

## BLTC – Quality Improvement Strategy Summary Quarter 2, 2015

LEVEL OF CARE																																	
<p>An evaluation for Level of Care (LOC) is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.</p> <p><b>Analysis:</b> YTD 2015, approximately 80 % of applications for LTC services met NF level of care.</p>	<div style="text-align: center;"> <h3>Number &amp; Percent of A&amp;D Waiver Applications Meeting NF LOC During the Initial Assessment</h3> <table border="1" style="margin: 10px auto; border-collapse: collapse;"> <caption>Data for: Number &amp; Percent of A&amp;D Waiver Applications Meeting NF LOC</caption> <thead> <tr> <th>Period</th> <th>Initial Assessments</th> <th># Met NF LOC</th> <th>% Met NF LOC</th> </tr> </thead> <tbody> <tr> <td>Quarter 1</td> <td>974</td> <td>754</td> <td>77%</td> </tr> <tr> <td>Quarter 2</td> <td>977</td> <td>778</td> <td>80%</td> </tr> <tr> <td>Quarter 3</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>Quarter 4</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>2015</td> <td>1,951</td> <td>1,532</td> <td>79%</td> </tr> <tr> <td>2014</td> <td>3,805</td> <td>2,946</td> <td>77%</td> </tr> <tr> <td>2013</td> <td>3,546</td> <td>2,599</td> <td>73%</td> </tr> </tbody> </table> </div>	Period	Initial Assessments	# Met NF LOC	% Met NF LOC	Quarter 1	974	754	77%	Quarter 2	977	778	80%	Quarter 3	-	-	-	Quarter 4	-	-	-	2015	1,951	1,532	79%	2014	3,805	2,946	77%	2013	3,546	2,599	73%
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<p>The Level of Care (LOC) on all enrolled participants is reevaluated at least annually or as specified in the approved waiver.</p> <p><b>Analysis:</b> YTD 2015, a random sample of internal file audits supported that annual level of care redeterminations were timely 97% of the time. The late assessments were due to staffing issues.</p> <p><b>Remediation:</b> All redeterminations were completed. NR's will continue to talk to their NM when an assessment will be late for a review of available resources.</p>	<div style="text-align: center;"> <h3>Number &amp; Percent of A&amp;D Participants Who Received a Timely Redetermination</h3> <table border="1" style="margin: 10px auto; border-collapse: collapse;"> <caption>Data for: Number &amp; Percent of A&amp;D Participants Who Received a Timely Redetermination</caption> <thead> <tr> <th>Period</th> <th># Due for Redetermination</th> <th># Completed within 364 Days</th> <th>% of Timely Redeterminations</th> </tr> </thead> <tbody> <tr> <td>Quarter 1</td> <td>74</td> <td>71</td> <td>96%</td> </tr> <tr> <td>Quarter 2</td> <td>76</td> <td>75</td> <td>99%</td> </tr> <tr> <td>Quarter 3</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>Quarter 4</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>2015</td> <td>150</td> <td>146</td> <td>97%</td> </tr> <tr> <td>2014</td> <td>282</td> <td>278</td> <td>99%</td> </tr> <tr> <td>2013</td> <td>286</td> <td>275</td> <td>96%</td> </tr> </tbody> </table> </div>	Period	# Due for Redetermination	# Completed within 364 Days	% of Timely Redeterminations	Quarter 1	74	71	96%	Quarter 2	76	75	99%	Quarter 3	-	-	-	Quarter 4	-	-	-	2015	150	146	97%	2014	282	278	99%	2013	286	275	96%
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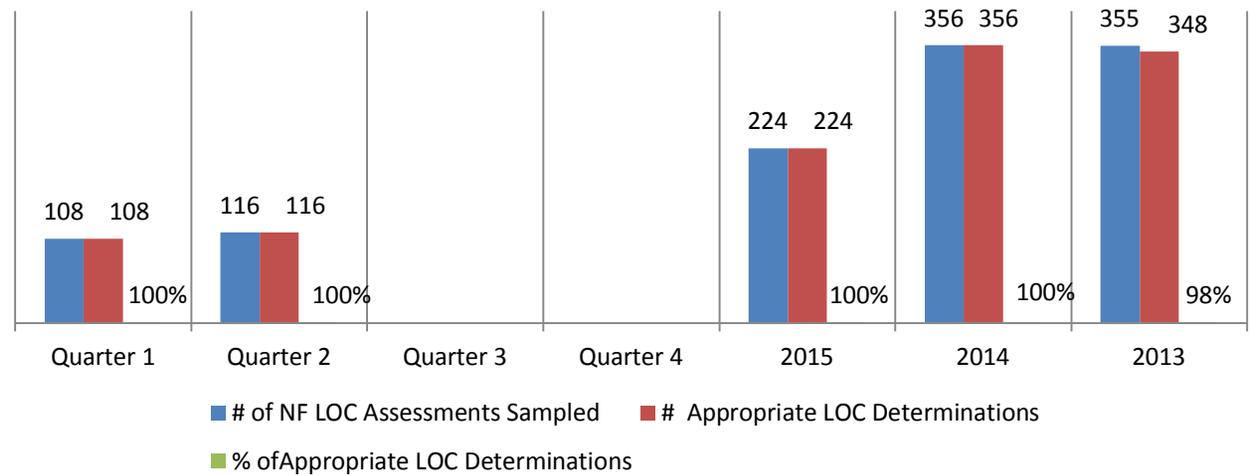
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The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the participant's level of care.

**Analysis:** YTD 2015, 100% of Assessments for Nursing Facility Level of Care were determined appropriately.

**Remediation:** None needed.

**Number & Percent of NF LOC Assessments Determined Appropriately**

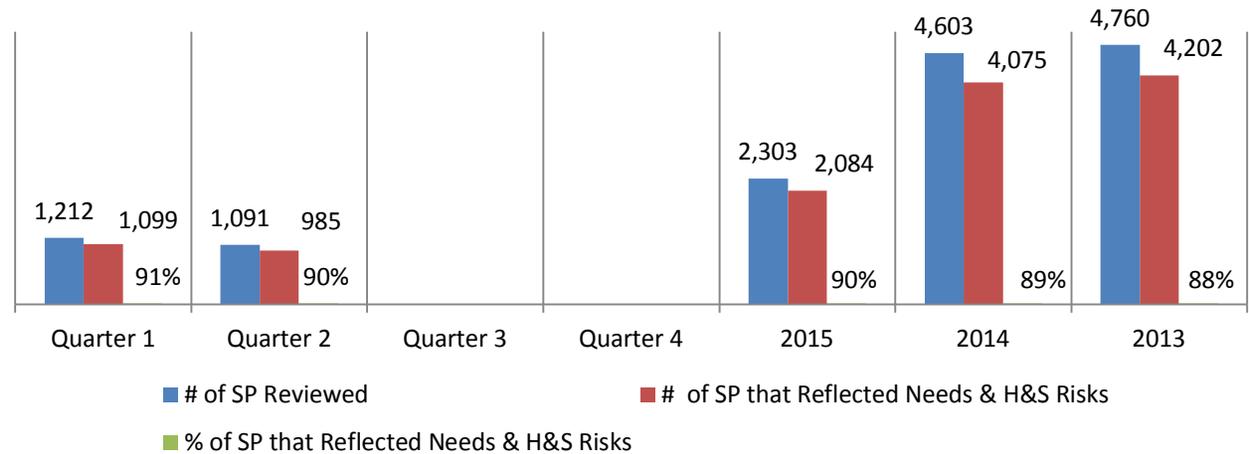


### SERVICE PLAN

a. Service plans address all participants' assessed needs (including health & safety and risk factors) and personal goals, either by the provision of waiver services or through other means.

