

**Committee on Family Care Quality
Wisconsin Council on Long Term Care**

Meeting of March 27, 2009

Approved Minutes

Members present: Karen Avery, Myra Enloe, Carol Eschner, Michelle Goggins, Joan Hansen, Martha McVey, Jennifer Ondrejka

Members absent: Mary Clare Carlson, Paul Cook, Pete Esser, Stephanie Griggs, Daire Keane, Michael Luber, George Potaracke, Eva Williams

Others present: Linda Murphy (for Eva Williams), Lorraine Barniskis, Karen McKim, Sabrina Fox, Tom Wieggers, Sara Karon, Judy Stych, Nachman Sharon, Carrie Molke, Nancy Crawford

Meeting call to order. Chair Carol Eschner called the meeting to order at 9:35 AM.

2007 Family Care Annual Report

Printed copies of the 2007 Family Care Annual Report were distributed to members. Only 50 copies were printed, but the report is on the web at www.dhs.wisconsin.gov/LTCare. The report is intended for consumers, people who work with consumers, and the general public; it is intended to not duplicate reports done by MetaStar. Karen McKim thanked the committee for their very valuable assistance in guiding the format and content of the report. The 2008 version is planned to be released by the end of May.

Evidence provided to CMS re effectiveness of Family Care

Karen provided several handouts related to the requirements for renewal of the two federal waivers under which Family Care operates. There was some committee discussion about efficiency and timeliness in getting out information on changes in guidance for using the functional screen.

Report from People First Wisconsin

This report was deferred due to the absence of People First representatives.

Comments from the public

There were no public comments.

Committee discussion on key quality indicators

Carol Eschner facilitated discussions about the key indicators of quality that were of most importance to committee members. Committee members, staff and visitors were divided into four groups; after adjustments made by the reconvened full group, the following indicators were identified as key:

From the MCO's perspective:

- Indicators related to member health and safety; examples:
 - Percentage transition from hospital to community with timely medication reconciliation;
 - Level of education provided to members;

- Rate of preventable hospitalizations
- Indicators related to service delivery; examples:
 - Coordination of services to members
 - Does the screen translate to outcomes that provide quality to members?
- Continuity of processes and care: to what extent are members progressing toward accomplishment of their identified outcomes?
- Quality of provider network; examples:
 - Medication management, utilization review
 - Identification of target expectations of providers
- Expectations within the first year of an MCO's implementation or rapid expansion:
 - Providers of employment services have been brought into the network
 - Other services important to younger populations have been brought into the network (Milwaukee)
 - Self-directed supports have been further developed
 - The MCO is prepared for possible emergency situations (heat wave, flood, etc.)
 - Infrastructure and processes are in place
 - Provider network in place
- Expectations within the second year:
 - Provider network is broadened to provide more choices and continuity of care

From the general public's perspective:

Continuing public education is needed, so that the public understands the program, its cost, and its benefits. Key messages should include:

1. Financial savings over the fee-for-service system, brought about primarily through better outcomes for people. (e.g., findings from the Independent Assessment of Family Care). Evidence of cost-effectiveness: doing right by people, but not with excessive expenditure of public funds. Basic information about rate setting – actuarially sound, not arbitrary.
2. Explanation of the benefits of the program for members; examples:
 - Results of member satisfaction surveys
 - Individual success stories
 - Evidence that FC does a good job of keeping people in their homes and communities
 - Information about the goals of FC and MCOs' effectiveness in achieving them; examples:
 - individualized planning and care management
 - choice
 - member safety and dignity
 - encouragement of independence and avoidance of the promotion of dependence
3. Information (e.g., maps) about the progress of statewide implementation; number of people served by each MCO. When will Family Care be available in each area? When will waiting lists be eliminated?
- Other:
 - Information about benefits to communities beyond the people who are directly served:
 - Expansion of service providers – more choices for private pay consumers; expansion of employment opportunities
 - Raises community expectations about standards of care
 - Services of ADRCs available to all elderly people and people with disabilities regardless of eligibility for Family Care. (Needs to be better known.)

