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**HOME CARE QUALITY:
EMERGING STATE STRATEGIES TO
DELIVER PERSON-CENTERED SERVICES**

by

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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Foreword

People who receive home- and community-based long-term services and supports comprise an inherently vulnerable population. Because they require assistance with everyday activities, these individuals are at great risk of harm if those who provide support services fail to show up, provide services in an indifferent or incompetent manner, or are coercive or abusive. Yet despite these risks, the home environment is where most people with disabilities choose to remain for as long as possible.

Our nation's long-term care system has developed an elaborate regulatory system to monitor quality in nursing home settings and, to a lesser degree, in skilled home health services delivered by agencies. These systems have focused predominantly on standards such as licensure and training requirements, and less on evaluating the quality of life and satisfaction of the consumers themselves. Little has been done to address quality assurance in personal care programs and the other, largely unskilled, home- and community-based long-term care services that are the focus of this report.

Part of the difficulty in developing any quality assurance system for home-delivered services is the difficulty of monitoring the care delivered in hundreds of thousands of private homes. Yet the growth of public funding for home- and community-based services makes the development of better systems for assuring quality imperative.

States have been the laboratories for innovation in long-term care systems changes. Therefore, the AARP Public Policy Institute (PPI) was interested in learning how states have approached the issue of home care quality. In particular, we were interested in learning about approaches to quality that specifically addressed consumer needs, preferences, and quality of life.

PPI asked the National Conference on States Legislatures to identify several states that had developed innovative quality assurance methods and to describe their approaches. It was our hope that the findings reported in this descriptive paper would be useful to other states as they work to improve the quality of services delivered to people with disabilities as well as their overall quality of life.

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Executive Summary

Introduction. The growth of publicly funded home care services and supports for persons with disabilities has led federal and state governments to devote increased attention to the quality of care being provided. Traditional methods for assessing quality, such as standards for home care agencies and workers, have been found inadequate in addressing whether consumers are satisfied with the care they receive, whether they receive the kind and duration of care they believe they need, and whether their quality of life has been maintained or improved. Even consumer satisfaction surveys often have failed to provide meaningful results because some consumers are reluctant to complain about services and because the surveys may not probe deeply enough or ask the right questions.

The danger to a consumer from poor quality of care includes not only unsafe, even life-threatening, situations but also a diminution in satisfaction with life itself. As consumers have become more assertive in expressing their expectations of care providers regarding their role in their own care and in the quality of their lives, advocates and public officials have stepped up efforts to create more “person-centered” initiatives to improve quality of care in the home. Programs in which consumers hire their own workers are one answer to ensuring that people with disabilities are getting the care they want in the way they want it delivered. Still, most public home care programs continue to depend on agency-provided workers, requiring states to monitor and assess the quality of care delivered – in terms of consumer goals.

Background and Purpose. With the support of the federal government, states are building new quality assurance systems around the concept of person-centered care. The Centers for Medicare and Medicaid Services (CMS) has created a quality framework for state Medicaid home- and community-based programs that requires states to tackle each focus area (such as consumer choice and control) with program design strategies, continual evaluation, and problem correction. CMS has also developed a grant system that provides funds for states to build quality systems that involve program participants in active roles, that obtain consumer feedback, and that develop methods to ensure improved responsiveness to consumer needs and goals by service providers.

The purpose of this paper is to highlight the quality improvement initiatives of three states to suggest models that could be developed by other states. In reporting on these projects and the successes and problems state officials have encountered, the authors hope to stimulate further discussion of a variety of state quality assurance approaches. The authors conclude with a checklist for state officials to use as they consider consumer-focused quality assurance programs.

Methodology. This paper reviews the efforts of Wisconsin, Washington, and South Carolina to ensure faster consumer access to services and supports, to guarantee that consumers receive prompt and competent assistance from care managers and providers, and to assess how well consumers are being served through feedback from the consumers

themselves. The states were selected after a broad review of all state quality assurance systems, aided by the insights of other long-term care state and federal researchers.

Findings. States are now taking incremental steps to change the paradigm that has dominated quality assurance systems for home care – a pattern that has almost forgotten the consumer in the process of documenting structure and process standards for providers. These traditional quality standards have been weak in helping care managers assess the outcomes of services to the consumer and the quality of life that the consumer is experiencing. The states that are highlighted in this report are using a more person-centered approach to quality assurance in home care through improved communication with consumers, greater responsiveness in care management, and more effective information technology.

Wisconsin:

- As part of its pioneering Family Care Program, Wisconsin has developed 14 “member outcomes” to find out how well care providers address the needs and goals of program participants.
- Wisconsin has created a participant feedback system to more accurately assess consumer outcomes. State officials have found it difficult to design a system, however, that provides useful information on which care managers can act. As a result, state officials have intensified interactions with the care managers to determine how well survey responses help the care managers improve their performance.
- State officials in Wisconsin believe that both parties are gaining valuable experience in better understanding consumer needs and goals through their interaction over the survey results.

Washington:

- Washington has developed an intensive monitoring system of the assessment and care plan processes to ensure that consumer needs are being correctly addressed by care managers who are key players in the system.
- In Washington, a new comprehensive assessment system has become a more consistent and reliable measure of consumer needs. A fast-track financial eligibility determination process is speeding up consumer access to services. Careful monitoring of care manager performance is helping to ensure the development of appropriate care plans for the consumer, effective delivery of services, and improved training for care managers.

South Carolina:

- South Carolina is utilizing information technology to help care managers assist consumers more quickly and to monitor consumer needs in both everyday situations and emergencies.
- South Carolina is using information technology in its case management system to allow care managers to respond more effectively to client needs. The state has also developed an electronic monitoring system to verify that a worker is present when he or she should be and to ensure backup if a worker fails to report to work.

The federal government is guiding states toward improved person-centered quality assurance systems for home- and community-based services programs, and has imposed more stringent program requirements to ensure quality standards are met by the states. These actions include the following:

- Establishing a quality framework to guide state quality system redesign.
- Requiring concrete evidence from states that they are systematically monitoring activities and correcting problems.
- Crafting a new Medicaid waiver program application that requires more detailed information from states on their quality management systems.
- Providing substantial grant support for quality redesign initiatives.

Conclusion. Researcher Rosalie Kane has argued that quality of home care should address not only the competent provision of services but also the values that are significant to consumers: independence, control, choice, dignity, and privacy.

With the encouragement of the federal government, a more person-centered approach to quality management is taking hold in states. This approach is designed to improve the real effect on the daily lives of consumers by ensuring that authorized services are actually delivered, eligibility is determined in a timely manner, and the voices of consumers are listened to by care managers and home care workers. Much work remains to be done, however, on measuring and documenting the outcomes of home care. If outcomes for consumers can be successfully measured, then state officials can examine “how various programs and practices are associated with the outcomes” (Kane, 2001).

Still, the quality assurance initiatives in the three states featured in this report point to the significant ongoing efforts that are being undertaken today to meet the challenge of ensuring quality care and support in the home. The challenge for state officials continues to be the creation of quality assurance systems that place consumer needs and goals for quality of life first.