**Analysis:** Service plans developed by A&D/PCS agencies are reviewed during the NRHV process. YTD 2015, there was a 1% increase in compliance with this requirement when compared to 2014 data.

**Number & Percent of Service Plans (SP) that Reflect Participant Health Care Needs & H&S Risk Factors**



## BLTC – Quality Improvement Strategy Summary Quarter 2, 2015

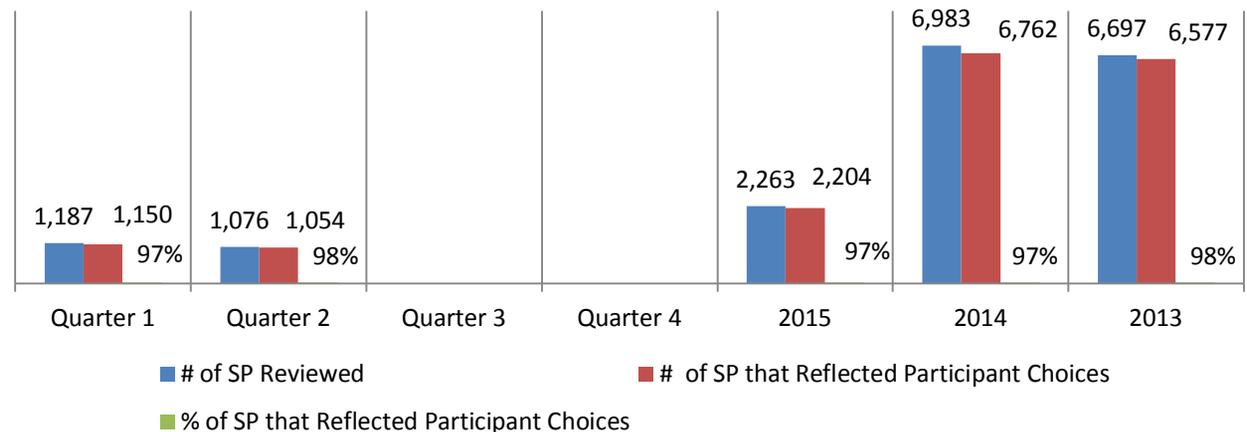
**Remediation:** Providers are sent the results of the NRHV review at the time of the authorization for services. They are expected to remediate the deficiency. In addition, the provider is sent a cumulative report based on all reviews of participants receiving services from their agency 2 times per year and must send a Corrective Action Plan (CAP) if their overall compliance is less than 85% or the statewide average, whichever is higher.

b. The State monitors service plan development in accordance with its policies and procedures.

**Analysis:** This requirement is monitored through the NRHV process (participant question). YTD 2015 data is consistent with 2014 data.

**Remediation:** Results of the NRHV report is sent to the agency for immediate remediation.

**Number & Percent of Service Plans (SP) that Reflect Participant Choices**



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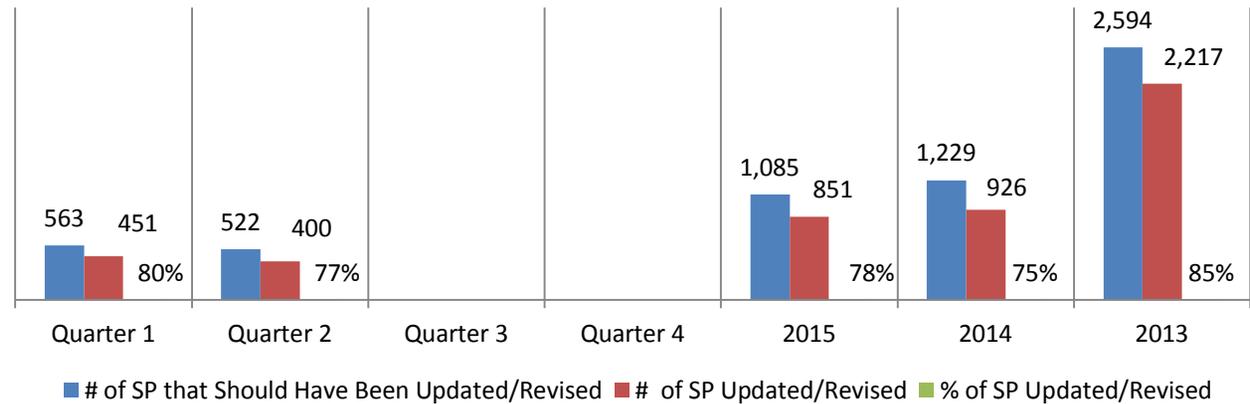
c. Service plans are updated/ revised at least annually or when warranted by changes in the waiver participants needs.

**Analysis:** This requirement is monitored through the NRHV process. YTD 2015, there was an overall 3% increase in compliance when compared to 2014 data.

**Remediation:** Results of the NRHV report is sent to the agency for immediate remediation.

**Note:** There was a 47% decrease in the number of Service Plans that should have been updated in 2014 when compared to 2013. The reason is unknown. YTD 2015, the trend appears to be reflective of 2013 data.

**Number & Percent of Service Plans (SP) Updated when Warranted by Changes in Participant's Needs/Goals**



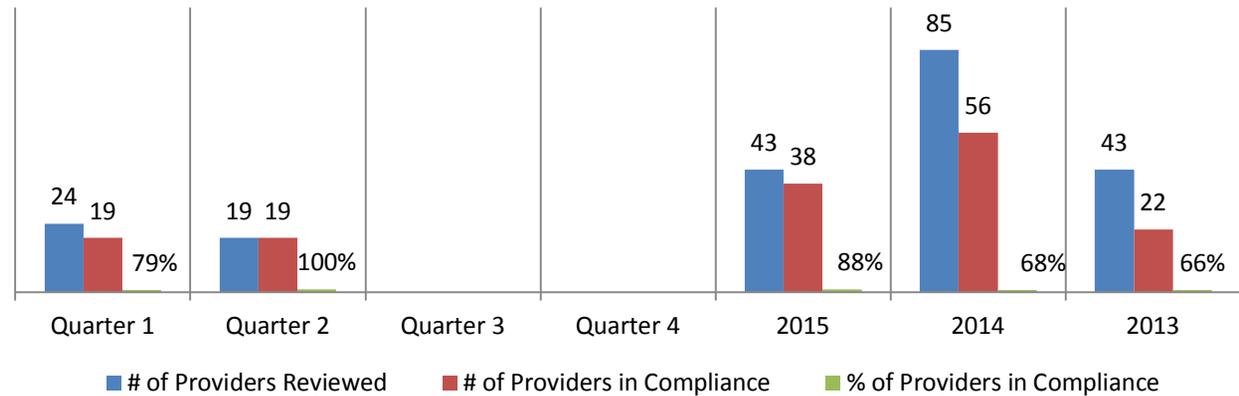
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d. Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

**Analysis:** This requirement is monitored through the Provider Review process. Analysis is a comparison of current data with the data collected in the same provider set in 2013. YTD 2015, there was a significant increase (22%) in compliance in this requirement.

