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# Quality Framework for Frail Elder Home and Community-Based Services

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# EXECUTIVE SUMMARY

## Background

The Executive Office of Elder Affairs (Elder Affairs) in Massachusetts oversees a wide array of supportive services for elders over 60 in Massachusetts. Some services- such as personal care, homemaker, and transportation- help to maintain elders in the community and prevent institutionalization, while other services- such as respite, adult day health and adult protective services- support caregivers or investigate/prevent elder abuse. Many of these services are organized under two programs, the Medicaid 1915c frail elder waiver program and the state-funded Home Care program. These programs are coordinated by 27 entities called the Aging Services Access Points (ASAPs) who also contract with other direct care providers.

Given the importance of quality monitoring and assurance, Elder Affairs and the ASAPs have instituted measures and processes to discover and remediate quality concerns over the years. However, these ASAP-specific measures vary across ASAPs, making it difficult to generate reliable aggregate information for Elder Affairs. The endorsement of the HCBS (Home and Community-based Services) Quality Framework by the Centers for Medicare and Medicaid Services (CMS) and the early implementation of the Senior Information Management System (SIMS) at Elder Affairs have created an opportunity to standardize and strengthen quality monitoring and reporting.

In order to accomplish these goals, Elder Affairs tasked a workgroup with the objectives of 1) scanning the ASAPs for their current quality management practices, 2) identifying an initial set of measures with which Elder Affairs can gather key quality information on waiver and Home Care participants, and 3) recommending strategies for implementing these measures. The workgroup consisted of key stakeholders at Elder Affairs, Medicaid, and the ASAPs. Elder Affairs requested that the Center for Health Policy and Research facilitate the workgroup process and provide technical assistance relevant to these objectives. This report summarizes the workgroup's findings and provides recommendations for implementing the initial slate of quality measures.

## Current Quality Management Oversight

Using several methods, ASAPs both monitor quality of services and respond to concerns. To monitor quality outcomes such as timely access to information, interdisciplinary case management, provider qualifications, and reduction of unmet need related to participant activities of daily living/instrumental activities of daily living (ADLs/IADLs), ASAPs use participant file data, written and oral participant feedback, and documentation on direct care providers. For example, ASAPs periodically review a sample of participant files, which include assessments and service plans, to monitor internally whether referred and/or authorized services are appropriate to needs. Concerns on the participant level are addressed using the interdisciplinary case management process, which involves the case manager and any other

professional assigned to the individual. More systemic quality concerns (e.g., from survey results or documentation of providers) are addressed using ASAP staff training, individual ASAP quality improvement plans, and the contract management process with direct care providers.

## Initial Slate of Measures

The workgroup selected an initial set of quality measures to build upon current quality measures and monitoring practices and to capitalize on the ongoing roll- out of the new information management system (SIMS), which is capable of providing more comprehensive ASAP-collected participant information more quickly. This set of measures reflects domains of interest and outcomes that are meaningful to Elder Affairs and the ASAPs. The measures can also be implemented expeditiously. Because specific participant experience (consumer satisfaction) questions are being addressed elsewhere, measures based on those questions will be identified through other Elder Affairs activities. The table below summarizes the workgroup's recommendations for the initial slate of measures (See Appendix D).

*Access Measures*

- % of individuals requesting information (current clients and elders/ families/ community members) who are provided information that is consistent with the type of information they requested
- % of intake/assessment clients whose assessment is conducted, translated or facilitated in their primary language
- % of recipients of HCBS waiver services who have in their record a signed "Recipient Choice Form" in English at a reading level no higher than 6th grade
- % of applicants whose eligibility for Medicaid waiver have been assessed within 10 business days of their identified need

*Person-Centered Planning and Delivery Measures*

- % of Comprehensive Data Set assessments and re-assessments that are completed within timelines as determined by Elder Affairs standards
- % of clients who received information on their right to choice in relation to service options and individual workers
- % of clients' unmet ADL/IADL needs, identified in the assessments, that are addressed within six months
- % of service plans that are modified to reflect a change in functional status or informal support as identified in a re-assessment
- % of clients who receive:
    - type of service
    - unit of service
    - duration of service
    - frequency of service

  from provider(s) as outlined in service plan

*Provider Capacity and Qualifications Measures*

- % of ASAPs whose staff meet provider qualification standards
- % of providers with deficiencies whose corrective action plans address these deficiencies
- % of clients who received service in accordance with their service plans

*Safeguards Measures*

- % of clients who received information on safeguarding their health and welfare in case of natural disasters and other public emergencies
- % of reports of critical incidents which are addressed appropriately
- % of clients assessed for housing environment safety
- % of clients identified as needing medication management whose service plan addresses medication management supports

*Rights and Responsibilities Measures*

- % of clients who received information on civic and human rights
- % of clients given Appeals information at initial screening and Request for Fair Hearing Information with waiver eligibility notification
- % of grievances showing evidence of appropriate resolution process follow-through and outcomes

*Satisfaction and Outcomes Measures*

- Annual client survey response rate
- Average duration of time receiving waiver services

*System Performance Measures*

- % of ASAPs that have quality improvement action plans that address issues identified through stakeholder feedback
- % of waiver clients' claims that are coded correctly and paid in accordance with waiver reimbursement methodology
- % of ASAPs that have a current annual plan to address quality improvement based on slate of measures
- % of ASAPs that have a written plan, including a Quality Improvement Plan, policies and procedures, and training in place to address any cultural, linguistic, and/or other accessibility barriers

## Recommended Implementation Strategies

Before these measures can be implemented for all ASAPs, it is recommended that they be pilot tested with a diverse cross-section of ASAPs. The recommended pilot phase of implementation should involve (a) specifying and operationalizing these measures, (b) clarifying guidelines on data collection, analysis, and reporting, (c) implementing these measures for a sample of ASAPs, and (d) evaluating and refining the measures and the guidelines based on the pilot experience.

