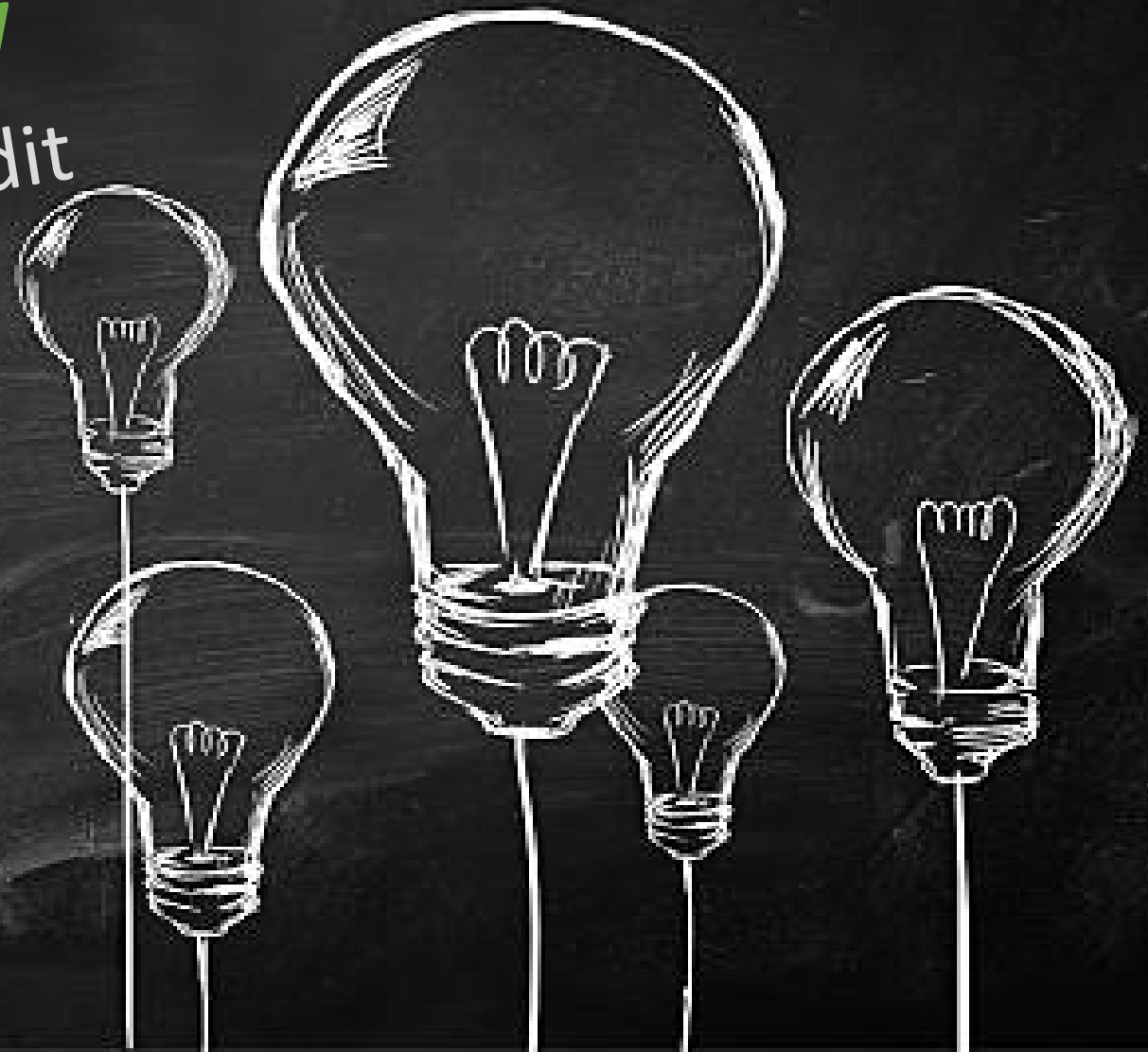
HELP ME HELP YOU

Redefining Quality

through the HCBS Provider Audit



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Alexandra (Ali) Fernández, Bureau Chief
Bureau of Long Term Care,
Division of Medicaid
Idaho Department of Health and Welfare

Chris Barrott, Program Policy Analyst
Bureau of Long Term Care,
Division of Medicaid
Idaho Department of Health and Welfare

Pettar Amador, CEO
A Better Care Home Health, Inc

Mitzi Lewis, PAS Director,
Living Independent Network Corporation

Instead of Fighting the Darkness, you bring in the light

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SURVEY
SAYS....