Introduction

Millions of older Americans receive publicly funded personal care services in their homes to help them with daily activities, such as dressing, bathing, and toileting, that they cannot carry out themselves. Federal and state governments spent more than \$21 billion on Medicaid-funded home- and community-based services (HCBS) in fiscal year (FY) 2004, about \$5 billion of which was for programs specifically targeted to older persons and adults with disabilities (Burwell, Sredl, and Eiken 2005). Such services have made it possible for many older persons to achieve greater independence and dignity at home despite frailty or illness that might otherwise have forced them into institutional care.

The public agencies that fund these services for millions of Americans often find it difficult, however, to assess and monitor the care that is provided in homes by numerous workers and family caregivers. Nevertheless, in the interest of safety and protection for consumers, states continue to look for methods that will help them ensure the quality of home care.

The customary approach to state supervision of home care quality has been reliance on “structure and process” standards for home care agencies and their workers. For example, state and federal regulations require that home care agencies be licensed, that personal care workers undergo a specific number of hours of training, and that states monitor home care agency performance. These types of standards have not been able, however, to address whether consumers are satisfied with the care they receive, whether they receive the kind and duration of care they believe they need, and whether their quality of life has been maintained or improved.

The traditional focus on home care quality is almost solely on health and safety issues, often ignoring or minimizing quality-of-life outcomes. As one federal official said, building “an entire system around monitoring, inspection, and sanctions . . . loses the larger point, particularly with regard to HCBS where so much of what is quality . . . really comes from its ability to operate in a person-centered way to afford people choices and services and more control over services so that the individual participating in the program is a co-producer, in many ways, of quality” (Hamilton, 2003).

Thus, the issue of quality involves quality of life as well as quality of care. Without attention to both dimensions of quality, an individual’s independence and dignity can be threatened, as well as that person’s health and security. When an aide fails to arrive or shows up much later than expected, the care recipient may be forced to remain in bed, limiting needed mobility; may miss a meal; or may even have his or her health threatened by a delay in receiving essential medication. The dangers of poor-quality home care range from unsafe, even life-threatening, situations to the erosion of an individual’s satisfaction with life itself.

An August 2004 decision in an Arizona lawsuit underscores a state’s responsibility for ensuring that persons with disabilities get the services identified in their care plans. The class-action complaint *Ball vs. Biedess* charged that the state’s managed long-term care

(LTC) program had failed to make certain that recipients of HCBS received their prescribed services. The judge ordered the state to make extensive reforms to ensure that it “provide(s) each individual who qualifies for its services with those services . . . without gaps” (Arizona Center for Disability Law, 2005).

The movement toward greater consumer choice and control over home care services in recent years has changed the dynamic in state LTC programs. Many publicly funded programs today offer consumers the opportunity to choose their own personal care assistants and to determine when and how they want their workers to deliver their care. Still, most public home care programs continue to depend on agency-provided workers, requiring states to monitor and assess the quality of care provided – in terms of consumer goals.

Background and Purpose

The definition of “quality”: “The question of how to assure quality in LTC is a vexing one, challenging regulators, frustrating families, and provoking providers for more than three decades” (Hawes, Fall 1997). This statement still applies today. Difficulties begin with the definition of “quality.” The research literature is rife with discussions of what constitutes quality home care services.

The federal Centers for Medicare and Medicaid Services (CMS) has defined quality as “the degree to which services and supports for individuals and populations increase the likelihood for desired health and quality-of-life outcomes and are consistent with current professional knowledge” (U.S. Centers for Medicare and Medicaid Services, 2005). At a conference on community-based care, a state Medicaid official suggested the questions public officials should ask: “Did the right people get the *right* services and supports *when* they needed them, *where* they wanted them, and *when* they wanted them? Did the services and supports result in the well-being of the person who received them?” (Bezanson, 2002).

Rosalie Kane, a long-time researcher and writer on quality issues in LTC, has proposed 11 quality-of-life domains:

- security
- comfort
- meaningful activity
- relationships
- enjoyment
- dignity
- autonomy
- privacy
- individuality
- spiritual well-being
- functional competence

According to Kane, these kinds of outcomes are generally minimized in quality assessment and are “given credence only after health and safety outcomes are considered.”

Though maintaining the health and safety of home care consumers is critical, Kane does not believe it should be the overriding goal. She maintains that a good quality of life “should be elevated to a priority goal for LTC rather than a pious after-thought to quality

of care.” If the 11 outcomes listed can be successfully measured, Kane says, researchers could “plausibly examine how various programs and practices are associated with the outcomes” (2001).

The federal response to home care quality issues: In a March 1994 report on the status of quality assurance and measurement in HCBS, the U.S. General Accounting Office (GAO) said that goals for home- and community-based LTC often were “articulated differently by administrators, service providers, and customers with some potential for conflict.” According to this report, a coherent program of quality assurance “requires that program goals be articulated well enough to identify the types of performance or outcomes to be assured, measured, or prevented” (U.S. GAO, 1994).

In a June 2003 review of Medicaid HCBS waiver programs for older persons, the GAO said it had identified weaknesses in CMS oversight of the programs, and problems of quality of care. “More than 70 percent of the waivers for the elderly . . . documented one or more quality-of-care problems,” the report said, with the most common problems being “failure to provide necessary services, weaknesses in plans of care, and inadequate case management” (U.S. GAO, 2003).

The GAO researchers faulted CMS for not developing “detailed state guidance on appropriate quality assurance approaches as part of initial waiver approval” and for not adequately monitoring state waivers and the quality of beneficiary care. The GAO review covered 15 of the largest HCBS waiver programs for older persons (U.S. GAO, 2003).

Before the 2003 GAO report was published, CMS had already begun work on a number of quality initiatives for state development and was regularly communicating with state policymakers to encourage the development of these strategies. The agency has mounted a major campaign to ensure that states are integrating a person-centered focus into their Medicaid-funded HCBS. A person-centered focus involves giving consumers greater responsibility for defining quality care and for helping to determine how quality should be measured.