First, the initial slate of measures needs refinement through specification and operationalization. Issues to be addressed include definitions, numerator and

denominator decisions, and populations. Second, further refinement of each measure will necessarily include the identification of data sources, data collection and analysis methods, and reporting formats. Third, measures should be implemented with a diverse cross-section of ASAPs to test these measures.

Finally, after the pilot phase of measure implementation, the next step in the process is to study or evaluate and refine the measures. Evaluation should include analysis of the ease of data collection, reliability and validity of the measures. Based on the results of this evaluation, modifications to the measures should be discussed. Potential remediation steps related to specific quality measures and other implications of the measurement system should also be discussed as part of this review. As the full implementation of this initial slate of measures occurs, it will be important to maintain momentum by continually improving the slate of measures, including the consideration and possible adoption of additional measures developed and presented in Appendix H.

Throughout this entire process, an implementation workgroup, under Elder Affairs' leadership, could be a useful vehicle to facilitate the pilot test, to coordinate the subsequent state-wide roll out, and to ensure that necessary staff members receive training in data collection guidelines. An implementation timetable will be useful, in part, to ensure necessary coordination with the SIMS roll out.

As noted, this project addresses the three objectives of Elder Affairs:

- scanning the ASAPs for their current quality management practices,
- identifying an initial set of measures with which Elder Affairs can gather key quality information on waiver and Home Care participants, and
- recommending strategies for implementing these measures.

The final products include an inventory of quality practices across the ASAPs, an initial slate of measures along with proposed measures for future consideration, and a strategy for pilot testing the measures prior to statewide implementation. Thus, this project provides a foundation for Elder Affairs and the ASAPs to continue and strengthen quality management activities.

# I. BACKGROUND

The Executive Office of Elder Affairs (Elder Affairs) currently operates a Medicaid 1915c home and community-based waiver, which provides services to elders who meet nursing facility level of care and can be served effectively in their community. Approximately 6000 elders per month are currently served by this waiver. Waiver services include environmental adaptations, personal care, homemaker, and transportation. Waiver services are delivered to qualified elders as part of the larger state Home Care Program, which provides similar supportive services to elders who either are not MassHealth eligible or do not qualify for waiver services.[1]

Waiver services (and state Home Care services) are coordinated by 27 agencies called Aging Services Access Points (ASAPs). Among ASAPs' core services are information and referral, service coordination/case management, and, in most ASAPs, adult protective services. The ASAPs contract with other providers such as homemaking and personal care agencies to deliver home-based direct care services.

In addition to their core and contracted Home Care and waiver services, ASAPs provide other services, such as caregiver support and SHINE (Serving the Health Information Needs of Elders) services. Most ASAPs are also Area Agencies on Aging and have additional missions and objectives. As such, each ASAP has a different offering of services and may differ from one another in their funding sources. Thus, with these differences in some of their operations, ASAPs are subject to additional quality assurance requirements other than those associated with the Home Care and waiver programs.

*Quality Management for Waiver Services*

As noted, ASAPs serve both waiver and non-waiver participants whose services are subject to slightly different financial and clinical requirements. For waiver participants, who must meet nursing facility level of care, the Centers for Medicare and Medicaid Services (CMS) require that providers of waiver services meet certain waiver assurances. These waiver assurances are broadly categorized as level of care, service plans, provider qualifications, safeguards, and financial integrity. (See Appendix A for a more comprehensive description of the waiver assurances.) The state Medicaid agency is accountable to CMS for meeting these waiver assurances and has delegated most of the operational and quality oversight of waiver services to Elder Affairs. As brokers for waiver services, ASAPs, in turn, are accountable for quality oversight of their own services (e.g., assessment and case management) and of the providers of waiver services. (In contrast, CMS and the Medicaid agency do not oversee the quality of the state-funded Home Care program).

In the past, Elder Affairs has implemented a host of quality measures and quality management requirements (e.g., the ASAP Performance Outcome Measures of 1998) to assist ASAPs in ensuring quality service for all ASAP clients. (See Appendix

[1] Waiver services include Chore, Companion, Supportive day services, Grocery shopping and home delivered meals, Supportive home care aide, Home health aide, Homemaker, Laundry, Personal care, Respite, Skilled nursing, Transportation (non-emergency and non-medical), Home based wandering response, Transitional assistance, and Environmental adaptation.

B for a sample of the quality measures implemented by Elder Affairs.) ASAPs, in turn, have developed a broad scope of quality management practices (to be described below) in response to these Elder Affairs requirements.