CREATE THE SOLUTION TO ANY PROBLEM

Our provider relationships needed improvement

Data collected was not meaningful and/or relevant

Audits and messaging were inconsistent and inefficient

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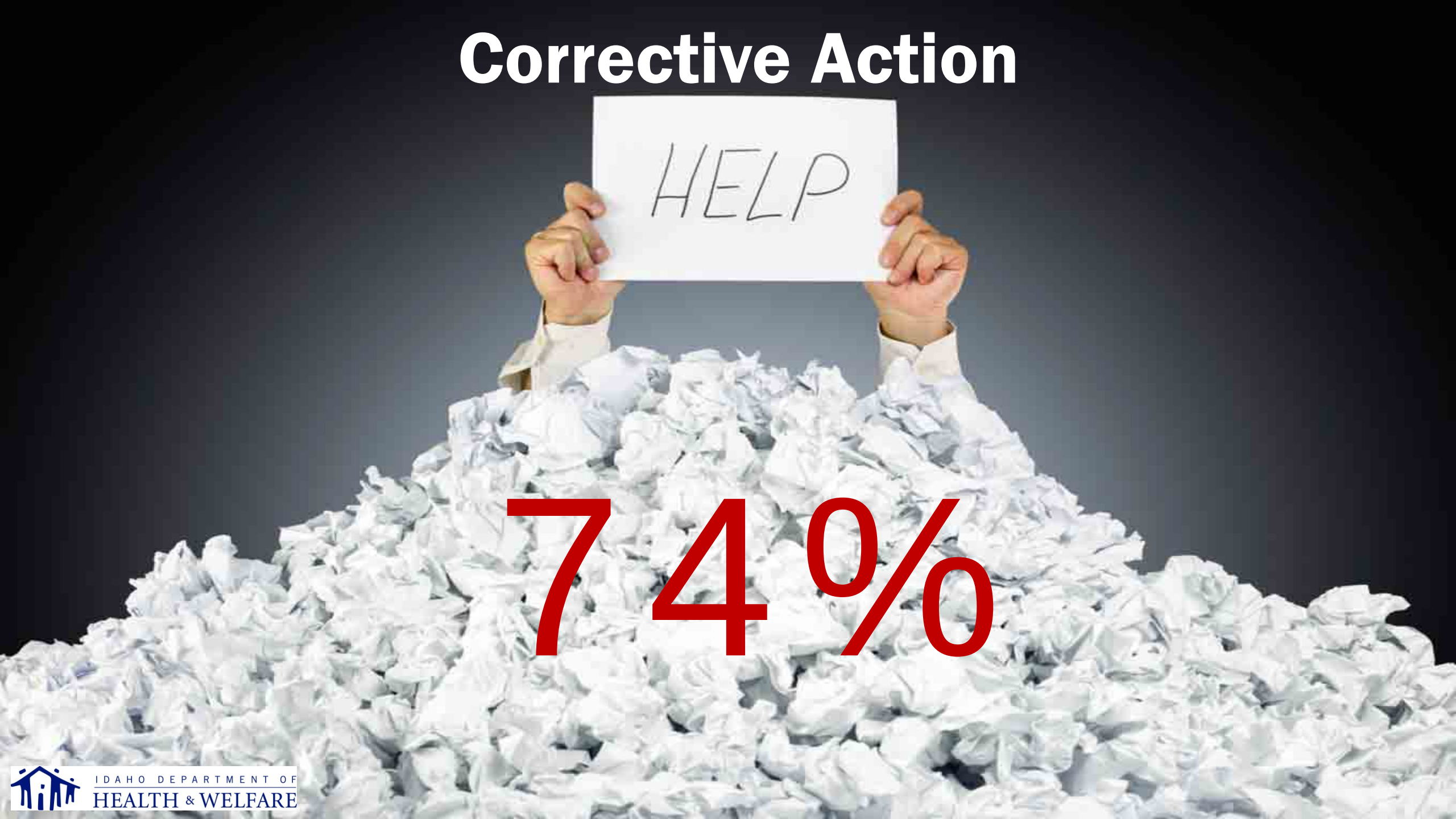
gotcha

CONSISTENTLY INCONSISTENT

Data Collection

- **40+** data elements collected at each audit
- Sample sizes were too small to be statistically valid
- Several data measures collected were not within our scope of authority
- Data points were not always meaningful or relevant
- Data collection was cumbersome, time consuming, and often subjective
- Interpretation of the data was inconsistent from QA Specialist to QA Specialist

Corrective Action



74%

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CMS Review of Quality Assurance

In 2008, Idaho Medicaid was placed on corrective action for failure to demonstrate that we substantially met our 1915(c) waiver assurances.