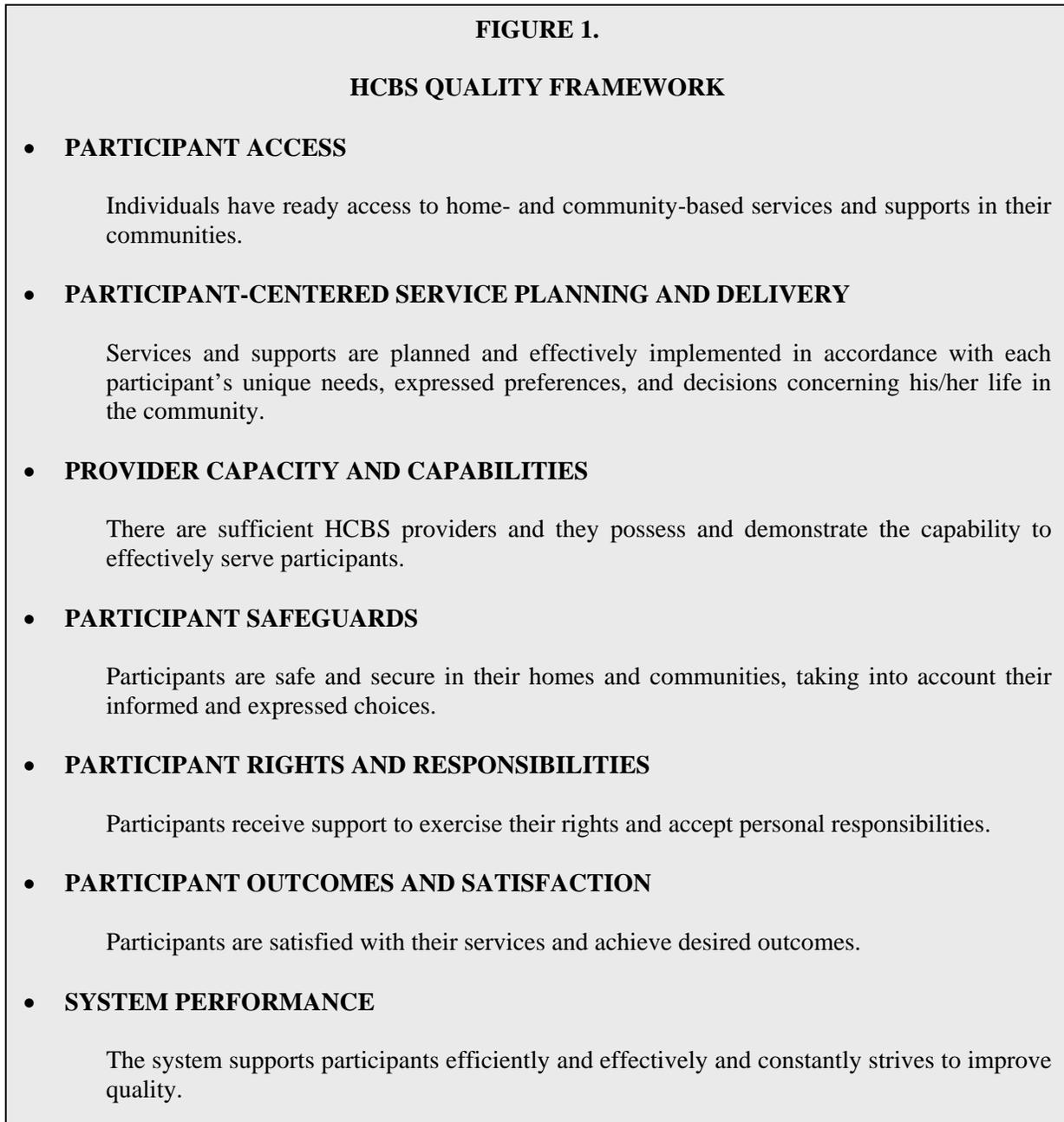
In 2001, CMS initiated the National Quality Inventory Project (NQIP), in conjunction with state agencies. Its purpose was to obtain baseline information about quality initiatives in state HCBS waiver programs. While this project did not evaluate the effectiveness of these efforts, it did confirm that most states had launched major initiatives to improve and strengthen their quality assurance systems (Smith, 2004). A survey conducted by the NQIP revealed that states were at different stages of development in their quality programs, and that many lack the information technology capabilities necessary to monitor their programs’ effectiveness.

In May 2002, the federal government launched Independence Plus to assist states in offering greater opportunities for consumers to direct their own LTC services. Today, most states have adopted consumer-direction concepts in at least some of their publicly funded programs. Another major federal effort has been the development of a quality framework for states to use with participants in Medicaid HCBS waiver programs. The

quality framework, developed through the NQIP, consists of seven topic areas or domains. Five of the seven domains focus on the consumer:

- participant access,
- participant-centered service planning and delivery,
- participant safeguards,
- participant rights and responsibilities, and
- participant outcomes and satisfaction.

The other two domains cover provider capacity and capabilities, and system performance. (See Figure 1 for quality framework components.)



The goal of the quality framework model is to help states build quality into the design of HCBS programs. This process involves multiple methods of feedback and information gathering, and ways to engage program participants in active roles in the quality assurance system. Successful implementation of the quality framework requires states to tackle each focus area through program design strategies, continual evaluation, problem correction, and system improvement. CMS suggests that states look at:

- the way consumers get access to services,
- the choices made available to them in planning their services, and
- the results of those services in improving their lives and their health.

The federal government followed up with guidelines in 2004 that require states to provide CMS with concrete evidence that they are systematically conducting monitoring activities, taking appropriate action to correct any problems they discover through the monitoring process, and making systematic improvements, if necessary. CMS has also crafted a new application for Medicaid HCBS waiver programs that requires more detailed information from states on their quality management (QM) systems. In the past, CMS had to wait until a state applied for a renewal of its waiver program to view a state's QM strategies. With the new application format, states must describe their QM systems up front and in detail.

CMS has continued this support with the distribution of systems change grants. CMS awarded quality assurance grants to 19 states in 2003 and to another 9 states in 2004. West Virginia provides an example of a quality assurance proposal that emphasizes active roles for HCBS waiver participants and their families. Activities under the grant include conducting face-to-face surveys with participants in the Aged/Disabled (A/D) Medicaid waiver program and conducting at least two focus groups per year with A/D participants (HCBS Clearinghouse for the Community Living Exchange Collaborative, 2005).

Consumer satisfaction surveys: A staple of state quality assurance systems has been the consumer satisfaction survey. Consumers are asked whether they are satisfied with their case workers, their care plans, and their personal care workers. Are workers performing their jobs properly? Are they courteous? Consumers generally give high ratings to their workers and services ("satisfaction" ratings of 90 percent or higher). These surveys have often failed, however, to provide any depth of information about a consumer's preferences in service delivery or desired outcomes. Rosalie Kane notes the "well-known reluctance of many older people to criticize those providing care, both because of inherent courtesy and because of dependence on providers" (2000).

In response, Scott Geron and colleagues at Boston University developed the Home Care Satisfaction Measure (HCSM) to provide "a standardized, general scale . . . that is relatively brief, is easy to administer, and meets standard psychometric criteria for validity and reliability." The researchers hypothesized that consumers consider several different dimensions when evaluating their satisfaction with a service. The HCSM consists of 60 items measuring dimensions of satisfaction with five major home care services – homemaker service, home health service, case management, home-delivered

meal service, and grocery service. Items under each category have five response options: yes, definitely; yes, I think so; maybe yes; maybe no; or no, definitely not (Geron et al., 2000).

After a number of statewide programs (such as Hawaii and Florida) began using the HCSM, the researchers said that the adaptability of the HCSM had been “encouraging” but needed further research. After the survey was used with participants in Ohio’s PASSPORT home care program, researchers concluded that the HCSM was “a valid and robust instrument.” They recommended changes in some of the items, however, because of consumer confusion by such questions as, “Is the worker thorough?” (Kunkel et al., 2001).

Indiana researchers developed a client feedback system that asks participants in the Medicaid HCBS program for older persons to rate the quality of the care they receive from a home care agency. These participants are also given an opportunity to comment in general about their care, without reference to specific questions on the survey. Though participants generally rated their workers and their care positively, they also reported serious deficiencies in worker performance, such as tardiness and theft, when surveyors probed more deeply (Kinney et al., 1997).