In addition to the quality assurance, measurement, and reporting activities currently in place, several factors are converging that have an effect on quality measurement practices. From 2002 to 2004, CMS drafted and refined the Quality Framework for Home and Community Based Services to help guide states to ensure quality of waiver services. (See Appendix C for a full description of the CMS Quality Framework.) In addition, Elder Affairs is implementing a new information management system, the Senior Information Management System (SIMS) that will provide more comprehensive ASAP-collected participant information to Elder Affairs and ASAPs more quickly than before, enabling better monitoring for quality improvement purposes.

## II. OBJECTIVES

Capitalizing on CMS' quality expectations and factoring in the early implementation phase of the new information management system for ASAPs, Elder Affairs embarked on an effort to design a strategy that builds upon, standardizes, and strengthens quality oversight of waiver services and state Home Care services. This strategy was intended to be used for waiver participants *and* State Home Care participants in order to avoid requiring ASAPs to implement two separate quality processes.

To develop this strategy, Elder Affairs requested that the University of Massachusetts Medical School/Center for Health Policy and Research (UMMS/CHPR) facilitate a workgroup and provide technical assistance to the workgroup to carry out three objectives:

a) review/assess existing quality management practices over waiver and Home Care Program services

b) develop a foundational slate of standardized measures to provide Elder Affairs with a manageable set of key information

c) outline a potential implementation plan for this foundational slate of measures.

The workgroup was composed of representatives from the ASAP network, Home Care program administrators, and elder waiver oversight staff at both MassHealth and Elder Affairs. (See the Acknowledgements for a complete listing of all workgroup members.)

## III. METHODS

To assist the workgroup in completing the first objective, UMMS/CHPR conducted an inventory of existing ASAP quality management practices using a UMMS/CHPR-

developed inventory tool. The inventory tool was based on the CMS Quality Framework. The CMS Quality Framework domains are:

- access;
- person-centered planning and delivery;
- provider capacity and qualifications;
- participant satisfaction and outcomes;
- safeguards;
- rights and responsibilities; and
- system performance

All 27 ASAPs completed the inventory tool. ASAPs also provided supporting documentation regarding these practices. Results of the inventory were reviewed by the workgroup and are described in the section below.

To address the second objective, the workgroup held monthly meetings to develop and prioritize measures to be used by Elder Affairs and ASAPs to collect key information on quality at the ASAP and participant levels. These measures represent the initial slate and are designed as a beginning step in this effort (See Appendix D for the initial slate.) Several key factors were considered as the workgroup identified the initial slate of measures: relevancy to CMS' waiver assurances and Quality Framework; ease of data collection (e.g., through the use of SIMS); and ease of specification/ operationalization. The measures were selected by the workgroup via a consensus-building process.

To address the third objective, UMMS/CHPR reviewed current practices as reported in the inventory, brainstormed strategies with the workgroup during meetings and researched implementation of other quality strategies through a literature review and attendance at the Home and Community-Based (HCBS) Conference 2006.[2] In addition, technical experts at UMMS/CHPR were consulted throughout the project to provide general assistance related to measure construction and assistance with potential implementation concerns.

Findings pertaining to each objective will be discussed below.

## IV. CURRENT QUALITY MANAGEMENT OVERSIGHT OF ELDER WAIVER AND NON-WAIVER SERVICES

Quality management practices at the ASAPs have been driven, in large part, by program instructions promulgated by Elder Affairs. In program instructions over the past ten years, Elder Affairs has emphasized quality objectives such as timely access to information, interdisciplinary case management, provider qualifications, and reduction of unmet need related to participant activities of daily living/instrumental

[2] The HCBS Waiver Conference is sponsored annually by the National Association of State Units on Aging.

activities of daily living (ADLs/IADLs). These outcomes and processes reflect, to some degree, those on the CMS Quality Framework. (See Appendix E for a presentation based on the Inventory results and additional information on existing quality management practices regarding waiver and non-waiver services within the Home Care Program.)

To ensure that these and other quality objectives are met, ASAPs have engaged in a variety of discovery, remediation, and improvement methods. These methods enable the ASAPs to uncover or evaluate whether the objectives are being met and to address issues that may arise. Particularly noteworthy are discovery methods that may become more efficient after the full implementation of the new information management system. These are (a) reviews of participant file data (e.g., assessment, service plans, service utilization data, and progress notes), (b) provider reports, and (c) participant surveys regarding ASAP and provider services. Data sources will be described further in the section below.

All ASAPs are required to designate Quality Managers who collect, analyze, and report these data. In most cases, Quality Managers combine this role with other responsibilities such as training, information technology, or program management. While the current ASAP quality management system supports collection, analysis, and reporting of a large amount of broad-ranging information, the scope and type of data vary across ASAPs. This variation makes it difficult to easily generate information in a uniform way for the entire waiver population served by ASAPs and for individual ASAPs. However, upon the completion of the state-wide roll out in FY 2007, SIMS is expected to support ASAPs' and Elder Affairs' ability to provide more comprehensive, consistent, and rapid data reporting in future years.

Remediation and improvement tools and mechanisms for addressing deficiencies have included ASAP staff supervision, ASAP quality plans and committees, and contract management. Each of these discovery methods and applicable remediation/improvement methods are discussed below. (See also Appendix F for a more detailed description of the discovery methods.)

