for FY 13-14 and 90.6 percent for FY 12-13.
- Partnership improved its results for 7 Care Management Review (CMR) standards, and scored 90 percent or higher for 10 of the 14 standards. Family Care improved its results for four CMR standards and scored 90 percent or higher for eight standards.
- Continues to demonstrate sound methodology when implementing Performance Improvement Projects.

2014 Challenges or Next Steps
Increase compliance scores for all partially met standards of the annual quality review to achieve a met status.
Medicare Part C and D Star Measure Ratings

Star ratings are used to establish quality bonuses and by consumers to compare health plans. They are a combination of results from HEDIS, Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) and administrative data. Health plans that have overall ratings of four or more receive quality bonus payments to reward and incentivize quality.

2013 Analysis
Care Wisconsin received a CMS star rating of 3-1/2 stars.

2014 Challenges or Next Steps
Star Steering Committee will evaluate the Star rating process and develop sound methodology for increasing overall Star rating to minimum of four Stars in 2014.