In 2000, CMS commissioned The Medstat Group, Inc. to create a new Participant Experience Survey (PES), designed to be administered in person to participants in Medicaid HCBS waiver programs. (The PES consists of three different instruments: for persons in elderly/disabled waiver programs, in programs for the mentally retarded/developmentally disabled, and in brain injury programs.) The PES solicits participant feedback on HCBS services and supports, and generates performance indicators for quality monitoring. The survey covers 33 performance indicators and can be administered in only 15 minutes. The goal is to elicit feedback on concrete experiences of consumers, which gives a state an opportunity to follow up quickly if a person complains of being treated with disrespect or experiences physical abuse, for example. (For a sample of the questions on the survey, see Figure 2.)

While the federal government has been developing these initiatives, many states have also been exploring new QM strategies. The purpose of this paper is to highlight the quality assurance techniques used by several states that can serve as models to be used in other states. These states pay significant attention to consumer concerns in their quality assurance projects. States can implement a consumer focus in a variety of ways, including ensuring that authorized services are actually delivered, eligibility is determined in a timely manner, and the voices of consumers are listened to by care managers and home care workers. The intent is to look at the real effect of quality assurance techniques on the daily lives of consumers, rather than evaluating structures that may or may not achieve quality-of-life outcomes for consumers. In reporting on these projects, the authors hope to stimulate further discussion of promising state quality assurance approaches.

FIGURE 2.

THE PARTICIPANT EXPERIENCE SURVEY

Sample questions include the following:

- Access to care
 - Do you ever go without eating when you need to?
 - Is this because there is no one there to help you?
- Choice and control
 - Do you help pick the people paid to help you?
 - Would you like to help pick the people paid to help you?
- Respect and dignity
 - Do the people paid to help you treat you respectfully in your home?

Sample performance indicators include the following:

- Access to care – Percentage of program participants requiring personal assistance with bathing who report they are sometimes unable to bathe because no one is there to help them.
- Choice and control – Percentage of program participants who do not help choose their staff but would like to.
- Respect and dignity – Percentage of program participants who report being injured.

Source: Galantowicz, 2004.

Methodology

To provide a sense of how states are attempting to address the new person-centered approach to quality assurance, this paper describes the initiatives of three states (Wisconsin, Washington, and South Carolina). The states were selected after a broad review of all state quality systems, aided by the insights of other LTC state and federal researchers. Other sources of information included the CMS and state websites, and a website specifically devoted to state HCBS programs.

The paper focuses on the quality assurance strategies that the three states have developed for their Medicaid HCBS waiver programs for older persons. The authors selected waiver programs because of the recent considerable growth in spending for these programs and in the numbers of people they serve, and because of the actions of CMS to stimulate and encourage states to build quality assurance designs into these programs. The paper

focuses exclusively on agency-provided HCBS because that remains the predominant service delivery method. While not within the scope of this report, a useful area for further research would be an examination of quality assurance methods in consumer-directed HCBS programs.

The following is a descriptive report, not an evaluation, developed by the authors from written material from state agencies that operate HCBS programs and from telephone interviews with the officials who design and monitor quality assurance systems in the three study states.

WISCONSIN: MEMBER OUTCOMES IN THE FAMILY CARE PROGRAM

“Quality is measured by the extent to which each member’s self-identified outcomes are being met and how well the Care Management Organization is providing supports to help the member meet those outcomes.”

Wisconsin Council on Long-Term Care

Summary: As part of Wisconsin’s pioneering Family Care program, the state has developed 14 member outcomes used in interviews with program participants to determine how well their providers address their needs and goals. Members play a key role in defining their goals, ensuring that their care plan reflects them, and then indicating whether the goals have been met. The system considers each individual’s preferences when determining whether a desired outcome has been achieved. These developments build on Wisconsin’s earlier experience in integrating quality assurance into its HCBS Community Options Program (COP).

A. COP

The mainstay of Wisconsin’s publicly funded HCBS since the 1980s has been COP, which is both Medicaid- and state-funded. The regular state-funded component (COP-R) began in 1981 and serves people who have low incomes that do not meet Medicaid financial eligibility criteria. The Medicaid-funded component (COP-W) was created in 1987 for persons financially eligible for Medicaid and functionally at risk for nursing home placement.

Administrative responsibility for COP rests with county human services agencies in Wisconsin. Counties contract with private agencies to conduct functional assessments of applicants for LTC services, although county employees make the final eligibility determination.

Another Medicaid HCBS waiver program for older persons and persons with disabilities is the Community Integration Program II (CIP II), which has slots that become available after a nursing home bed is closed. The financial and functional eligibility requirements are similar to the criteria for COP-W. Participation in all COP, CIP, and Medicaid waiver programs totaled about 25,000 people in 2003, of which about 31 percent were age 65 and older.

B. Ensuring Quality of COP Services

Wisconsin places a high priority on ensuring quality of care for COP. The Department of Health and Family Services (DHFS), which has state-level responsibility for LTC services in Wisconsin, contracts with The Management Group to operate a quality assessment and improvement program. A major part of that program consists of in-home visits to between 400 and 500 LTC clients each year by a quality assurance coordinator.

These in-home visits have three components: (1) a health and safety check of the home, (2) a conversational interview (not a standardized format) that constitutes a satisfaction survey, and (3) an outcomes-based interview. In the satisfaction interview, questions such as the following might be asked about the person's care manager:

- Was he/she responsive to your preferences for care?
- Did he/she understand your situation?
- Was he/she knowledgeable about resources?
- Did he/she respond in a timely fashion to your requests? (Wisconsin DHFS, 2002)

The outcomes-based interview tries to assess such issues as whether the person is free from abuse and neglect, connected to informal supports, and supported in continuing his or her usual hobbies and activities. After this visit, the quality assurance coordinator provides an immediate overview of the interview to the care manager responsible for the client.

In 2003, 435 randomly selected participants responded to 22 questions during in-person interviews. The following factors were studied regarding care management services:

- responsiveness to consumer preferences,
- quality of communication,
- level of understanding of consumer situation,
- professional effectiveness,
- knowledge of resources, and
- timeliness of response.

The following factors were studied for in-home care:

- timeliness,
- dependability, and
- responsiveness to consumer preferences.

The following combines and summarizes the findings of the survey:

- Care manager is effective in securing services—93%
- Good communication exists between consumer and care manager—94%
- Care manager is responsive—91%
- Consumer actively participates in care plan—90%
- Consumer is satisfied with in-home workers—92%

C. Redesigning LTC—The Family Care Program

In 1999, Wisconsin began developing the Family Care demonstration project – a managed LTC program in five counties (Fond de Lac, La Crosse, Portage, Richland, and Milwaukee) that combines all sources of funding for community and institutional care. The program operates under federally approved 1915(b) and 1915(c) Medicaid waivers.

A care management organization (CMO) receives a capitated payment each month for providing a full range of LTC services for each enrollee. The populations covered include older persons and other adults with physical disabilities, and persons with mental retardation or developmental disabilities; enrollment totaled 9,139 persons for the five counties as of May 1, 2005. In Milwaukee County, the program covers only frail elders, who number 5,436 of the five-county total. Slightly more than two-thirds of all the participants are women, with a mean age of 74 years. (The average age at enrollment in the Milwaukee CMO is 76 years.)

Key values underpinning the program include consumer choice and consumer outcome-focused quality. The program provides each participant or member with an interdisciplinary team. Working together, the member and team identify the member's needs and the outcomes desired from the services provided. The program describes its goals as “A start-to-finish focus on member outcomes, so that each care management team is aware of, and supportive of, the results that each consumer seeks from his or her long-term care” (Wisconsin DHFS, 2005).