### *a. Current Data Sources for ASAP Quality Management*

<u>Participant File Data</u>. ASAPs review participant files to identify issues related to participant progress as well as identify areas where improvement is needed. Data sources or information reviewed include participants' intake/assessments,[3] service plans, service authorizations, and service delivery. For example, assessments and re-assessments are reviewed by nurse managers for completeness and for participant changes in ADL/IADL needs. Service plans are reviewed for their "appropriateness,"[4] while service delivery is compared with service authorizations. These reviews are periodically conducted by case management supervisors or other assigned staff members for a sample of participants and help to identify issues

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[3] Intake occurs at the time of an individual call and gathers preliminary clinical and financial data while full assessments occur in person after intake has determined the individual is likely to be eligible for ASAP services.

[4] "Appropriateness" is generally understood to mean meeting identified ADL/IADL needs.

related to participant needs as well as potential ASAP staff or direct provider staff deficiency. The scope of participant file reviews is broad; specific measures and review criteria (e.g., for what constitutes “meets standards” versus “not meeting standards” or “appropriateness”) vary across ASAPs.

Documentation regarding Direct Care Providers. ASAPs contract with providers for direct care services to participants. To monitor these providers, ASAPs conduct periodic reviews of providers’ records and performance. The frequency of provider reviews by ASAPs differs depending on the length of time a provider has had a contract with the ASAP and the type of service delivered by the provider. A provider review includes, but is not limited to, determining whether provider staff members have received all necessary licensing, certification, and training documentation; and how the provider is addressing cultural and linguistic needs of participants. All ASAPs have designated contract managers who manage contracts and conduct regular reviews, some in collaboration with other ASAPs who contract with the same provider. The specific data acquired in these reviews differs across ASAPs.

Prior to SIMS, some participant file information and documentation on direct care providers had been available in the information system called HOMIS. HOMIS was designed to assist Elder Affairs and ASAPs to monitor payments to direct care providers. HOMIS, however, is in the process of being replaced by SIMS.

Written and Oral Participant Feedback. To obtain information directly from participants on their perception of service quality (one component of quality management), ASAPs conduct annual participant surveys and have a compliment/complaint reporting process. Surveys are often targeted to users of specific services (e.g., information and referral callers/users, personal care assistance users, laundry service recipients, or case management clients). Usually in written format, these surveys often focus on the timeliness of the service, the demeanor of the staff, and overall satisfaction of participants. Because the survey questions and sampling methods vary across ASAPs, it is very difficult to compare participant satisfaction data across ASAPs. A compliment/complaint process and regular contacts with participants by case managers/assessors supplement the participant surveys by informing ASAPs of participant views in a timelier manner.

*b. Remediation and Improvement Methods*

Direct supervision or interdisciplinary case management is a primary means of addressing any quality issues related to provider staff, ASAP staff, or participant concerns. Supervision of the participant’s assigned case manager by his/her supervisor helps to address issues on an individual level. Occurring weekly (for new staff) or at appropriate intervals, this remediation mechanism is further strengthened by ongoing meetings among nurses and case managers or other ASAP staff involved in the delivery of service to a participant.

On a more systemic level, staff training assures uniform practices across all staff, increases staff competency, and improves services system-wide. Staff training includes quality improvement training and case management training to help case

managers and nurses recognize and address participants' needs. Training also helps to standardize and reinforce practices and information conveyed during supervisory coaching and annual evaluation of individual staff.

Pursuant to Elder Affairs' requirements, ASAPs maintain internal quality committees that review quality data collected via the discovery methods described above. These internal quality committees typically meet on a quarterly basis and represent the range of ASAP internal units. One of the key responsibilities of quality committees is development of annual quality improvement plans that identify quality improvement goals for the agency.

Another vehicle that ASAPs themselves have created to help improve quality is the ASAP quality manager workgroups. These voluntary workgroups, one meeting in eastern Massachusetts and the other in western Massachusetts, consist of ASAP staff responsible for quality management at their respective agencies. They meet during alternate months to share perspectives and ideas on common quality-related issues.

Contracts management by the ASAPs is another major vehicle for remediation of provider-specific issues. For example, providers are required by ASAPs to submit corrective action plans when serious problems occur and are monitored to ensure their implementation. ASAPs may respond to repeated problems with a specific provider by modifying the terms of the contract or by not renewing in the next contract cycle.

### *c. Concluding Remarks on Current Quality Management Practices*

As described above, currently, ASAPs perform quality oversight over their providers and participants. ASAPs collect information on virtually all of the CMS Quality Framework domains. These significant quality oversight activities, in turn, have enabled ASAPs and Elder Affairs to obtain important information on participant access to services, provision of services, and changes to participant ADL/IADL unmet needs. In addition, ASAPs have established a number of remediation and improvement systems to respond to issues that may arise from these sources of information through supervision mechanisms, quality committees, and contracting protocols.

Though the ASAPs have implemented and continue to perform many vital quality management activities, the measures and their review methodology at individual ASAPs differ across ASAPs. These measures do not consistently align with quality outcomes that may be of interest to Elder Affairs and CMS. Consequently, this decentralized and varied manner in which information is gathered along with limited resources has hindered Elder Affairs' ability to collect reliable aggregate information and to identify, analyze and respond to issues in a systematic way.

## V. SLATE OF MEASURES

*Guiding Principles*

An initial slate of measures was developed by the workgroup to address this need for consistency. Several key guiding principles were agreed upon at the outset of this task.