This resulted in the first major overhaul of our QA system.

Data collection improved considerably, but over time we identified that we still had significant challenges.

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The problems…

- Our relationship with providers was adversarial
- Data collected was not always meaningful or gathered efficiently
- The corrective action process did not drive performance improvement

We were expending a lot of resources – and still were not meeting CMS expectations!

We were getting the work done with a little light, but what could we do if we increased the light?

THE AHA! MOMENT

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Increasing the Light

We identified that if we wanted Quality we had to change our processes and identify the barriers

1. Maintaining a punitive relationship with providers **doesn't enhance Quality**
2. Collecting a lot of data **doesn't enhance Quality**
3. Issuing a high volume of requests for Corrective Action **doesn't enhance Quality**

If the Plan doesn't work, Change the Plan.

But never change the goal

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Teaching an Old Dog New Tricks

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Awareness is the beginning of change

- The most critical element to redefining quality was shifting our culture.
- We could not begin to work on our relationship with providers without also working to improve internal buy-in.
- Effective change management to mitigate the natural aversion to change.

When you're in your own lane there is no traffic

- Program Integrity
- Licensing & Certification
- Provider Enrollment
- Other state entities and partners

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service delivery

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Three Guiding Questions

1. Does it tell us information we need to make business decisions?
2. Does it tell us or our providers how we are performing our respective functions?
3. Does it have a positive impact on our participants?

NO – *let it GO*

YES – then it is time and effort well spent!

Goal: Improve relationships with Providers

Outcome:

- Open line of two-way communication and feedback
- Actively seek input from providers on challenges and barriers
- Take advantage of opportunities to collaborate

- Provider Help Aids hosted on state website
- Provider input on Help Aids and provider materials
- WebEx based bi-annual provider training which resulted in a **70% increase** in attendance
- Invite Providers as guest speakers at our bi-annual conferences
- Quarterly face-to-face meetings with provider organizations

COLLABORATION

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Training Modules

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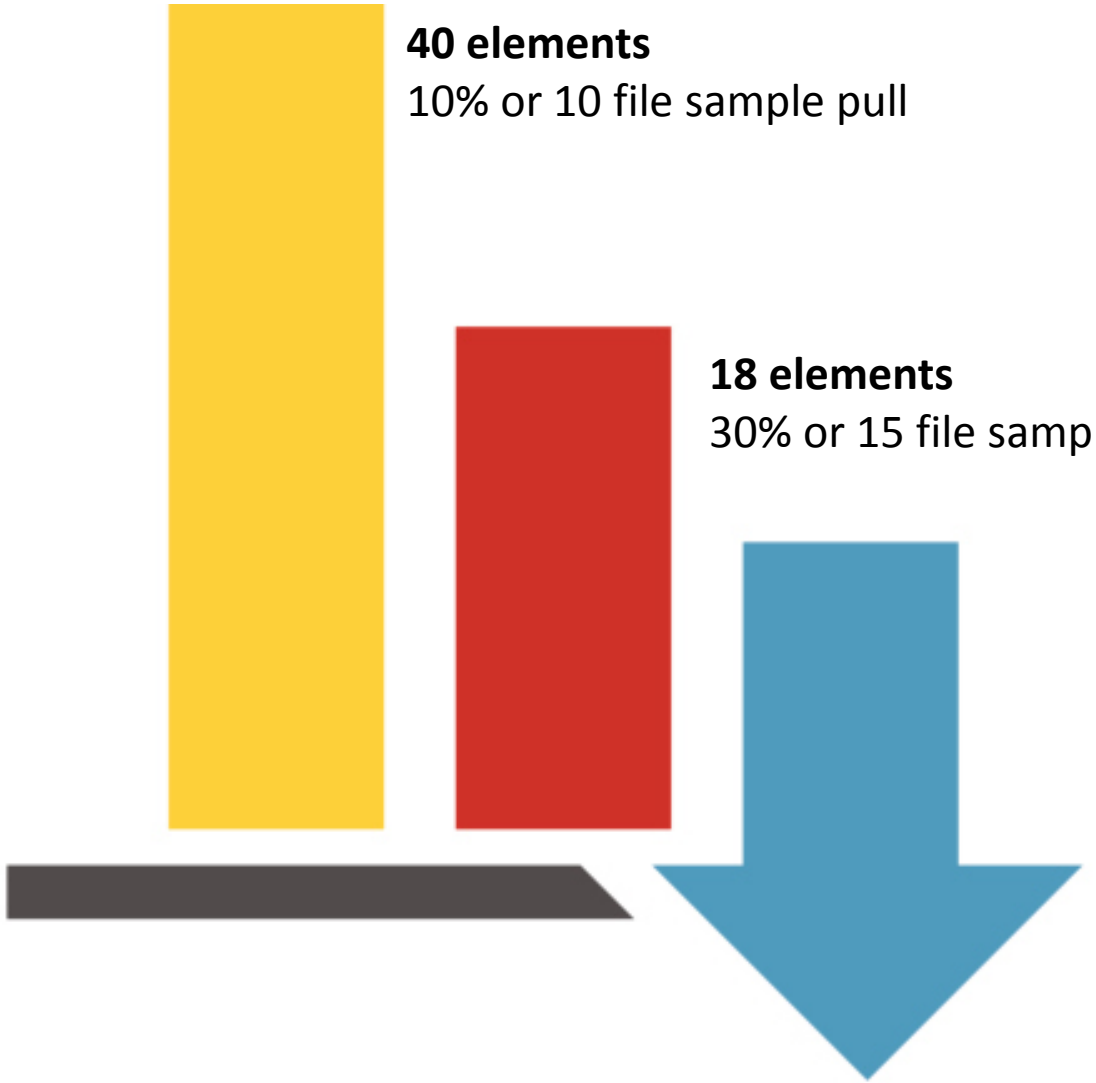
Goal: Refine data collection to be efficient, meaningful, and relevant