An evaluation of the Family Care Program by The Lewin Group in July 2003 concluded that the program had “substantially met the goals of increasing choice and access and improving quality through a focus on social outcomes” (The Lewin Group, 2003). An independent assessment by APS Healthcare concluded in a December 2003 report that each CMO possessed “a strong orientation toward member centeredness, which means Family Care members are given the opportunity to take an active role in decision-making” about their services (APS Healthcare, 2003).

D. Member Outcome Interview Tool

Prior to the enactment of Family Care, in December 1997, the DHFS Center for Delivery Systems Development convened the Designing Quality Work Group, which included consumers, providers, advocates, and staff members of several DHFS bureaus. The focus of the group's work was on ensuring that the quality measurement system

- was based on outcomes relating to a member's health and quality of life,
- incorporated an objective assessment of whether these outcomes were present for each member, and
- provided for system improvement based on these objective assessments.

The outcomes are designed to take into account “each individual’s attitudes, beliefs, culture, behaviors, and environmental circumstances.” The work group developed a list of 14 items divided into three categories: self-determination and choice, community integration, and health and safety. Examples of outcomes under “self-determination and choice” are “People choose their services” and “People choose their daily routines.” An example under “health and safety” is “People experience continuity and security.” (For a complete list of the 14 items, see Figure 3.) These outcomes were then incorporated into the Family Care program.

FIGURE 3.

WISCONSIN FAMILY CARE MEMBER OUTCOMES

A. Self-Determination and Choice

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

B. Community Integration

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

C. Health and Safety

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

Through mid-2005, DHFS had conducted five rounds of interviews of a random statewide sample of Family Care members. The interview method was developed by the Council on Quality and Leadership and adapted by DHFS for use in Wisconsin and for each target population of frail elderly, adults with physical disabilities, and persons with mental retardation/developmental disabilities.

The first round of interviews began in November 2000, with the fifth round completed in June 2005. At the time this paper was being completed, the full results of Round 5 had not been published. State officials provided some early data, however, for this report. A total of 501 persons were interviewed in the fourth round, of which 374 were older persons. The process worked as follows:

Step 1 – The interviewer engages the member in conversations that address the member’s experience in each of the 14 outcome areas. Interviewers are provided with a list of sample questions prepared by the state, but are not required to ask any of these specifically or verbatim, as long as the conversation provides enough information to make a “present/not present” determination about each of the 14 outcome areas. Figure 4 illustrates possible questions the interviewer might ask for the “People are satisfied with services” outcome.

Step 2 – The interviewer meets with the member’s care manager to determine if the latter understands the member’s desired goals or outcomes and has been providing the services and supports to help reach those goals. For each of the 14 outcomes, the interviewer records a yes or no to whether the outcome, as defined by the member, is present or absent.

Step 3 – The interviewer repeats the process to determine whether the care manager has arranged for the services or supports that will help the member reach his/her goals or outcomes.

Step 4 – On the basis of the member’s answers to these questions or to a general discussion of the services they receive, the interviewer asks him- or herself:

- Is each outcome present for each person as he or she defines it?
- Is the organization providing supports and services to promote achievement of these outcomes? (Wisconsin DHFS, 2002)

For each outcome, two results have been reported: the percentage of interviewed members who reported that the outcome was present (quality of life) and the percentage of members for whom support of that outcome was found to have been provided by the CMO (quality of service). (For an example of questions an interviewer might ask an older member for the “People are satisfied with services” outcome, see Figure 4.)

FIGURE 4.

**WISCONSIN FAMILY CARE PROGRAM OUTCOME:
People are satisfied with services**

Key questions for the CMO member:

1. What do you like about the help you receive? What don't you like?
2. What would you like to change about the services you receive?
3. If you are unhappy or disagree with a service, do you know whom you can talk to?
4. Do people do what you want them to?
5. If people come into your home to provide services, are your home and personal belongings respected and kept the way you want?
6. Who do you talk to about the kind of help you need or want?
7. Does your care manager/caregiver/service provider communicate with you in a way you understand?
8. Do you think your care manager/caregiver/service provider is aware of your needs relating to the type of disability or illness you have?

E. The Results of Member Outcome Interviews

The APS Healthcare assessment concluded that Family Care members consistently reported high levels of satisfaction with such categories as “self-determination and choice” and “health and safety.” The highest findings across all three population groups included “People have privacy,” “People are free from abuse and neglect,” and “People are safe.” For older persons, the highest rated outcome in the fourth round of interviews was “free of abuse” at 88 percent, followed by “People have privacy” at 87 percent (Wisconsin DHFS, 2005).

The scores for the category “People choose their services” illustrates how state officials hope consumers will benefit from the member outcome tool. The third round of interviews reported that 48.4 percent of older members said yes when asked if they choose their services. By the fourth round of interviews, that figure had risen to 54 percent, and then to 61 percent in the fifth round of interviews.

Family Care staff believe that sharing and discussing the survey results with care managers helps the managers to more fully understand their outcome-focused mission, in

a way that feedback on other aspects of their performance (properly completing paperwork, staying within budget, etc.) does not. They believe that understanding is the most valuable benefit of the member outcome interviews.

In addition, feedback from the interviews indicates which outcomes and supports need additional or different supports. In fact, an independent analysis of member outcome results found that the longer an individual remained in Family Care, the more likely he or she was “to have achieved desired outcomes, and to be receiving appropriate support for those outcomes” (APS Healthcare, 2003).

F. Next Steps

The surveys are intended to help the CMOs use information to monitor and improve care, to help provide feedback for training care managers, and to provide guidance to DHFS in comparing results by target groups and by counties. DHFS officials say that initial results of the member outcome interview system and the reaction of the CMOs to those results may result in system redesign, at least in part. CMO managers have said, for instance, that simple “present” and “not present” determinations fail to provide the care managers with enough useful information to assist in their efforts to improve performance. DHFS continues to refine process measures and continues to adapt the measurement tool for appropriate use with older persons.

One possibility for future interviews may be experimenting with ways to get more detailed and timely feedback from the interviews to the care managers and supervisors. Interviews could be conducted with a view toward providing one-on-one feedback to each care manager for the purpose of professional development. Care management teams could be allowed to select the clients for interviews and encouraged to select their toughest cases, so they can assess the value of consulting with the interviewers on those cases.

G. Other Quality Initiatives

The CMOs in the Family Care Program have quality responsibilities that are based on the member outcomes process. Each CMO is required to design an annual performance improvement project for 1 of the 14 member outcomes for their participants. In addition, the state periodically reviews a sample of individual care plans to ensure that member needs and preferences are being addressed (Justice, 2003).

Wisconsin also received \$1.2 million in federal grants in October 2003, which included funding to help county agencies improve the quality of the community LTC system, for the project Bringing Quality Close to Home. County agencies are working with state staff members and consultants to develop better ways to improve quality. The funds also support ongoing work to develop measures of quality of life for consumers in COP, CIP, and Family Care.