**Remediation:** Providers with deficiencies in this area were sent requests for CAPs.

**Services are Delivered in Accordance with the Service Plan  
(includes type, scope, amount, duration & frequency)**



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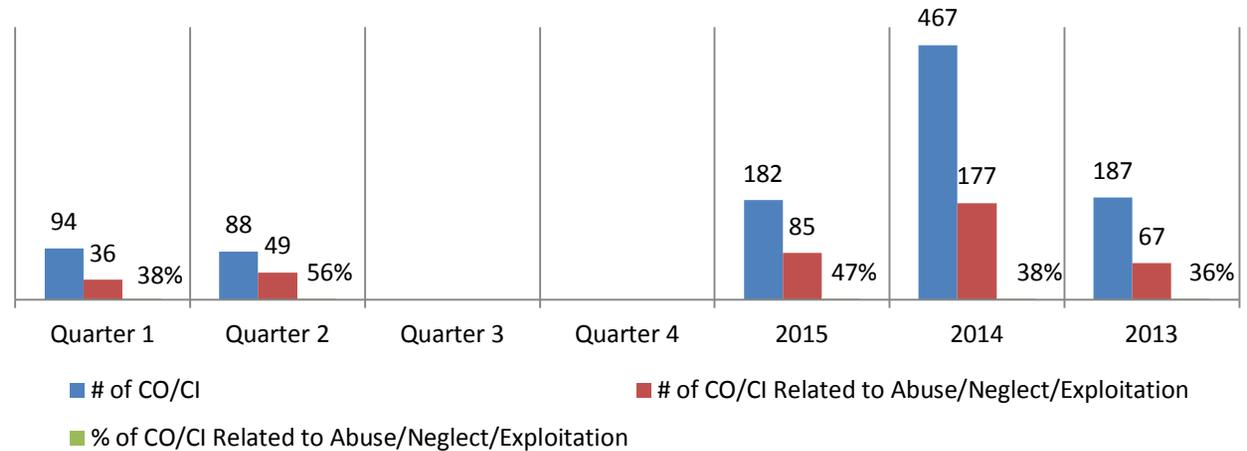
### HEALTH AND WELFARE

The State, on an on-going basis identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

**Analysis:** The percent of complaints related to Abuse, Neglect or Exploitation has increased in 2015. This increase is due to questions regarding abuse and exploitation being added to the NRHV process. In Q1, the number of reports of Abuse/Exploitation in the CO/CI data base was not consistent with participant experience data. This was remediated by QIS staff in Q2.

**Remediation:** QIS staff will continue review NRHV “yes” responses to abuse and exploitation questions and the data entered into the CO/CI SharePoint. The Q2 2015 CO/CI Report includes corrected Q1 2015 data.

**Number of Complaints/Critical Incidents Related to Abuse/Neglect/Exploitation**

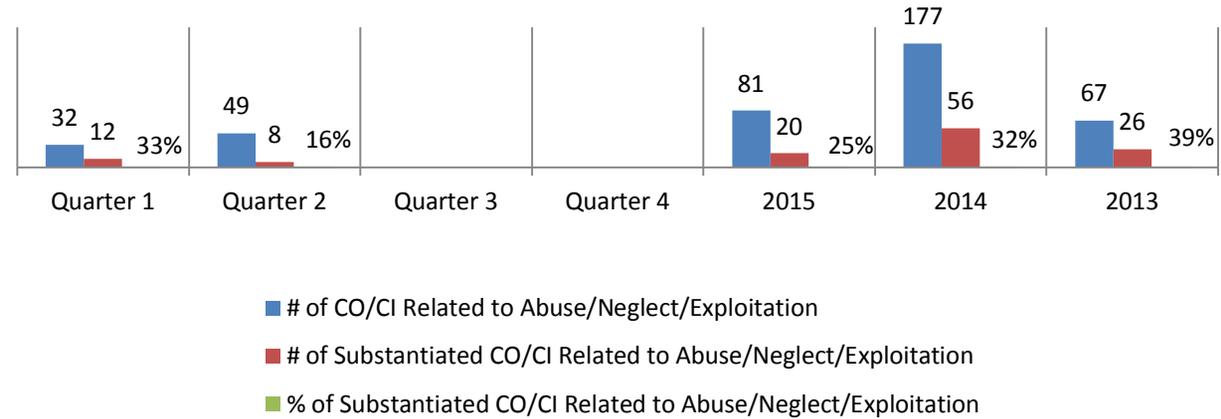


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2) Complaints/Critical Incidents are classified, investigated and referrals are made to appropriate resources and services as necessary.

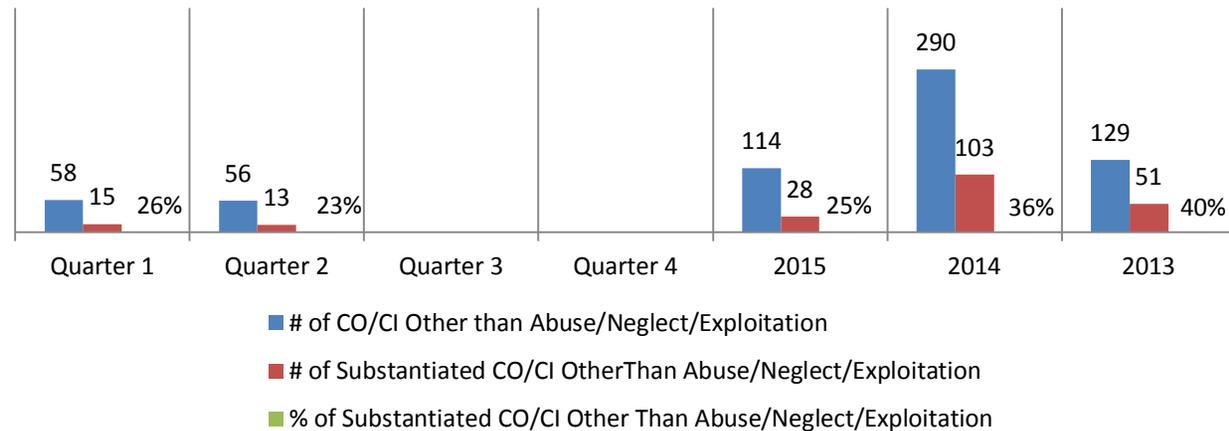
**Analysis:** YTD 2015, the % of substantiated critical incidents related to abuse, neglect or exploitation decreased, when compared to the previous 2 years. Details of substantiated critical incidents are detailed in the Complaint/Critical Incident Q2 2015 Report.

**Number & Percent of Substantiated Complaints/Critical Incidents Related to Abuse/Neglect/Exploitation**



**Analysis:** YTD 2015, the percent of substantiated complaints other than abuse, neglect, or exploitation is less than the previous 2 years data.