1. Measures would be based on the quality domains of the CMS Quality Framework and CMS quality assurances for HCBS waivers.
2. Measures would be applicable to both Medicaid waiver and state-funded Home Care services, to the maximum extent possible, to minimize any duplicative effort to collect information regarding waiver and non-waiver participants and to standardize and implement a more structured quality management system. The group, however, recognized that certain measures were mandated by CMS waiver assurances but would not necessarily apply to state-funded Home Care services. Thus, where appropriate, measures could be separately tracked for one population.
3. Measures, preferably but not exclusively, would be based on information currently collected or information that would be available in the new information management system.
4. Measures pertaining to participant-reported outcomes and satisfaction would be addressed more fully at a later point or after a standard set of survey questions is developed for all ASAPs. Additionally, measures on participant-directed service, system safeguards against natural disasters, and restrictive interventions were not considered at this point because these domains are being addressed through other Elder Affairs quality improvement mechanisms.[5]

Below are the descriptions of each measure and their relevance to quality assurance and improvement. These measures will provide valuable information to both ASAPs and Elder Affairs. For example, ASAPs can use these data to evaluate their own services and those of their direct care providers while Elder Affairs can use the same information to evaluate ASAPs-coordinated services and the impacts on participants. (See Appendix D for the initial slate.)

[5] Some of these mechanisms include Elder Affairs' initiatives to incorporate consumer-directed services and to develop continuous operations plans across all ASAPs.

### *a. Access*

Access outcomes focus on whether or not individuals have access to home and community-based services. Access encompasses several key services that individuals may receive at different points in time. In cases where individuals are seeking information on community-based supports, ASAPs will be monitored for whether they are providing these individuals with the right information at the right time. Through timely evaluation and determination of financial and clinical needs and eligibility for services, ASAPs have an opportunity to help expand the individual's access to available community-based supports, regardless of whether these supports are delivered by the ASAPs.

In cases where individuals are deemed eligible for ASAP services, access includes timely evaluation and determination of the appropriate level of care and of appropriate services (e.g., Home Care program or waiver program). This determination of level of care allows participants to take advantage of the broadest available array of services for which they are eligible. For waiver participants, all waiver requirements must be met, including receiving information describing their right to choose between community–based and institutional supports. Compliance with this requirement helps to ensure continued federal financial participation of waiver services and ensures that waiver participants are informed of their waiver rights. For participants meeting nursing facility level of care, service authorization and provision should be timely, thus helping to delay or prevent institutionalization.

**Table 1. Initial Measures on Access**

| Access Outcomes | Measures |
|---|---|
| Individuals and families receive comprehensive information that meets their needs in a timely manner. | • % of individuals requesting information (current clients and elders/ families/ community members) who are provided information that is consistent with the type of information they requested |
| Intake and eligibility processes are user-friendly. | • % of intake/assessment clients whose assessment is conducted, translated or facilitated in their primary language |
| Waiver applicants are aware of their choice between HCBS waiver services and nursing facility services. | • % of recipients of HCBS waiver services who have in their record a signed "Recipient Choice Form" in English at a reading level no higher than 6th grade |
| Applicants' services are initiated in accordance with program time requirements. | • % of applicants whose eligibility for Medicaid Waiver have been assessed within 10 business days of their identified need |

*b. Person-Centered Planning and Delivery*

Person-centered planning and delivery outcomes focus on ensuring that individual choice and preference in supports are maximized, that services are delivered as authorized, and that service utilization leads to desirable outcomes. Key areas where participant choice should be maximized are service options and direct staff. Although an ASAP's geographic location may limit the number of available provider agencies for a specific service (e.g., only one provider for a specific service), choice is supported to the maximum extent possible. Once services are planned and authorized, they need to be monitored by case managers to ensure that services are delivered in accordance with service plans and that service plans are meeting expectations. This type of monitoring helps to ensure that participants receive supports as intended and that both ASAPs and Elder Affairs are properly billed. Monitoring changes in participants' ADL/IADL unmet needs and ASAP ability to meet those needs will help ASAPs and Elder Affairs to evaluate the impacts of their services.

**Table 2. Initial Measures on Person-Centered Planning and Delivery**

| Person-Centered Planning and Delivery Outcomes | Measures |
|---|---|
| Assessments obtain comprehensive information to support the development of a personalized service plan, including information on informal caregivers' level of support. | • % of Comprehensive Data Set assessments and re-assessments that are completed within timelines as determined by Elder Affairs standards |
| Clients receive information on a wide range of service options. | • % of clients who received information on their right to choice in relation to service options and individual workers |
| Service plans address clients' assessed ADL/IADL needs either by waiver or other supports. | • % of clients' unmet ADL/IADL needs, identified in the assessments, that are addressed within six months |
| Enrolled clients are reevaluated according to their changing needs. | • % of service plans that are modified to reflect a change in functional status or informal support as identified in a re-assessment |
| Services are furnished in accordance with the service plan. | • % of clients who receive:<br>o type of service<br>o unit of service<br>o duration of service<br>o frequency of service<br>from provider(s) as outlined in service plan |

*c. Provider Capacity and Qualifications*

Crucial to ensuring quality service is the monitoring of the capacity and qualifications of providers. Given the diversity among ASAP case management staff and direct care providers that serve waiver and Home Care participants, provider measures center on whether providers meet qualifications, rather than the specific nature of those qualifications. In addition, provider-specific issues (e.g., deficiencies) will also be monitored. By monitoring incidents across providers, both ASAPs and Elder Affairs will better understand the provider-related issues and the extent to which they are addressed.