Lessons Learned

- Designing an interview tool to measure the outcomes of services and supports can be difficult and requires frequent testing to determine how well responses are helping care managers improve performance. Benchmarks for each outcome are difficult to establish because of each individual's unique set of circumstances and goals.
- An interview instrument may need to go beyond simple yes and no responses to elicit enough detailed information about outcomes to assist care managers. However, results from the member outcome tool have sparked extensive discussion between state officials and CMO staff about what the 14 outcomes mean and how best to determine whether they are being met.
- Family Care members have had frequent opportunities through the member outcome tool to indicate their satisfaction with the outcomes of their care. CMOs have been alerted to the survey results and are expected to respond.
- Assessing consumer outcomes more carefully should enable providers to understand the personal goals of each person and to adapt services to meet those goals and each individual's needs.

WASHINGTON: COMPREHENSIVE ASSESSMENT AND CARE MANAGER MONITORING

“To provide quality, well-planned, efficient and accountable home- and community-based care is one of the central missions of the Aging and Disability Services Administration. The development of a Quality Assurance system is critical in accomplishing this mission.”

Washington Aging and Disability Services Administration

Summary: Washington has a wide-ranging approach to QM that includes a comprehensive assessment system to determine eligibility for services and to develop a care plan tailored to each individual’s needs, and a monitoring process to ensure that care managers are meeting their responsibilities. Other person-centered initiatives include special monitoring of high-risk home care clients and a fast-track financial eligibility process that speeds access to home care services.

A. A Tradition of HCBS

For more than 20 years, Washington has been providing services in the home and in residential settings through its Medicaid waiver program, Community Options Program Entry System (COPES), approved in 1983 shortly after the federal government initiated the waiver program. Five years after starting COPES, the state also implemented a Medicaid Personal Care program as an option under its Medicaid state plan.

Washington has had a steady record of expanding HCBS in its LTC system. In FY 2003, the state was providing HCBS to almost 38,000 persons. More than half (53 percent) of the state’s LTC population was receiving services at home, 18 percent in community residential settings, and 29 percent in nursing facilities. The caseload for nursing homes dropped from slightly fewer than 15,000 residents in 1997 to about 12,500 residents in FY 2004 (Leitch, 2003).

The state agency that administers all LTC programs in Washington is the Aging and Disability Services Administration (ADSA) of the Department of Social and Health Services. One of ADSA’s divisions is Home and Community Services (HCS), which has 39 local offices throughout the state. At department headquarters and in the local HCS offices, staffs of about 279 social workers and 47 community nurse consultants perform initial assessments.

B. Care Assessments

The assessment process takes place during a face-to-face home visit, with functional eligibility determined through the use of an automated comprehensive assessment reporting evaluation (CARE) tool. The state describes CARE as an interactive tool that “allows the assessor to gather the client’s needs and plan how they will be met at the same time.” The computer application is “very user friendly and easily navigated, allowing social workers to concentrate on their client, gather more accurate information

than ever before, and plan how best to meet client's needs" (Washington Department of Social and Health Services, 2005).

CARE is designed to collect demographic data and information on functional needs and abilities and on health and medical status, and to determine eligibility for services, develop a care plan, and authorize services for clients requesting LTC services. CARE allows care managers to complete assessments in people's homes by using laptop computers. Teams are identified for each client, allowing case managers to share cases. The system also allows care managers or team members (with security rights) to enter a record of each "service episode" (e.g., phone call, home visit, nurse review) and to make changes to a client's demographics when warranted.

The client's strengths, limitations, preferences, and equipment needs are identified for every activity of daily living (ADL). Nursing referrals are triggered by client characteristics in each assessment, such as a diagnosis of an unstable condition, need for caregiver training, immobility issues affecting the care plan, medication regime and nutrition issues affecting the plan, and skin breakdown protocol. Skin observation protocols are triggered automatically if the assessment identifies the client as being at risk for skin breakdown. Caregiver directions are printed automatically on the plan of care with instructions on how the caregiver can prevent skin breakdown through transfers, bathing, nutrition, and positioning in chair and bed (Washington ADSA, 2004).

Consumers play a major role in the process. They are asked about their preferences for daily routines, such as how long they like to sleep and when they prefer to have their meals. They are thoroughly involved with the case manager in developing their care plans, and they choose a qualified provider, if they wish. If they are found to be financially eligible for services (a process that takes place concurrently with the functional eligibility determination), an area agency on aging (AAA) takes over responsibility for overseeing their care plans and services.

The AAA system in Washington has about 419 case managers, nurse case managers, and case aides who provided services to about 25,000 individuals in their homes in FY 2004. State officials stress the importance they attach to training for case managers, particularly training in interview skills to ensure they are responsive to the needs of the clients. More than 1,100 local and state staff members have each undergone four days of CARE training.

As of April 2, 2004, more than 25,000 clients had CARE assessments. About 73 percent of in-home clients assessed with CARE were determined to need as many or more hours of service as they had previously received before the CARE system was instituted (Washington ADSA, 2005). Besides the use of CARE, the care manager will gather information about the client from all available sources, including family and medical records, as long as the client has given them permission.

C. High-Risk Cases and Inter-Rater Reliability Assessments

The agency also has a system for going into the homes of selected program participants for backup or more intensive assessments either because the consumer has been designated as a high-risk case or because special inter-rater reliability (IRR) assessments are needed. Consumers are identified as high-risk if they are at risk of falls, have decreased mobility or skin problems, or have issues of medication management. The goal of visits to some of these clients is to uncover any gaps in service delivery and to identify plans of care that are working well for consumers with these particular care needs. A consumer experience survey is also completed on these visits.

For IRR assessments, management staff case managers go into individuals' homes (with the consent of the individuals) to check on the original assessment. The goal is to compare the IRR assessment with the case manager's assessment to see if any corrections are needed. Corrections would be triggered if, for example, the consumer's total ADL score varied by five or more points from one assessment to the other or if in the category of "decision making" the case manager had indicated that the consumer had no or few preferences regarding ADLs, yet the IRR assessment showed otherwise.

D. Fast-Track Eligibility Determination

While social workers or nurses (case managers) are determining functional eligibility, a separate financial eligibility process is under way. Financial eligibility workers are located within the same ADSA offices as the case managers. The fast-track process in Washington allows the case manager to authorize delivery of services before the full financial eligibility process is completed. If the case manager believes he or she has sufficient financial information to reasonably conclude that the applicant will be eligible for publicly funded services, the case manager will complete an assessment and service plan and authorize services for 90 days.

According to the state, eligibility workers are to "presume" eligibility and approve Medicaid coverage for services *in a day*. Further, applications can be taken over the telephone, by mail, or during a home visit by an eligibility worker. Full applications must be completed by eligibility workers within 90 days. The state says that the expedited process has reduced the average time required to determine eligibility from an individual's full application from 37 days to 17 days (Mollica, 2004). Presuming eligibility and speedily completing full eligibility determinations allows state workers to begin in-home services faster. Vulnerable individuals and their families are assisted more quickly and thus are generally able to avoid institutionalization.

