

2014 Provider Quality Improvement Tool

The Home and Community-Based Services Quality Improvement Project is intended to encourage provider quality improvement efforts with the incentive of a one percent rate increase. Providers must submit their Quality Improvement project to DHS through an [online form](#) by Dec 31, 2014. The online form will be available in October. **This pdf document is provided for your planning purposes only.** For additional information please visit the [2014 Continuing Care Rate Changes](#) website or email questions to dhs.ccarates@state.mn.us.

Background and provider identification

1) Enter your Minnesota Health Care Program (MHCP) enrolled provider name or legal corporation name.

2) Do you use a National Provider Identifier (NPI) number to bill Medical Assistance?

Yes

No

2b) If yes, check how many NPI numbers are included in the quality improvement plan for which this plan is being submitted.

One

Two

Three

Four

Five

Six

Seven

Eight

Nine

Ten

Eleven or more

2c) Enter one primary 10- digit NPI number to be used for future log-in. _____

2d) Enter the remaining 10-digit NPI numbers you indicated are included in the quality improvement project for which this plan is being submitted. _____

You checked eleven or more numbers. Please enter the remaining NPI numbers. _____

3) Do you use a Unique Minnesota Provider Identifier (UMPI) number to bill Medical Assistance?

Yes

No

3b) If yes, check how many UMPI numbers are included in the quality improvement plan for which this plan is being submitted.

One

Two

Three

Four

Five

Six

Seven

Eight

Nine

Ten

Eleven or more

3c) Enter one primary 10- digit UMPI number to be used for future log-in. _____

3d) Enter the remaining 10-digit UMPI numbers you indicated are included in the quality improvement project for which this plan is being submitted. _____

You checked eleven or more numbers. Please enter the remaining NPI numbers. _____

4) Do you deliver services under one of these programs or services? (Check all that apply)

- ICF/DD
- Day training and habilitation
- Home and community-based waiver services (BI, CAC, CADI, DD, or Elderly Waiver)
- Alternative Care
- Home care (Private Duty Nursing, Skilled Nursing, Home Health, Therapies)
- I do not deliver services under any of these programs

If you do not provide any services under the programs above, you are not required to submit a quality improvement project. You may still submit your quality improvement project. DHS is interested in learning about it and will use the information to help identify promising practices among providers. If you would like to continue please indicate the type of services you provide: _____

5) Check all the counties/tribes in which you provide services related to this quality improvement plan.

- | | | |
|--|--|---|
| <input type="checkbox"/> All 87 counties | <input type="checkbox"/> Kittson | <input type="checkbox"/> Sherburne |
| <input type="checkbox"/> Aitkin | <input type="checkbox"/> Koochiching | <input type="checkbox"/> Sibley |
| <input type="checkbox"/> Anoka | <input type="checkbox"/> Lac Qui Parle | <input type="checkbox"/> St. Louis |
| <input type="checkbox"/> Becker | <input type="checkbox"/> Lake | <input type="checkbox"/> Stearns |
| <input type="checkbox"/> Beltrami | <input type="checkbox"/> Lake of the Woods | <input type="checkbox"/> Steele |
| <input type="checkbox"/> Benton | <input type="checkbox"/> Le Sueur | <input type="checkbox"/> Stevens |
| <input type="checkbox"/> Big Stone | <input type="checkbox"/> Lincoln | <input type="checkbox"/> Swift |
| <input type="checkbox"/> Blue Earth | <input type="checkbox"/> Lyon | <input type="checkbox"/> Todd |
| <input type="checkbox"/> Brown | <input type="checkbox"/> Mahnomen | <input type="checkbox"/> Traverse |
| <input type="checkbox"/> Carlton | <input type="checkbox"/> Marshall | <input type="checkbox"/> Wabasha |
| <input type="checkbox"/> Carver | <input type="checkbox"/> Martin | <input type="checkbox"/> Wadena |
| <input type="checkbox"/> Cass | <input type="checkbox"/> McLeod | <input type="checkbox"/> Waseca |
| <input type="checkbox"/> Chippewa | <input type="checkbox"/> Meeker | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Chisago | <input type="checkbox"/> Mille Lacs | <input type="checkbox"/> Watonwan |
| <input type="checkbox"/> Clay | <input type="checkbox"/> Morrison | <input type="checkbox"/> Wilkin |
| <input type="checkbox"/> Clearwater | <input type="checkbox"/> Mower | <input type="checkbox"/> Winona |
| <input type="checkbox"/> Cook | <input type="checkbox"/> Murray | <input type="checkbox"/> Wright |
| <input type="checkbox"/> Cottonwood | <input type="checkbox"/> Nicollet | <input type="checkbox"/> Yellow Medicine |
| <input type="checkbox"/> Crow Wing | <input type="checkbox"/> Nobles | <input type="checkbox"/> Bois Forte (Nett Lake) Band |
| <input type="checkbox"/> Dakota | <input type="checkbox"/> Norman | <input type="checkbox"/> Fond du Lac Band |
| <input type="checkbox"/> Dodge | <input type="checkbox"/> Olmsted | <input type="checkbox"/> Grand Portage Band |
| <input type="checkbox"/> Douglas | <input type="checkbox"/> Ottertail | <input type="checkbox"/> Leech Lake Band |
| <input type="checkbox"/> Faribault | <input type="checkbox"/> Pennington | <input type="checkbox"/> Mille Lacs Band |
| <input type="checkbox"/> Fillmore | <input type="checkbox"/> Pine | <input type="checkbox"/> White Earth Band |
| <input type="checkbox"/> Freeborn | <input type="checkbox"/> Pipestone | <input type="checkbox"/> Red Lake Band |
| <input type="checkbox"/> Goodhue | <input type="checkbox"/> Polk | <input type="checkbox"/> Lower Sioux Band |
| <input type="checkbox"/> Grant | <input type="checkbox"/> Pope | <input type="checkbox"/> Prairie Island Community |
| <input type="checkbox"/> Hennepin | <input type="checkbox"/> Ramsey | <input type="checkbox"/> Shakopee Mdewakanton Community |
| <input type="checkbox"/> Houston | <input type="checkbox"/> Red Lake | <input type="checkbox"/> Upper Sioux Community |
| <input type="checkbox"/> Hubbard | <input type="checkbox"/> Redwood | |
| <input type="checkbox"/> Isanti | <input type="checkbox"/> Renville | |
| <input type="checkbox"/> Itasca | <input type="checkbox"/> Rice | |
| <input type="checkbox"/> Jackson | <input type="checkbox"/> Rock | |
| <input type="checkbox"/> Kanabec | <input type="checkbox"/> Roseau | |
| <input type="checkbox"/> Kandiyohi | <input type="checkbox"/> Scott | |