Outcome:

- Revised all waiver performance measures for clarity and completed a crosswalk to our data points
- Evaluated every data point to our three guiding questions
- Identified opportunities for efficiencies in data collection methods (move to electronic data submission)

DATA ELEMENTS



40 elements
10% or 10 file sample pull

18 elements
30% or 15 file sample pull

55% reduction in elements ensuring that only meaningful data is collected and reported

Electronic Submission of Documents

- No data was submitted electronically
- Audit was conducted On-site only

Before

After

- 90% data was submitted electronically
- Provider conducted a self audit
- Desk audit was conducted
- On-Site Audit was focused and relevant

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Provider Audit Spreadsheet

Before

- Providers were not enlisted to provide relevant data
- All data elements were validated in each individual staff/participant file

After

- Providers completed a state approved Audit spreadsheet with only relevant data
- Providers identified areas of deficiency prior to the audit beginning
- Areas of deficiency were easily identified for the state auditor
- All data was shared with providers

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Quality Survey Data

Before

- Survey data was captured on paper
- Each individual survey was sent with assessment data

After

- Survey data is captured electronically
- Survey data is sent quarterly in an Excel format
- Providers can manipulate the data to determine trends and deficiencies

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Audit Sample Size

Before

- 10% of files were audited on-site only

After

- Various auditing methods allowed us to increase our sample size up to 100%
  - Survey data
  - Audit spreadsheet
  - Specialized reports

Goal: Ensure consistent audits and communication across the state

Outcome:

- Auditors do not interpret Idaho Rule, division Policy Analysts have responsibility for interpretation
- Focused our audit on **Service Delivery**
- Created a new, streamlined database
- Created Job Aids that clearly outline processes and procedures

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Desk Review

- Allows providers the opportunity to self audit *and* remediate before the Medicaid audit begins
- Larger sample size is possible because providers are partnering in the audit process
- Efficient use of staff time considering the limited Medicaid resources
- Drives the on-site audit

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EFFICIENCY!

- Provider enters the required data into the spreadsheet
- Excel easily identifies areas of deficiency
- QA Specialist enters comments on each file audited
- Spreadsheet is shared with the provider for the purposes of technical assistance to ensure compliance to Idaho rule and contractual agreements

Provider enters information on 100% of staff and 30% of participants *based on random sample*

STAFF INFORMATION					CRIMINAL HISTORY				TRAINING	ADDITIONAL REQUIREMENTS		
					This section is to be completed for all employees that did NOT have an ISP Background Transfer. If the ISP Transfer was completed please do not complete the dates in this area.			*Please enter the date on the ISP documentation*				
Last Name	First Name	Job Title	Licensure	Hire Date	Notary Date on Fingerprint Application *If no value please enter N/A*	Date of Fingerpint Completion *If no value please enter N/A*	Date on Notice of Clearance Letter *If no value please enter N/A*	ISP Background Check Date *If no value please enter N/A*	Training Completion Date	Health Screening	Direct Care Start Date	Endorsements
Armstrong	Zach	Head Fred		5/5/2017	1/15/2017	2/15/2017	5/5/2017	5/11/2017	1/15/2017		1/10/2017	

Spreadsheet immediately identifies areas of deficiency for auditor.