E. Monitoring the Process

State staff members review a sample of care plans on a regular basis to ensure the quality and accuracy of assessments and care plans and to determine whether care managers or their supervisors have responded in a timely manner to quality-of-care issues that may have been identified. The Washington Department of Social and Health Services issued a quality assurance monitoring application manual in October 2004 that describes seven

modules incorporating 79 compliance questions that relate to areas such as the assessment process, care planning, and case management functions. Each question has a list of responses that the reviewer would choose from if the response to the question indicates a quality problem. For example, for the question, “Is there documentation that the required case management visits/contacts occurred within the response time outlined in the LTC manual?”, the possible responses from which the reviewer can choose include the following:

- No documentation of initial face-to-face contact after placement/transfer
- No documentation of all additional face-to-face contact(s)
- No documentation of other collateral professional contact(s)
- Good documentation of care manager visits
- All response times met

For the question, “When caregiver stress is indicated on the Caregiver Status screen, was a referral made to support services or other options discussed?”, the possible responses for the reviewer to check include the following:

- No documentation that the care manager offered support services or other options to caregiver
- No documentation that the care manager addressed caregiver stress/barriers to providing care
- Other information indicates caregiver stress; no documentation of action taken by care manager to address issue
- Discussed options to prevent stress, though stress not indicated (Washington ADSA, 2005).

If none of the possible responses is appropriate for the individual client’s situation, the reviewer may leave the question unanswered, indicate NA (not applicable), or write comments in the space provided. The no responses trigger an analysis of the case manager’s work.

F. Goals of the Quality System

From the consumer’s perspective, Washington’s quality assurance system is intended to

- focus on the quality and accuracy of the assessment and care plan,
- determine whether issues that have been identified regarding quality of care have been responded to in a timely manner,
- review whether clients require the care and services for which they have been authorized,
- determine that clients are receiving the services for which authorization and payment have been made, and
- collect client feedback to determine satisfaction with services.

As the QA monitor manual explains, “this process of data collection enhances inter-rater

reliability and allows us to pinpoint the specific reason an element was wrong, thus enhancing the accuracy of outcomes. It also provides data on . . . where and what kind of training needs to occur” (Washington ADSA, 2005). The program’s intent is to identify training needs for quality improvement and to identify best practices at both the state and AAA level so strategies can be shared across the state. Ultimately, the goal is to impact the consumer by improving the quality of the care management he or she receives and, thus, the quality of services.

Lessons Learned

- The CARE system helps to streamline access for consumers to LTC services. Having demographic and service data entered into the system and therefore accessible to other state workers saves the consumer the frustration of having to provide information repeatedly. If the case manager changes, the new case manager can get up to speed on the case quickly.
- Designing a standardized documentation process for case managers allows a state’s quality assurance system to more accurately track case manager performance, and ensures that consumer needs are being accurately addressed.
- Such a system can be used for more effective training and follow-up monitoring of case managers.
- Consumers benefit when case managers understand how to assess consumers’ needs and then work with them to develop a care plan that provides for an appropriate number of hours of service relevant to their needs and provides for prompt delivery of services.

SOUTH CAROLINA: THE ROLE OF INFORMATION TECHNOLOGY AND QUALITY OF CARE

“The philosophy of Community Long-term Care case management is to optimize the client’s life choices and rights . . . to ensure that services are appropriate to the needs of individual clients [and] are of acceptable quality . . . to recognize and strive to honor the client’s decisions regarding locus of care and services received, to acknowledge and respect the client’s right to be treated with consideration and dignity.”

South Carolina Department of Health and Human Services, 2005

Summary: South Carolina has made innovative use of information technology to enhance the capability of care managers and the competency of the care management system, to ensure that consumers are receiving the services they need, and to track home care worker visits.

A. Community Long-Term Care Program

South Carolina’s two Medicaid HCBS waiver programs for older persons operate under the state’s Community Long-Term Care (CLTC) program administered by the Bureau of Long-Term Care Services, Department of Health and Human Services. The Elderly/Disabled (E/D) waiver program provides case management, personal care, specialized medical equipment, adult day health care, and other services for older people and adults with physical disabilities who are functionally eligible for nursing home services. About 11,000 persons received E/D waiver services in FY 2004, with another 3,000 persons on a waiting list.

For persons eligible for the E/D waiver who wish to direct their own services, a new waiver program called SC Choice began in July 2003. The program began in three pilot counties in northwest South Carolina and is now operating in six counties, with a total enrollment of about 7,000 persons.

B. The Role of Care Management

The CLTC program has about 115 care managers, called care advisors. Applicants for the state’s HCBS programs are assessed by these workers at 1 of the 13 Bureau of Long-Term Care Services area offices. The state’s care management system has been evolving since 1991 when it was first developed, with more recent revisions incorporating new technological innovations in information technology.

Care advisors enter the information they receive from participants, family members, and providers in the care management system through laptop computers, including assessment information, care plans (called service plans in South Carolina), and care notes. Care advisors can thus access these data quickly, review cases frequently, and revise service plans when necessary. With the information stored in the database, a manager or new worker who might take over a case can access the information easily and quickly.

The state also provides care advisors with cellular telephones and fax machines so they can reach (and can be reached by) participants and providers, thus minimizing travel to keep up with possible changes in the lives and health of participants. Care advisors make occasional trips to regional field offices to download information from their computers to the care management system database. (The information in the regional office databases is also downloaded to the central office every day.) The database provides a way for supervisors to monitor how often care advisors have been meeting with participants, how well the care advisors are drafting care plans, and whether they are meeting the needs that were identified in participant assessments.

In February 2001, the state implemented automated reminders, or triggers, between the state's assessment information and the service plans. The assessment entered into the system generates a list of the consumer's needs or problems, goals for addressing those needs, and interventions to meet those goals. For each problem area, the system will make recommendations for goals and interventions. If a need has been identified in the assessment information in the care management system but not covered in the care plan, the system will alert the care advisor to that oversight. Previously, the care advisor would have had to consult pages of a paper assessment to check whether all identified problems had been addressed in the care plan.

System-generated reports provide demographic information on program participants and cost and utilization information on services. The system also verifies that care advisors are meeting regularly with participants, developing service plans, and conducting reassessments when appropriate.

C. Emergency Backup System

As part of the assessment process, care advisors determine a person's needs in the event of a natural disaster or other emergency and the individual's risk level based on his or her needs. That information is then built into the person's plan of care. A person needing assistance in getting out of bed in the morning would be designated at a level different from that of someone who needs less intensive care.

The first line of contact for the consumer in such emergencies is informal supports, such as family members, friends, and neighbors. If a worker does not show up or there is some other emergency, such as a hurricane or other natural disaster, the client can reach the care advisor on his or her cell phone. If there is a need for services and no informal supports are available, the care advisor helps the client find another worker through a list of provider agencies in the area or individuals in the Attendant Program, a personal care service under the Medicaid HCBS program.

D. Care Call Electronic Monitoring System

One of the most significant problems for officials who operate HCBS programs and their in-home clients is the availability of reliable home care workers or personal care attendants. Do they show up at the time and on the day they are expected and do they provide the type and amount of assistance for which public dollars are paying? One of

the major findings of the 2003 GAO report on oversight of HCBS for the elderly was that a substantial number of consumers were not receiving the services authorized in their care plans. Ensuring the delivery of authorized services was seen as a fundamental quality issue.

South Carolina has addressed this issue with the development of the Care Call electronic monitoring system to verify the delivery of services across all of the state's waiver programs. Care Call is a toll-free telephone check-in and check-out system for in-home personal care, attendant, companion, and nursing providers. When the home care worker arrives at a client's home, the worker makes a phone call to the system, which verifies that he or she is present in the client's home and registers an activity. The worker also logs out when the tasks/services are completed. These two calls define the time period during which the worker is providing services. The system compares services reported with the services authorized. The system depends on the care worker to accurately record the services provided; however, most states do not provide even this level of regular scrutiny of the delivery of authorized services.