- Information about how Wisconsin compares to other states on cost, member outcomes and the percentage of the population served. How Wisconsin is unique in the US with its approach to integrating funding, populations and services.

From providers' perspective:

- What rates are being paid and how are they set?
- For medical providers:
 - Is there good medical follow-through of recommendations?
 - Upon hospital discharge, is there good follow-through support in home?
- How good is communication and coordination between the MCO and providers?
- Do members get better care, back-up and support when needed?
- Business costs
- How many members use SDS? How well are they supported?
- What are the regulatory requirements? Which of them are specific to a particular MCO?
- What other providers are in the network? What is their level of satisfaction? Do many of them drop out?
- What is the turnover rate of MCO staff and of provider staff?
- What training is available? Who pays for it?
- What is the level of member satisfaction? What is the disenrollment rate?
- For employment providers, what are employment levels of members?
- How fast is the MCO growing?
- How good is the continuity of providers' relationships with members?
- How well is the MCO able to fill gaps in its provider network?
- Is there fair access to service contracts when a new service is added?
- Is demand for the service provided adequate and continuous enough to meet business needs?

Expectations in the first year of implementation or rapid expansion:

- The enrollment process is smooth; the time from intake to service provision is short.
- Communication between the MCO and providers and members is good.
 - Does the provider get a copy of the member-centered plan? How is the provider notified of changes?
 - Lines of communication are clear.
 - There are continuing relationships between providers and members
- Payments are adequate and timely.

Expectations in the second year:

- How much is SDS used? How well is it supported?
- How is the physical and mental functioning of members changing and how is that communicated between providers and MCO?

Expectation of mature MCOs:

- How does the MCO support me?
- What are the personal experience outcomes of members?

From consumers' perspective:

- Choice of providers and continuity of care
- Ease of entry and amount of time it takes to get help (both initially and ongoing)
- Grievances/appeals/denials of service or equipment; disenrollments
- Health outcomes and personal outcomes stable or improved
- Good balance between risk and safety

- Self-directed options are well explained and available
- Care planning is consumer driven
- Cost-share issues: Is the value of the services included worth the cost to individual members? What are the financial implications for consumers budgets of enrolling?
- Easy-to-understand satisfaction surveys are conducted
- Simple reports of statistics on the MCO are available
- Word-of-mouth reports on the MCO are generally good
- Communication is good between consumers and care managers

Expectations in first year of implementation/rapid expansion:

- The provider network is adequate to provide choices for consumers
- Entry into the MCO is easy
- Needed services are provided with expediency
- The MCO has the infrastructure to assure easy enrollment, access to needed services and choice of providers.
- Continuity of care

Expectations in second year:

- Consumer-driven planning is stronger
- Options for self-directed supports are available and supported
- Analysis of grievances, appeals, disenrollments
- Word of mouth assessments of MCO; analysis of consumer satisfaction surveys

Expectations of mature MCO:

- Health outcomes are improved, or at least stable
- Personal outcomes are improved, or at least stable
- There is a good balance between risk and safety
- SDS is being used for services beyond supportive homecare and personal care

There was some discussion of what expectations of MCOs are realistic in very early years of implementation and rapid expansion versus those in more mature stages. There was general agreement expectations cannot be as high in very early stages of development. The challenge is to keep the vision of high expectations alive during the early building stages. When results of quality oversight of new or rapidly expanding MCOs are published, narrative should be included to explain the context.

Committee business

- With one small correction, minutes of the January 23, 2009 meeting were approved unanimously on a motion by Joan Hansen, seconded by Myra Enloe.
- Announcements: Carol Eschner read to the committee the letter sent from Heather Bruemmer to Secretary Karen Timberlake conveying the biennial budget recommendations from the Long Term Care Council.
- Future agenda items: It was decided to move the previously scheduled May 23rd meeting to June 19th. That will allow time for completion of the 2008 Family Care Annual Report, so that this information will be available for a follow-up discussion of key quality indicators. The goal will be to develop recommendations to the full LTC Council on areas of focus for DHS oversight in the coming year.

Meeting adjourned at 3:35 PM.