**Number & Percent of Substantiated Complaint/Critical Incidents Other Than Abuse/Neglect/Exploitation**



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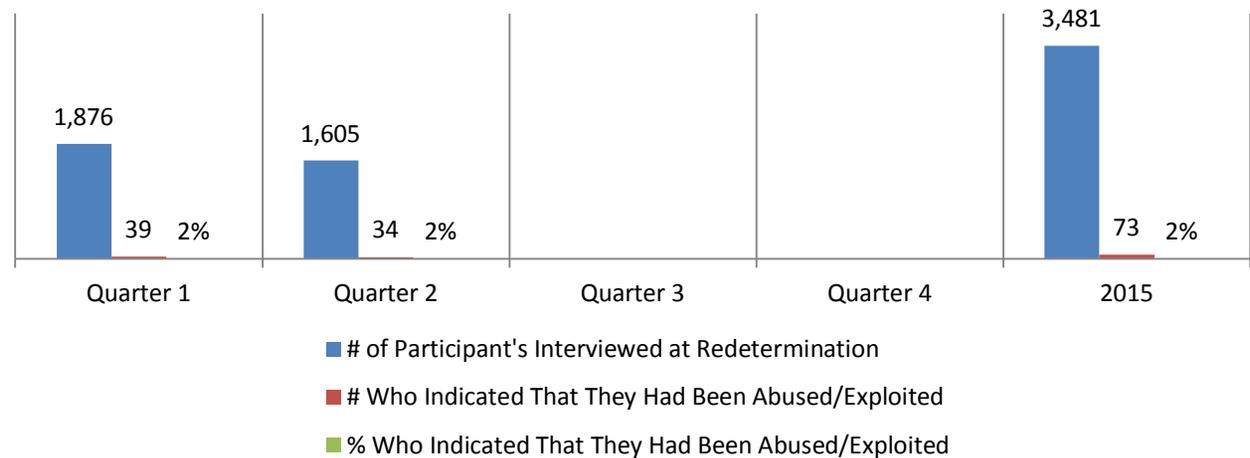
2. Questions regarding abuse, neglect and exploitation were added to and revised in the Nurse Reviewer Home Visit (NRHV) Process in 2015.

**Remediation:**

The results of this question are not reported to providers, allowing participants to talk confidentially. The process is for these reports to be followed up by QIS and reported to Adult Protection when indicated.

**Improvement Needed:** Not all reports were entered into the CO/CI SharePoint in Q1 2015. QIS staff reviewed NRHV forms with a “yes” response and if appropriate entered them into the CO/CI SharePoint. This chart is reflective of corrected Q1 2015 data.

**Participant Experience Related to Abuse/Neglect/Exploitation**

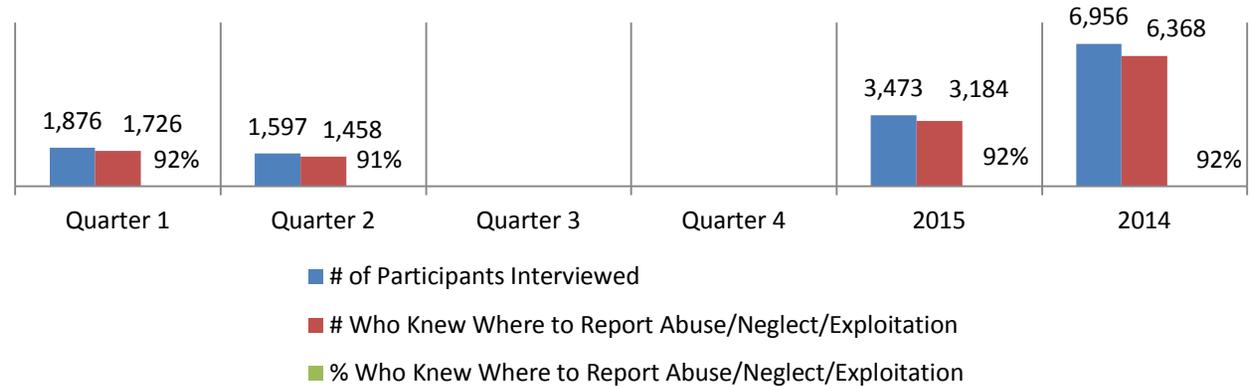


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2. Participants are given information on where to report Abuse/Neglect/Exploitation at the initial assessment and annually at redetermination.

**Remediation:** None needed.

### Participants Who Stated They Know Where to Report Abuse/Neglect/Exploitation



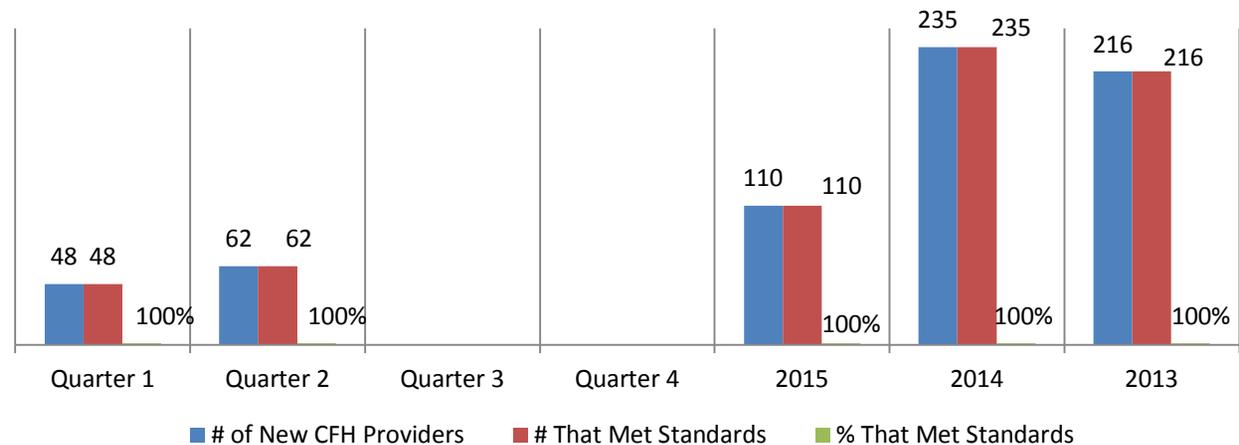
### QUALIFIED PROVIDER - LICENSED

The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

**Analysis:** YTD 2015, 110 new CFH providers were approved. All were in substantial compliance.

**Remediation:** None needed.

### Number & Percent of New Licensed/Certified Providers that Met Licensure Standards - CFH

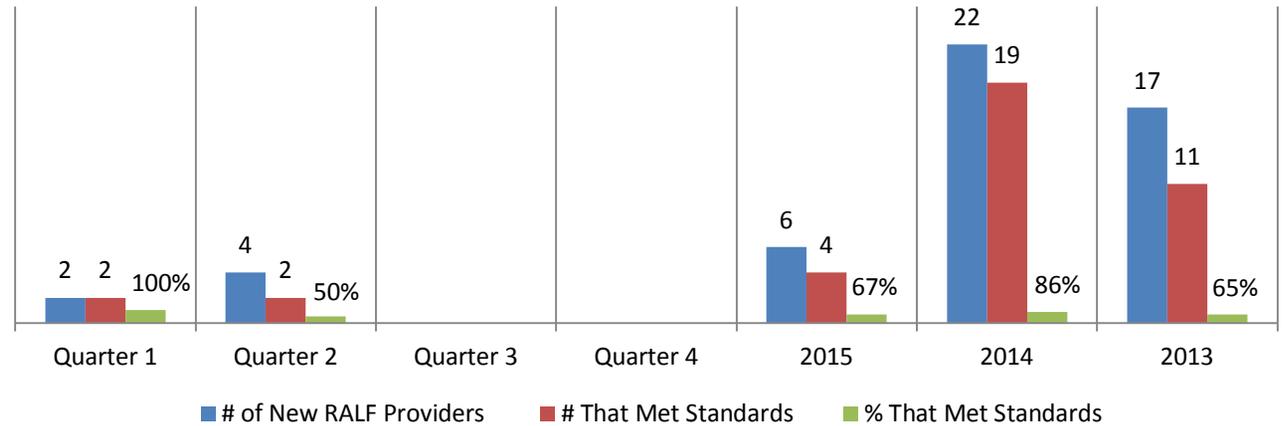


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**Analysis:** YTD 2015, 6 new RALF surveys were conducted. 67% were in substantial compliance and licensed.