Each worker has his or her own identification number, and each consumer receiving services under the Community Long-Term Care program also has an identification number. In addition to ensuring that the client receives "the right care, on the right day, at the right time, and from the right person," the Care Call system stores all appropriate information (i.e., date, time, activity, caller ID) for billing and exception reporting (South Carolina Department of Health and Human Services, 2005).

Care advisors, who have, on average, a caseload of about 80 consumers, monitor the records of these consumers monthly to check whether they have been receiving the appropriate number of hours of service. (In the case of high-risk consumers, the monitoring takes place weekly.) If the Care Call records show fewer hours of service than have been authorized, the care advisor will determine whether the consumer *needs* fewer hours (and then will change the authorized hours on the care plan) or whether the consumer is not receiving the proper amount of service.

State officials say that care advisors have also found cases where the worker has logged in *more* hours of service than authorized, alerting the care advisor to check whether the consumer has greater needs than first anticipated. This, too, can generate a change in the care plan.

The Care Call system operates on two levels, say state officials. It saves money by checking whether authorized services have been provided and thus should be paid for, and it ensures people are getting the services the care advisors determined that they need. The program also helps consumers manage their budgets because they get a record of the services they have received and the amount paid for those services.

Lessons Learned

- Use of information technology in the care management system allows care advisors to spend more time with consumers to respond more effectively to their needs in a timely fashion.
- Provision of cell phones to care advisors means that consumers can contact them directly and quickly without having to go through field or state offices.
- Filing information about the consumer in the care management system keeps care advisors up to date on their clients with accessible and useful data, and allows other workers to take over, if necessary, without delays in providing assistance.
- Development of the Care Call system improves worker reliability in making home care visits. The consumer has greater assurance that a worker will show up on time and provide the authorized amount of service. If problems arise, a care advisor can contact the consumer immediately and arrange for backup assistance.

FINDINGS

States are taking incremental steps to change the paradigm that has dominated quality assurance systems for home care – a pattern that has focused on structural and process issues, largely overlooking quality-of-life concerns faced by consumers. These process and structure standards have been weak in helping care managers determine whether consumers are actually receiving the services they need and want, whether they are being treated with dignity and compassion, and whether they are realizing the outcomes they seek.

Recognition by policymakers of these limitations in quality assurance systems – and the insistence of consumers and their families – have led to new person-centered approaches to assessing the quality of home care. The states whose programs have been highlighted in this report have found several innovative ways to make the consumer the focus of their efforts as they redesign their quality assurance systems.

- Wisconsin has found that developing a participant survey that more accurately assesses consumer outcomes is a difficult process that requires considerable communication with the care managers, who are expected to act on the survey information. Despite the problems they have encountered with the new survey tool, state officials believe that they and the care managers are gaining valuable experience in better understanding consumer needs and goals through their continuous interaction over the survey results.
- Washington has developed a system for home care that speeds access to services and supports through a quick determination of program eligibility and a focus on the quality and accuracy of the assessment process and the care plan. The state's comprehensive assessment system has become a consistent and reliable measure of consumer needs. Careful monitoring of care manager performance is helping to ensure the development of appropriate care plans for the consumer and effective delivery of services. Frequent supervisor monitoring of care managers ensures that officials will be able to catch problems promptly and improve training.
- South Carolina is demonstrating how to develop quick backup systems when workers fail to show up for work or in emergencies such as natural disasters. The state has made innovative use of information technology to ensure that consumers are receiving the services they need and to track home care worker visits. The system ensures that care managers and providers will be able to respond rapidly to address problems if they arise.

These states and others are being assisted in their efforts by vigorous federal actions that include the following:

- Establishing a quality framework to guide state QM system redesign.
- Requiring concrete evidence from states that they are systematically conducting monitoring activities and correcting problems.
- Crafting a new Medicaid waiver program application that requires more detailed information from states on their QM systems.
- Providing substantial grant support for quality redesign initiatives.

CONCLUSION

Researcher Rosalie Kane has argued that a good quality of life has been treated as “a pious after-thought to quality of care” by states regulating publicly funded home- and community-based services and supports. Quality of home care should address not only the competent provision of services, she says, but also the values of significance to consumers: independence, control, choice, dignity, and privacy.

This person-centered approach to QM, through improved communication with consumers, greater responsiveness in care management, and more effective information technology, is beginning to take hold in states, with the active encouragement of the federal government. Such efforts look at the real effect on the daily lives of consumers by ensuring that authorized services are actually delivered, eligibility is determined in a timely manner, and the voices of consumers are listened to by care managers and home care workers. However, much work remains to be done on measuring and documenting the outcomes of home care. Quality assurance for home- and community-based services and supports is a work in progress. If outcomes for consumers can be successfully measured, then state officials can implement the programs and practices that are associated with improved outcomes.

The quality assurance initiatives in the three states featured in this report point to the significant ongoing efforts that are being undertaken today to meet the challenge of ensuring quality care and support in the home. The challenge for state officials continues to be the creation of quality assurance systems that place consumer needs and goals for quality of life first.

CHECKLIST FOR HOME CARE QUALITY

Focus of Quality Assurance Program:

1. Are quality assurance efforts developed around a person-centered focus? How is such a focus incorporated into the delivery of services?
2. Has the state articulated its mission and values in regard to quality assurance in a clear statement of purpose made available to consumers, workers, and providers?
3. Have person-centered measurable outcomes been defined in the quality system?
4. Is there a plan for regular monitoring of service delivery? How quickly can care managers and service providers respond to problems that arise?
5. What is the assessment and care planning system? Are care managers trained in ways to involve the program participant in the assessment and care planning processes?
6. Is a system in place to provide backup workers in emergencies or service breakdowns?

Consumer Participation:

1. Has the state implemented mechanisms for increasing consumer participation in quality assurance efforts? Do consumers have input into the development of quality standards and measurement of home care outcomes?
2. Are care plans responsive to consumer needs and preferences? Do workers ensure the participation of consumers in the development of their care plans?
3. How does the state determine consumer satisfaction with services and supports? How often are consumers asked their opinions about their workers and the type and duration of care they are receiving?
4. Do consumers know how and where to file grievances or complaints about services?

(Developed by the authors, based on the CMS Quality Framework)

RESOURCE LIST ON QUALITY ASSURANCE LINKS

The following state agencies have quality assurance responsibilities for the three states featured in this report:

Wisconsin:

Bureau of Quality Assurance
Division of Disability and Elder Services
Department of Health and Family Services
(608) 266-8481

Washington:

Quality Assurance Unit
Division of Home and Community Services
Aging and Disability Services Administration
Department of Social and Health Services
(360) 725-2604

South Carolina:

Bureau of Long-Term Care Services
Division of Community Long-Term Care
Department of Health and Human Services
(803) 898-2590

Federal Resources:

Centers for Medicare and Medicaid Services

Communications to states on HCBS quality issues:
www.cms.hhs.gov/medicaid/waivers/qcomm.asp

Technical assistance to states: www.cms.hhs.gov/medicaid/waivers/tabrochure.pdf

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