**Table 3. Initial Measures on Provider Capacity and Capabilities**

| Provider Capacity and Capabilities Outcomes | Measures |
|---|---|
| Clients are supported effectively by competent and qualified providers. | • % of ASAPs whose staff meet provider qualification standards<br>• % of providers with deficiencies whose corrective action plans address these deficiencies |
| There are sufficient providers to meet service needs. | • % of clients who received service in accordance with their service plans |

*d. Safeguards*

CMS require that states ensure the health and welfare of their waiver participants. Health and welfare are multi-faceted; important components include environmental safety and medication management. Complementing participant-level safeguards will be system-wide safeguards to address broader risks affecting all participants. In addition, to identify any population-based trends, critical incidents related to health and safety will be defined and monitored for all waiver participants.

**Table 4. Initial Measures on Participant Safeguards**

| Participant Safeguards Outcomes | Measures |
|---|---|
| System level safeguards exist to ensure clients' well-being. | • % of clients who received information on safeguarding their health and welfare in case of natural disasters and other public emergencies |
| Critical incidents are assessed and managed. | • % of reports of critical incidents which are addressed appropriately |
| Clients' housing environments are assessed for safety risks. | • % of clients assessed for housing environment safety |
| Medication management is assessed and offered as needed. | • % of clients identified as needing medication management whose service plan addresses medication management supports |

e. *Rights and Responsibilities*

As recipients of waiver services, participants have certain rights and responsibilities. ASAPs are responsible for ensuring that participants are informed of these rights and responsibilities to ensure informed decision-making. Particularly important are participant rights to choose a provider (as described above), to request a fair hearing, and to file grievances. Monitoring these processes will help Elder Affairs ensure that participants receive key information consistently across all ASAPs and that participants are informed consumers.

**Table 5. Initial Measures on Rights and Responsibilities**

| Rights and Responsibilities Outcomes | Measures |
|---|---|
| Clients are provided information and/or guidance regarding civic and human rights responsibilities and opportunities. | • % of clients who received information on civic and human rights |
| Clients are provided information about complaint and appeals process. | • % of clients given Appeals information at initial screening and Request for Fair Hearing Information with waiver eligibility notification |
| ASAPS respond and follow up on grievances in a timely manner (to be defined). | • % of grievances showing evidence of appropriate resolution process follow-through and outcomes |

### *f. Participant Satisfaction and Outcomes*

Direct participant feedback regarding services constitutes a key component of quality assurance and improvement. There was group consensus that a more standardized survey with a core set of consumer survey questions will be implemented in the future. Therefore, the short-term measure selected by the workgroup focused on the response rate of the current ASAPs' surveys. This beginning step will evaluate the extent to which written surveys are an effective method of obtaining participant feedback.

Given that ASAPs' overall goal is to "assist elders [to] maintain residence in the community consistent with their clinical and psycho-social needs and in the most cost-effective manner possible,"[6] the workgroup also identified the average duration of time receiving waiver service as a proxy for time not spent in a nursing home for individuals who are eligible for nursing home stays. The group recognized that this measure could be quickly implemented while stronger measures of consumer satisfaction and outcomes are identified and refined.

**Table 6. Initial Measures on Participant Satisfaction and Outcomes**

| Participant Satisfaction and Outcomes | Measures |
| --- | --- |
| Clients have the opportunity to express satisfaction with their services and supports. | • Annual client survey response rate |
| Services and supports prevent or delay nursing home placement. | • Average duration of time receiving waiver services |

[6] Chapter 19A of the Massachusetts General Law, Section 4B Aging Services Access Points

### *g. System Performance*

To help ensure quality improvement, a formal process of discovery, remediation and improvement needs to occur. Specifically, a systematic approach to collecting quality data and responding to the data is necessary. The ASAP Annual Quality Plan is one tool that has been employed historically in the ASAPs. This tool helps to focus all staff on important quality goals while giving Elder Affairs a broad understanding of how each ASAP is addressing agency-wide issues. Other important system performance components involve stakeholder involvement, financial integrity and cultural competency. Monitoring these processes will provide an indication of more global system performance.

**Table 7. Initial Measures on System Performance**

| System Performance Outcomes | Measures |
|---|---|
| Clients participate in the development and management of quality management. | • % of ASAPs that have quality improvement action plans that address issues identified through stakeholder feedback |
| Services are billed in accordance with plan of care. | • % of waiver clients' claims that are coded correctly and paid in accordance with waiver reimbursement methodology |
| Medicaid/Elder Affairs/ASAPs work collaboratively to improve quality of services by, in part, conducting systematic and continuous data collection and analysis on their services and system. | • % of ASAPs that have a current annual plan to address quality improvement based on slate of measures |
| System is sensitive to and addresses the ethnic, linguistic and cultural and accessibility needs of each individual client. | • % of ASAPs that have a written plan, including a Quality Improvement Plan, policies and procedures, and training in place to address any cultural, linguistic, and/or other accessibility barriers |

## VI. RECOMMENDED IMPLEMENTATION STRATEGIES FOR QUALITY MANAGEMENT[7]

A useful way to think about quality management and quality improvement is to think of the "PDSA" cycle, which stands for Plan, Do, Study and Act (see Berwick, 1998). The workgroup in its planning capacity developed these measures as part of the larger plan to improve the quality management system for waiver and Home Care services. The next stage involves implementing the plan as a pilot test, studying or evaluating that pilot test, and finally, acting on and implementing the plan widely with necessary refinements based on the study phase.