**Remediation:** None needed.

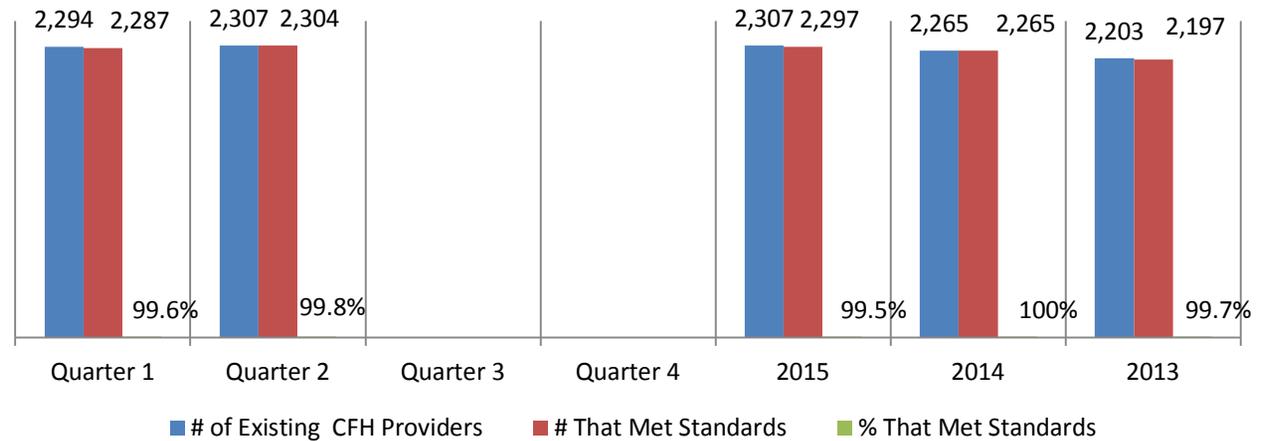
**Number & Percent of New Licensed/Certified Providers that Met Licensure Standards - RALF**



**Analysis:** YTD 2015, 10 of 2,307 existing CFH providers were not in substantial compliance with Certification standards.

**Remediation:** All 10 certifications were revoked and Medicaid provider agreements and authorizations were terminated.

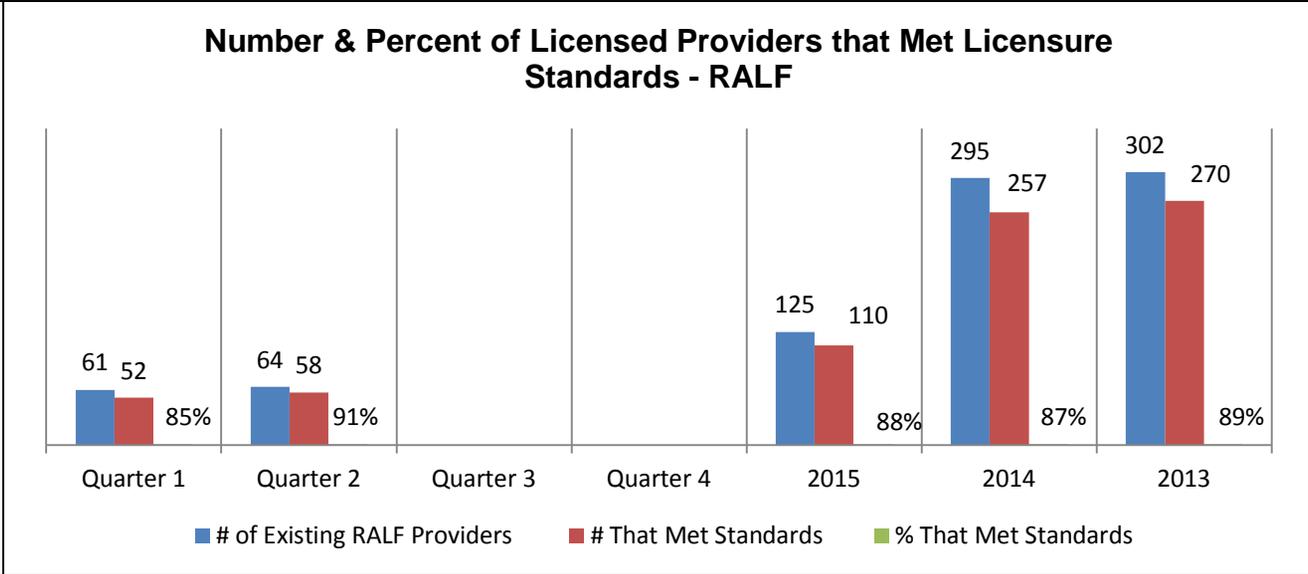
**Number & Percent of Existing Licensed/Certified Providers that Met Certification Standards - CFH**



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**Analysis:** YTD 2015, 15 of 125 existing RALF providers who were subject to licensure surveys were not in substantial compliance with standards.

**Remediation:** All 10 providers have either come into compliance or are in the Corrective Action Process.



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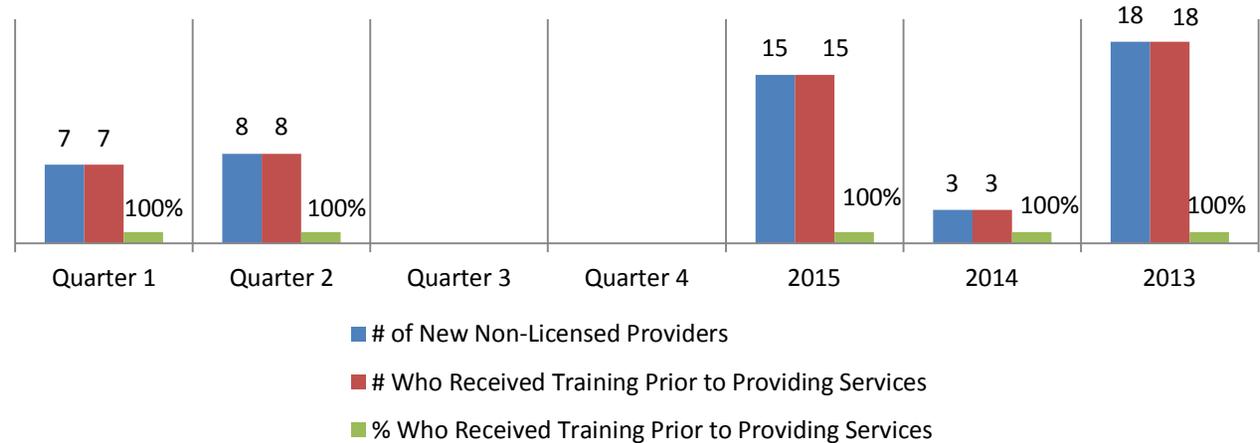
### QUALIFIED PROVIDER – NON-LICENSED

The State monitors non-licensed/non-certified providers to assure adherence to HCBS Waiver requirements.

**Analysis:** Our current process is that providers are not issued a provider number until New Provider Training has been completed.