These columns are hidden from the provider until the conclusion of the audit

DATE DIFFERENCE - *All dates in red are deficient*				
Notary Days # days from Notary date to Direct Care date	**Fingerpint Days** # days from Notary date to Fingerprint date (21 days max)	**Clearance Letter** # days from Fingerpint date to printed letter (14 days max)	**ISP Background** # days from Hire date to Transfer date (30 days max)	**Direct Care Days** # days from Training to Direct Care (0 days max)
5	31	79	121	5

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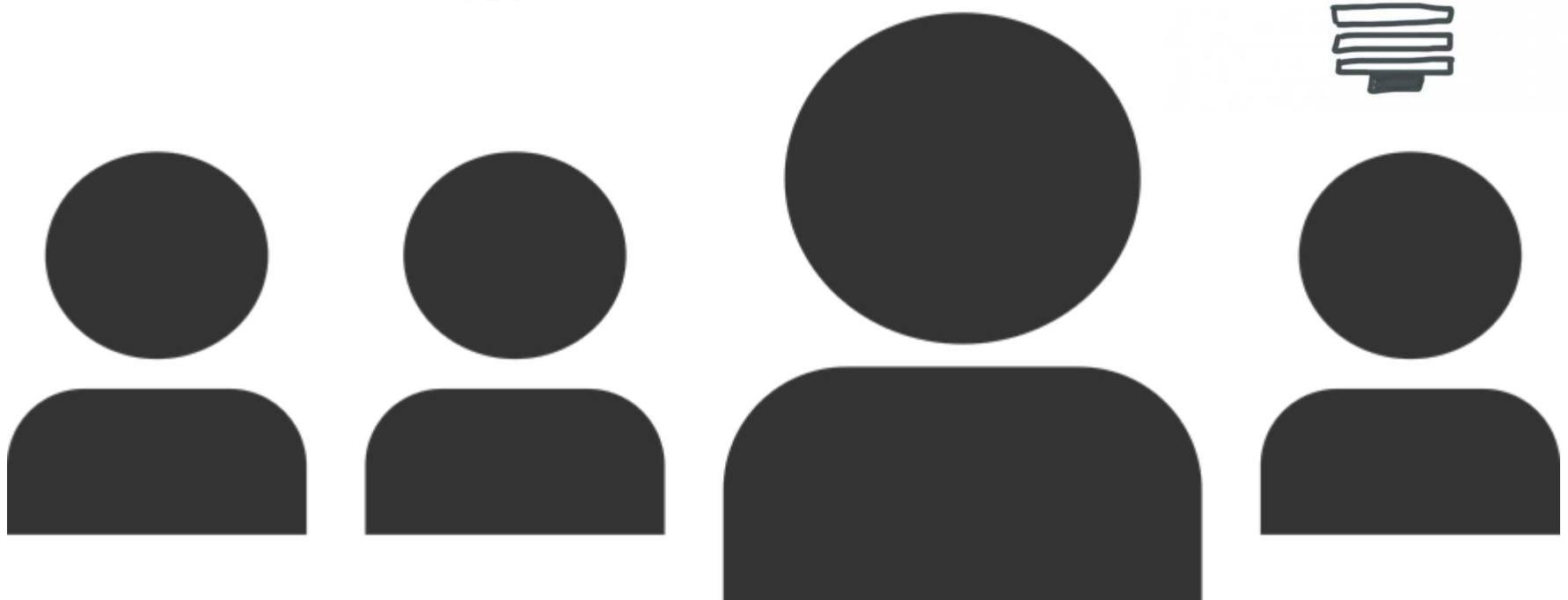
Providers Opinion



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Goal: **Change from the Stick to the Carrot**

Outcome:

- Provide information that allowed the provider to remediate and improve
- Allowed the provider to identify areas of improvement before the state identified them
- Allowed time for remediation
- Auditor first recognized the provider for their successes