Thus, before measures can be implemented for all ASAPs, they first need to be pilot tested. The pilot phase of implementing this initial slate of measures will involve (a) specifying and operationalizing these measures, (b) clarifying guidelines on data collection, analysis, and reporting, (c) implementing these measures for a sample of ASAPs, and (d) evaluating and refining the measures and the guidelines based on the pilot experience. This section represents suggestions for implementation in each of these four areas.

### *a. Specification of Measures*

As recognized by the workgroup, the initial slate of measures needs substantial refinement before further steps can be taken. Key questions that should be considered for each measure include:

1. What are the definitions of key terms?
2. What are the measure's numerator and denominator? (Timeframes and sampling will be discussed in the data collection section below)
3. Will the measure apply to the waiver population or to the entire ASAP client population? (While most of the initial slate of measures applies to the entire ASAP client population, some measures are specific to the waiver population. The answer to this question is particularly important in cases where resources may limit data collection capability.)

Appendix G contains considerations and additional questions for each of the initial measures.

### *b. Guidelines for Data Collection, Analysis, and Reporting*

As each measure is refined, the data source will need to be identified or created; the data collection method and analysis method will need to be identified; and reporting formats will need to be clarified.

<u>What are the Data Sources?</u> Data sources necessary for the initial slate of measures include: participant information gathered via information and referral, assessments

[7] These recommendations are based on workgroup discussion, workgroup review of draft recommendations, and additional research on sampling and reporting conducted by UMMS/CPHR.

and service planning (to be available electronically in SIMS); ASAP internal documents such as human resources information; and contract management documentation.[8] In general, participant file information will be the most frequently used data source and is most standardized because ASAPs use the same assessment and service plan forms. However, other data sources such as ASAP internal documents or reports on participant incidents may vary across ASAPs. Table 8 describes some potential discovery methods and how they can be used to gather information for various outcomes or domains.

**Table 8. Data Sources by Selected Outcomes or Domains**

| Possible Data Sources | Selected Outcomes or Domains |
|---|---|
| Participant file information in management information system | Information and referral<br>Timeliness of service plans, service provision, and assessments<br>Participant ADL/IADL changes |
| ASAP information and forms provided to clients/consumers | Informed decision-making by clients/consumers |
| ASAP human resources files | Provider capacity and capabilities |
| ASAP quality improvement documentation | ASAP system performance |
| Provider-related documentation | Provider capacity and capabilities |

<u>How are Data Collected from the Data Sources?</u> Developing clear guidelines for collecting data for all data sources is suggested. For standardized *and* electronic data sources, such as assessment and service plan data, collecting data for the entire population of interest may be feasible. However, for data sources such as ASAP internal and provider documentation and for other data in paper form (e.g., not accessible via SIMS), data collection may be facilitated by (a) taking a systematic and unbiased sample and (b) developing standardized data collection instruments.[9]

Thus, sampling methods may need to be developed. Decisions to consider include (a) whether data on a sample or the full population will be collected, and sample size, if applicable, (b) whether Elder Affairs will obtain a sample via site visits or via request for ASAPs to send the sample and data on the sample, and (c) what time frame will apply if data are collected for all cases. Both sampling method and sample size are important decisions and should be considered carefully and thoughtfully.

Sampling must take into account the need for accuracy as well as budget and time constraints. A sample of 10% of active cases is currently used in many ASAPs. Other sources have suggested using on-line calculators to compute the sample size needed, given the population size and the desired confidence level (Freedman &

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[8] These methods represent current understanding of the new information management system, which is being rolled out through June 2007. The exact immediate capability of the information management system remains somewhat unclear as well as what capabilities can be added in future enhancements. While the discovery methods listed in this report represent the expected method for the initial slate of measures, validation and refinement must occur over time.

[9] The data collection instruments are expected to be needed only for the small percent of measures that are not captured by SIMS data.

Taub, 2006). In the pilot phase, a variety of methods for sampling can be tested to determine the most appropriate and most cost-effective method(s).

Standardized data collection instruments help to collect consistent and sufficient information to understand the measures of interest and could make on-site data collection more efficient, when necessary. In addition, criteria related to how to score or rank data may need to be developed (Fralich, Booth, Gray, Bowe & Bratesman, 2005). Training on data collection guidelines/protocols can be provided to ensure consistency and reliability.

Who will Collect and Analyze the Data? It is recommended that Elder Affairs quality staff take the lead role in collecting and analyzing the data regarding services delivered via ASAPs. For data already accessible via SIMS, data collection and analysis can be conducted by Elder Affairs staff relatively quickly. For data collected by ASAPs in paper forms, such as internal human resources documentation and provider documentation, collection (with the aid of standardized data collection tools) and analysis would require relatively more resources and time. Sufficient resources must be planned for and allocated in order to achieve successful implementation of these tasks.