**Remediation:** None identified.

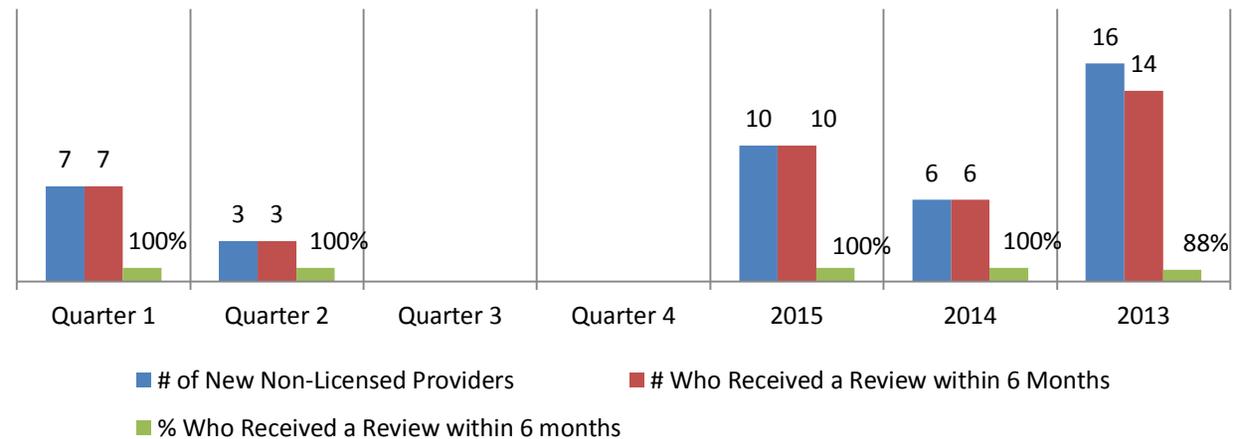
**Number & Percent of New Non-Licensed Providers Who Received Training Prior to Providing Services**



**Analysis:** YTD 2015, 100% of new providers received an initial Quality Assurance Review within 6 months of providing services.

**Remediation:** None identified.

**Number & Percent of New Non-Licensed Providers Who Had an Initial Review Within 6 Months**

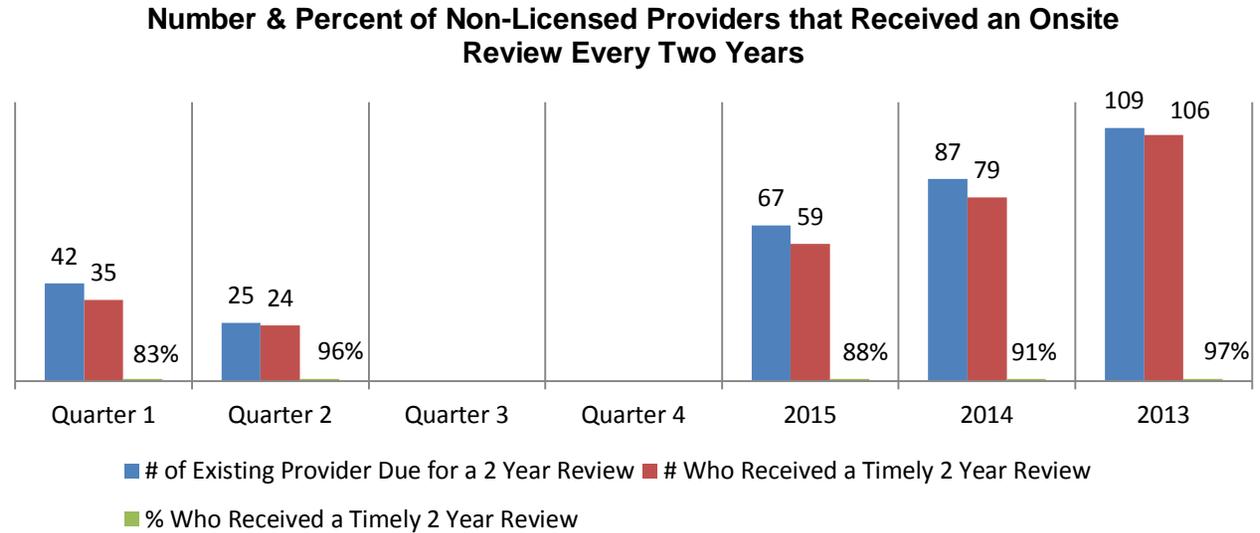


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**Analysis:** YTD 2015, 8 providers received a late QA Review. (Due to provider scheduling issues and HDM/PERS providers not sending in information for paper reviews in a timely manner. This is a 3% decrease in compliance when compared to 2014 data.

**Remediation:** Late reviews were completed.

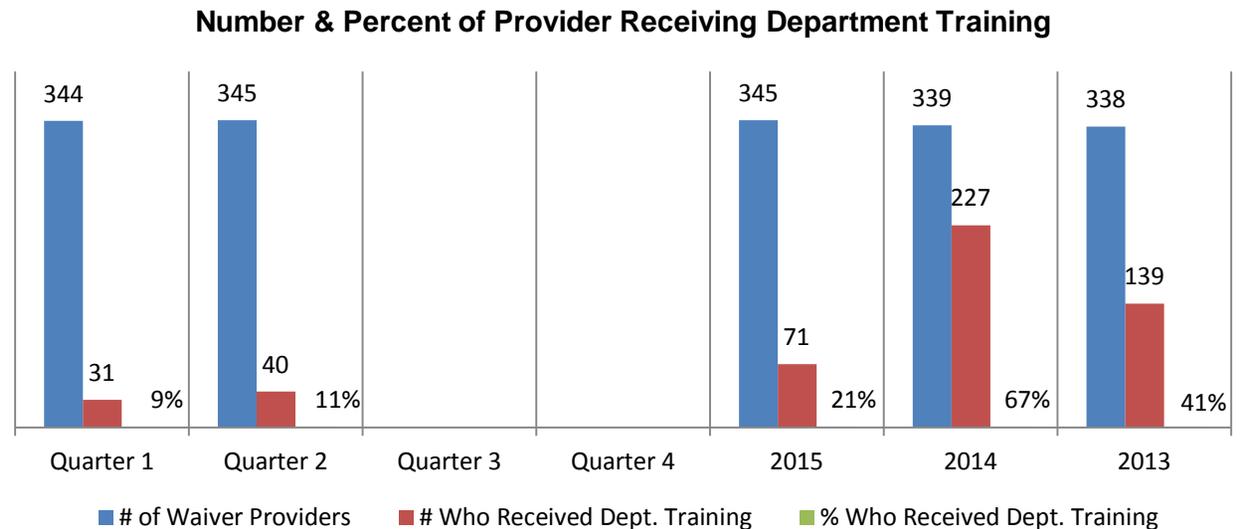
**System Improvement:** Language was added to PERS/HDM QA review letters stating that non-compliance with submitting information for review may impact their provider agreement.



**Analysis:** Documentation of provider training remains an issue. It is believed that there is on-going provider training by staff on a daily basis, in addition to formal provider training, which does not get entered into the SharePoint provider training site.