6) If you provide services under managed care, please check the health plans you are under contract with.

- | | |
|--|--|
| <input type="checkbox"/> Blue Plus | <input type="checkbox"/> Metropolitan Health Plans |
| <input type="checkbox"/> HealthPartners | <input type="checkbox"/> PrimeWest Health |
| <input type="checkbox"/> Itasca Medical Care | <input type="checkbox"/> South Country Health Alliance |
| <input type="checkbox"/> Medica | <input type="checkbox"/> UCare |

7) Do you provide contracted case management services?

- Yes
 No

7b) If yes, please select the counties/tribes in which you provide case management services related to this quality improvement plan. We encourage you to share your plan with your contractor if it affects those services. (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> All 87 counties | <input type="checkbox"/> Kittson | <input type="checkbox"/> Sherburne |
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| <input type="checkbox"/> Jackson | <input type="checkbox"/> Rock | |
| <input type="checkbox"/> Kanabec | <input type="checkbox"/> Roseau | |
| <input type="checkbox"/> Kandiyohi | <input type="checkbox"/> Scott | |

Quality Improvement Project Plan Objectives & Description

8) Which of the following objectives will your quality improvement project address? (Select one)

- Improve the quality of life of home and community-based services recipients in a meaningful way*
- Improve the quality of services in a measurable way*
- Deliver good quality services more efficiently while using the savings to enhance services for participants served*

9) How will your project address the objectives selected above? (Select up to three)

- Improves people's ability to perform everyday activities*
- Increases independence*
- Improves health*
- Reduces the rate of accidents, falls, infections, or other adverse health events*
- Increases community engagement*
- Increases access to competitive employment*
- Improves coordination of long-term services and supports with other health and wellness services*
- Helps people transition out of hospitals*
- Helps people transition out of nursing facilities*
- Helps people transition out of ICFs/DD*
- Increases person-centeredness of services*
- Uses participant feedback to improve services*
- Promotes positive behavior interventions*
- Increases capacity of the direct service workforce*
- Improves retention and stability of direct care staff*
- Implements new technologies that improve care*
- Implements new management or organizational strategies*
- Increases choice of community-based services*
- Increases employment options for participants*
- Improves choices for independent living*
- Increases capacity for data-driven decision making*
- Other (specify): _____*

10) What is the anticipated start date for this project? _____

The date entered must be June 30, 2015 or earlier for the project plan to be accepted by the commissioner.

11) What is the anticipated end date? _____

12) Implementing this plan requires: (Select up to three)

- Staff training*
- New staff*
- New technology for staff*
- New technology for people served in the program*
- HCBS recipient training*
- Caregiver training*
- New equipment for staff*
- Travel for staff*
- New equipment for people served in the program*
- Transportation for people served in the program*
- Revising organizational policies*
- Changing business practices*
- Surveys*
- Other (specify): _____*

13) Please briefly describe your project: (800 characters or less)

14) How will you know your project is successful? (300 characters or less)

15) Identify the performance measures you will use to measure the success.

- Performance measure: _____
 - Baseline, if available: _____
 - Goal: _____

- Performance measure: _____
 - Baseline, if available: _____
 - Goal: _____

16) Approximately how many people will the project affect? _____

Quality Improvement Resources & Collaboration

Your submission of this quality improvement tool will also be used by DHS to develop resources and support for meaningful quality improvement projects for you and other providers. We invite you to further engage in these efforts.

17) May we contact you about sharing your quality improvement project on the Quality Improvement website?

- Yes
- No

18) Would you like to connect with other providers to exchange information and experiences implementing quality improvement projects?

- Yes
- No

19) Are you interested in receiving additional information about quality improvement?

- Yes
- No

If yes, in what areas: (Select all that apply)

- Identifying areas for improvement
- Strategies for implementing change
- Measuring results
- Communicating results
- Continuous improvement
- Other (specify): _____

20) Would you be interested in providing information to other providers who need help with quality improvement projects?

- Yes
- No

If yes, in what areas: (Select all that apply)

- Identifying areas for improvement
- Strategies for implementing change
- Measuring results
- Communicating results
- Continuous improvement
- Other (specify): _____

I assure that the information provided accurately represents my organization's quality improvement project. I further certify that I am an authorized agent and have the authority to sign on behalf of my organization.

- Yes
- No

Submission Contact Information

First name of person submitting the *Quality Improvement Tool*

Last name of person submitting the *Quality Improvement Tool*

Title

Street Address (mailing)

City _____

State

- Iowa
- Minnesota
- North Dakota
- South Dakota
- Wisconsin
- Other

If you checked other, please explain.

Zip code _____

Phone Number _____

Email Address (Will be used for log-in) _____

Please provide the email address of a secondary point of contact: _____