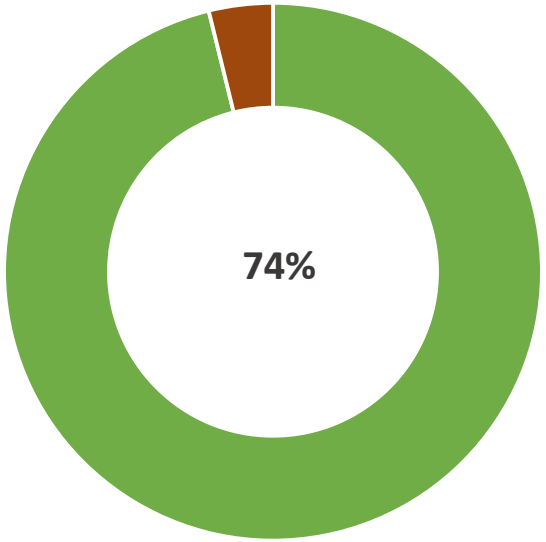
Provider Audit Findings

- Providers are given a ‘report card’ that identifies all components of the audit
- They receive a score of (1) **Meets**, (2) **Opportunity for Improvement**, (3) **Not Met**
- The focus of the Findings are to recognize compliance and clearly identify deficiencies
- The QA Specialist articulates remediation required and includes the audit spreadsheet with details for each file reviewed
- Providers have fifteen (15) business days to remediate all deficiencies

Corrective Action Requests

based on Provider Audits

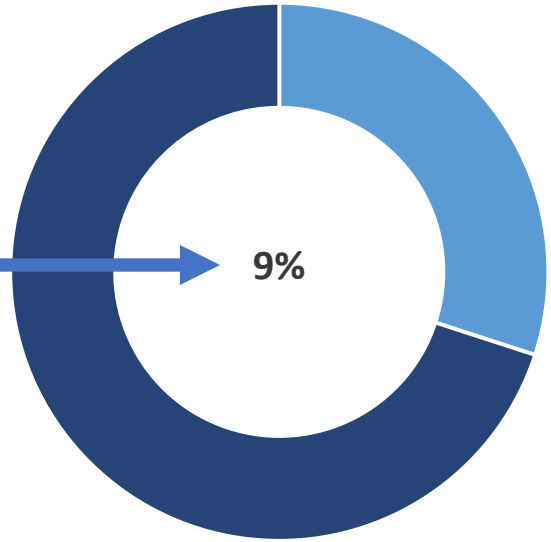
2011-2014



282 audits conducted for the time period

Average of 70 audits per year

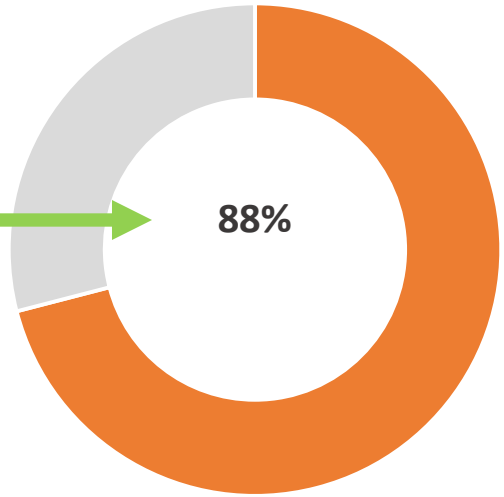
2016-2018



239 audits conducted for the time period

Average of 96 audits per year

Reduction in Corrective Action Issued



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Results are in…. …

- The Corrective Action process is now a **very** effective tool for driving performance improvement.

FOCUS

Follow One Course Until Successful

- Focus the audit on your expertise and oversight authority
- Remove all data elements that do not fit within the scope of the audit authority
- Establish relationships with other state divisions and leverage their expertise and authority (Program Integrity, Provider Enrollment, etc.)
- Redefine audit criteria around Service Delivery to ensure compliance with CMS and Idaho Rule as well as contractual agreements

Quality means a continuous process of improving our program through a collaborative relationship with our providers that results in positive outcomes for our participants.

Contact Us

Alexandra Fernández, Bureau Chief
Idaho Department of Health & Welfare, Bureau of Long Term Care
208-287-1179
Alexandra.Fernandez@dhw.Idaho.gov

Chris Barrott, Medicaid Policy Analyst
Idaho Department of Health & Welfare, Bureau of Long Term Care
208-732-1482
Chris.Barrott@dhw.Idaho.gov