**Remediation:** Provide training/reminders to NR/NM/SS to document provider training as it occurs.

**System Improvement:** A decision was made to conduct



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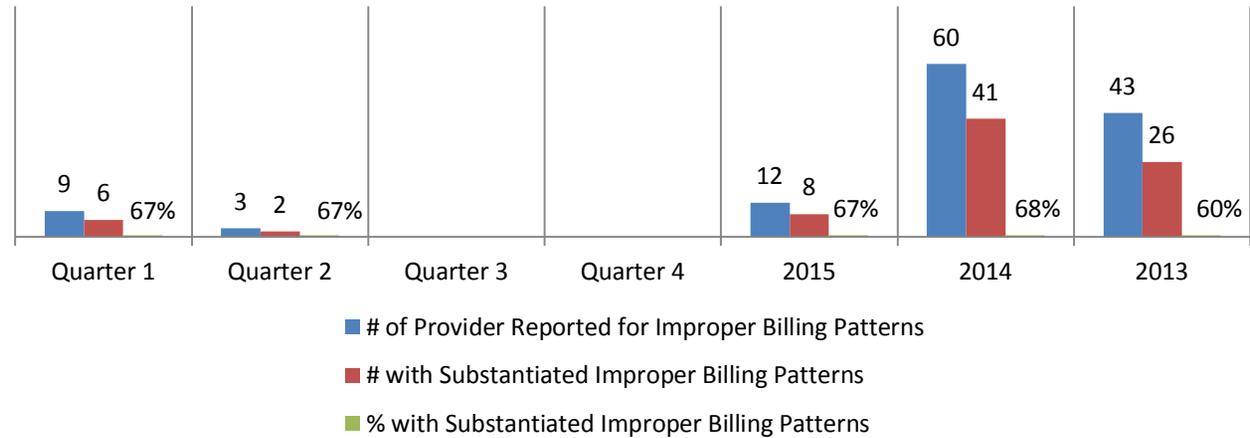
regional face to face provider training 2 times per year.

### FINANCIAL ACCOUNTABILITY

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved HCBS Waiver.

**Remediation:** 100% of substantiated improper billing issues or duplication of services were corrected or referred for further investigation.

**Number & Percent of Providers with Substantiated Improper Billing Patterns**



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## ADMINISTRATIVE AUTHORITY

The Medicaid Agency retains ultimate Administrative Authority and responsibility for the operation of the HCBS Waiver program by exercising oversight of the performance of Waiver functions by other state and local/regional non-state agencies and contracted entities.

### Remediation:

#### 1. Internal File Audits:

**Q1 - 26**

**Q2 - 26**

**Q3 -**

**Q4 -**

#### 2. Quality Provider Reviews:

**Q1 - 16**

**Q2 - 9**

**Q3 -**

**Q4 -**

CAPs requested in 25 of 25 reviews.

#### 3. Complaint/Critical Incident:

**Q1 - 27**

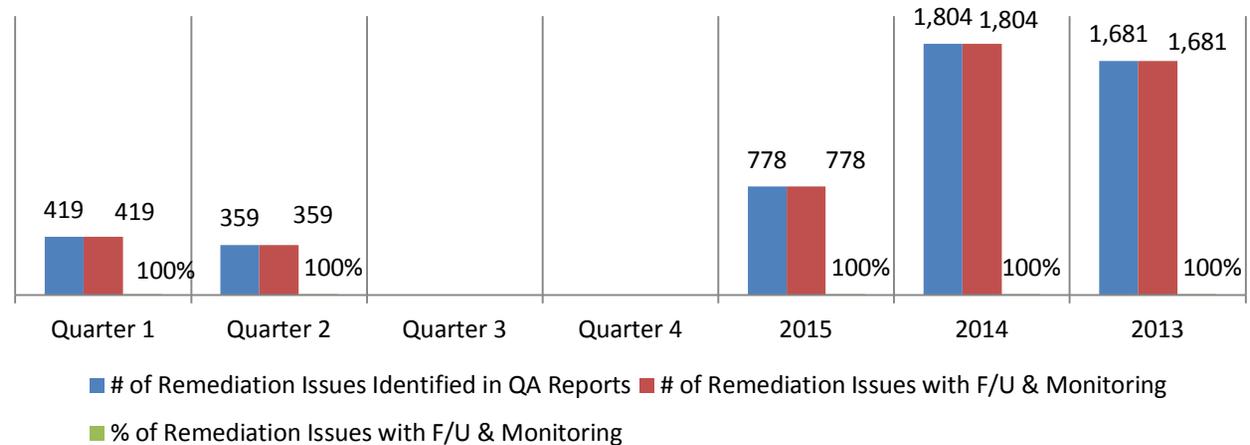
**Q2 - 21**

**Q3 -**

**Q4 -**

Remediation in 48 of 48 substantiated complaint/critical incidents.

**Number & Percent of Remediation Issues Identified in QIS Reports That Had Follow-Up and Monitoring**



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**4. Nurse Reviewer Visits:**

**Q1 - 350**

**Q2 - 303**

**Q3 -**

**Q4 -**

CAPs requested from all agencies not meeting the statewide average level of compliance. All agencies were sent copies of the NRHV form for individual participant remediation at redetermination.

**System Improvement(s):**

**YTD 2015**

- 1) Add compliance language to PERS/HDM provider letters.
- 2) Add more detailed abuse/exploitation questions of participant's at redetermination.
- 3) Implement routine provider training in Regions 2 times per year.

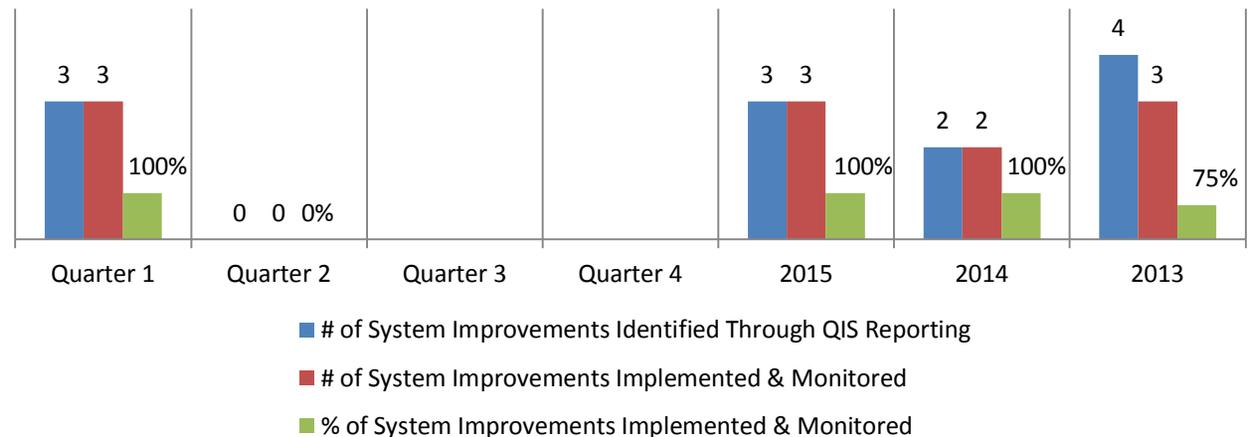
**Q1 – 3**

**Q2 – None**

**Q3 –**

**Q4 –**

**Number & Percent of System Improvements Identified/Implemented Through QIS Reporting**



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<b>Idaho Home Choice Transitions</b>	<b>Waiver</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2015 Total</b>	<b>2014 Total</b>	<b>2013 Total</b>	<b>2012 Total</b>	<b>2011 Total</b>	<b>Total IHC</b>
We have exceeded our Benchmarks in 2012, 2013, 2014 and are on track to exceed them again in 2015.  Q1 2015 and 2014 data were updated.	DD Waiver	6	4			10	13	13	16	2	54
	A & D Waiver	15	11			26	71	53	48	2	200
	Enhanced	2	5			7	9	8	2	0	26
	<b>Total</b>	<b>23</b>	<b>20</b>			<b>43</b>	<b>93</b>	<b>74</b>	<b>66</b>	<b>4</b>	<b>280</b>
	<b>Qualified Institution</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2015 Total</b>	<b>2014 Total</b>	<b>2013 Total</b>	<b>2012 Total</b>	<b>2011 Total</b>	<b>Total IHC</b>
	ICF/ID	5	4			9	10	11	14	3	47
	IMD	0	1			1	2	7	5	1	16
	SNF	18	15			33	81	56	47	0	217
	<b>Qualified Residence</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2015 Total</b>	<b>2014 Total</b>	<b>2013 Total</b>	<b>2012 Total</b>	<b>2011 Total</b>	<b>Total IHC</b>
	Supported Living	6	1			7	12	10	11	1	41
	Apartment	10	15			25	36	37	27	1	126
	Own Home	4	2			6	18	15	14	0	53
	Family's Home	0	0			0	15	9	9	0	33
	CFH	3	2			5	12	3	3	2	25
	RALF	0				0	0	0	2	0	2

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<b>PASRR Totals by Region</b>		<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2015 Total</b>	<b>2014 Total</b>	<b>2013 Total</b>	<b>2012 April - Dec</b>
*Began tracking PASRR data April 2012.	<b>Region 1</b>	221	229			450	781	753	678
	<b>Region 2</b>	153	132			285	509	474	398
There was a 10% statewide increase in PASRR Reviews in Q2 2015, when compared to Q1, 2015.	<b>Region 3</b>	190	227			417	790	718	554
	<b>Region 4</b>	362	465			827	1,433	1407	1099
Region 1 = 3.5% increase.	<b>Region 5</b>	187	188			375	939	876	614
Region 2 = no increase	<b>Region 6</b>	256	246			502	963	803	709
Region 3= 16% increase	<b>Region 7</b>	121	157			278	534	447	499
Region 4 = 22% increase	<b>Total</b>	<b>1,490</b>	<b>1,644</b>			<b>3,134</b>	<b>5,949</b>	<b>5,478</b>	<b>4,551</b>
Region 5 = no increase									
Region 6 = no increase									
Region 7 = 23% increase									

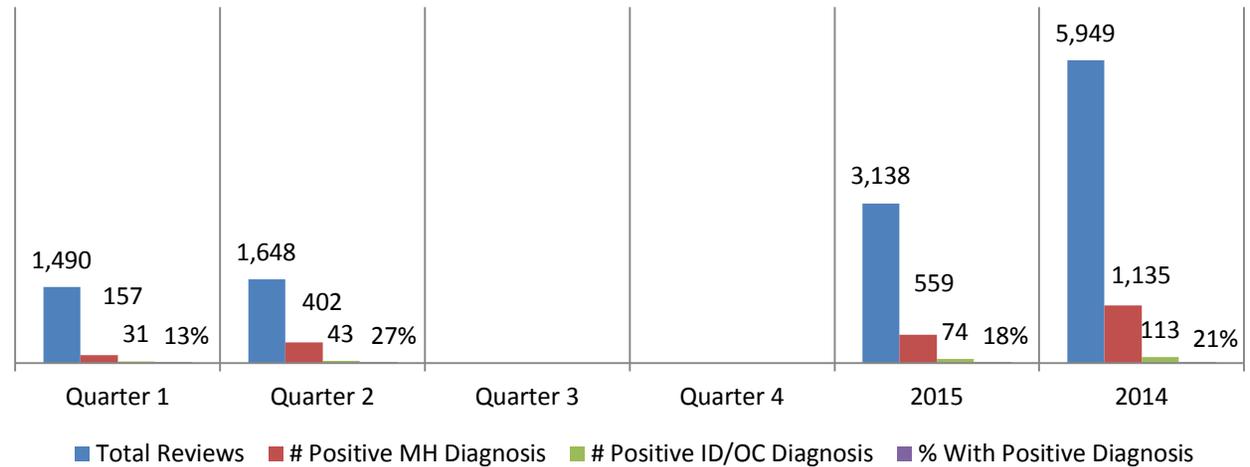
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### PASRR Reviews with a Positive Diagnosis

**Quality Improvement:**

The majority of PASRRs received are positive for suspected MI with appropriately prescribed antipsychotics to treat. These are reviewed at the BLTC level and approved without sending to State Mental Health Authority for further review.

**PASRR Reviews with a Positive Diagnosis**



### PASRR Reviews with Rehab and/or Specialized Services Ordered

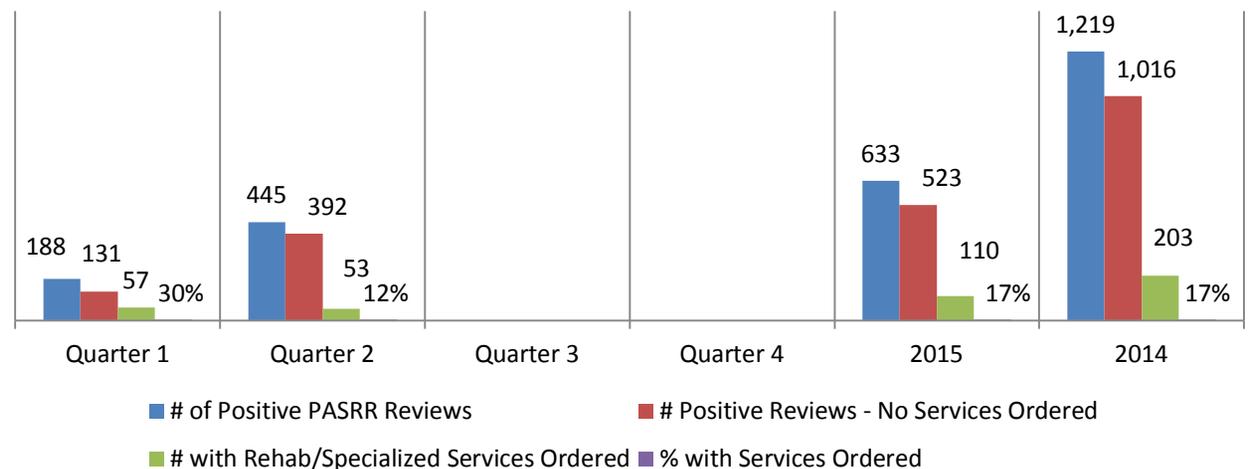
**Quality Assurance:**

Individuals who are recommended for specialized services are targeted for an annual Resident Review.

**Quality Improvement:**

We currently have 15 MH Specialized Services (SS) that can be authorized. These range from Psychiatric Diagnostic Evaluations to Partial Care-Support groups (including Substance Abuse criterion which

**PASRR Reviews with Services Ordered**



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is an area that is now also being focused on by CMS/PTAC). In addition to the Specialized Services, we now also have 31 suggestions that the SMHA can make to assist the NF with ideas to improve the person's quality of life, and be considered as they complete their Person Centered Care Plan. Currently Idaho has no Specialized Services that can be authorized in a NF setting for participants with intellectual disability. The BDDS is in the process of reaching out to CMS to determine what SS can be approved in the NF setting for Intellectual Disability/Related Condition (ID/RC) individuals.

**Recommendation:**

1. The PASRR chapter is being updated to include further clarification for NR.
2. If the person has Specialized Services in place then current information from the NF is included and sent to the SMHA/SIDA for annual review.
3. If the individual has a positive PASRR diagnosis, but no SS and no MH/ID changes, then BLTC will review and retrigger the annual review with no suggestions.

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<p>4. If there is a Status change identified than the current information from the NF is included and sent to the SMHA/SIDA for re-review.</p> <p>2. BLTC is still looking at caseload issues related to the number of PASRR reviews. (2.5 FTE increase in workload without increase in FTE since 2012.)</p>	
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