Once data are analyzed for each measure, further investigation may be warranted on measures whose findings do not seem consistent with expected outcomes. Reliability may also be studied by having more than one data collector collect the same data on the same population. Then inter-rater correlations can be reported and additional training on data collection protocol can be given if needed. Thus, analysis in the pilot phase may include some calculations specific to testing and evaluation of the measures. While these steps may necessitate resource allocation, they help to ensure that the data are a reliable basis for remediation. On a regular basis, these reliability and validity studies could also continue beyond the pilot phase to update the evaluation of measures and data collection.

It is also expected that the ASAPs will be involved in these activities as they have an interest in maintaining and improving quality.

What is the Format for Reporting the Measure? The format for reporting on the initial slate of measures depends on a number of factors. Chief among these factors are:

- The purpose of the reports,
- The audience for the reports and
- The frequency of the reports.

In the pilot phase, the purpose of reporting measures is to test the utility and validity of the measures in meeting Elder Affairs' goal of ensuring quality service. Thus, reporting should be comprehensive with numerator, denominator and percent presented. Appropriate or available comparisons over the pilot phase (e.g., percent change to both past data on similar measures and to measures collected over time) will allow for some initial understanding of the validity of the measures.

Actual formats for reporting measures will vary by measure. However, there are some considerations to keep in mind. Graphics (arrows, checkmarks) and colors may

be used quite effectively to represent the value of each measure and/or the change from year to year. For example, Massachusetts Department of Mental Retardation (DMR) uses arrows to highlight the change from the previous year; this is a simple and effective way to ensure that the data are understood correctly (2004). It is also important that reports provide enough information and are in a user-friendly format to allow the reader to interpret the results (e.g., Hibbard & Peters, 2003).

There is a potential additional consideration for reporting data on measures based on the new SIMS. With these measures, consultation should occur with the SIMS report development group to study the feasibility of reports being available on a more frequent basis and/or generated on an ad-hoc basis. For example, once the new system is fully rolled out, it may be possible for Elder Affairs and ASAPs to review monthly or quarterly reports on the measures based on SIMS data, depending on the need for monitoring.

Beyond the pilot phase, objectives of reporting could include analyzing ASAP performance over time, monitoring/reporting quality of waiver services over all ASAPs (a composite report), implementing remediation and improvement at the ASAP level, informing policy decision-making at a system level, or assisting consumers with informed decision-making regarding providers. [10] Information that leadership will need is necessarily different in content, form and level from information ASAPs need. Care must be taken to report data in appropriate and accessible formats. For example, a report for Elder Affairs leadership may consist of composite reports of brief tables with clear graphics to give enough information with which to make programmatic decisions. ASAPs may find reports with much more detailed information for each measure to be the most useful.

Conclusion on Guidelines for Data Collection, Analysis, and Reporting. The above issues should be comprehensively addressed for each measure. To ensure that each question is addressed in a systematic and transparent manner, development of a measure specification manual (codebook) is recommended. This type of specification manual can describe the measures, definitions, numerator, denominator, data source, collector, analyst and reporting format. This manual could then be used to ensure reliability and consistency. With such a manual and training, consistency in all phases of quality measurement may be greatly enhanced. Further, this manual can provide a foundation on which to refine and expand quality management activities. See Table 9 on the next page for a sample specification manual for an initial access measure.

[10] Discussion about public availability of certain reports may be warranted after the pilot phase is complete. Public reports for consumers may involve measures related to areas which they themselves consider important. Potentially, further exploration of consumers' needs and expectations about reports may be needed. See possible consumer involvement recommendations in C. Pilot Implementation of Measures.

**Table 9. Possible Specification Information for Measure**

| Quality Domain | Participant Access |
|---|---|
| Quality Outcome | Intake and eligibility processes are user-friendly |
| Measure | % of intake and assessments that were conducted, translated, and facilitated in the client's primary language |
| Definitions | Primary language=as identified by "language" on assessment tool<br>Conducted, translated, and facilitated= Either the intake and/or assessment staff spoke the participant's primary language or an interpreter facilitated the interview<br>(It is important to note that the documentation of these variables, including staff's linguistic ability, will be critical.) |
| Numerator | Number of intake and assessments that met the above criteria (evaluating only the most recent intake or assessment for each client) |
| Denominator | All current ASAP clients with an intake or assessment completed within a defined six-month span |
| Data Source | Administrative data reports from the information management system Accessible at Elder Affairs |
| Data Collector | Elder Affairs |
| Data Analysis | Elder Affairs |
| Reporting format | Data reported as a percent, with the total number in the denominator noted |

### *c. Pilot Implementation of Measures*

To help ensure that the pilot phase captures a full scope of possible issues, these measures should be piloted with a diverse cross-section of ASAPs: ASAPs representing different experience levels with SIMS,[11] large and small ASAPs, ASAPs that represent the cultural diversity of the elderly population; and ASAPs with different strategies for quality management (e.g., ASAP with dedicated quality management staff and ASAP with quality management as just one part of staff's responsibilities). To accommodate this variety of ASAPs, the measures may need to be tested in at least 6 ASAPs. Alternatively, data on some of these measures may be collected across all ASAPs, if SIMS reporting functions are available. Discussion with Elder Affairs and the SIMS report development group could be valuable to increase the amount of data collected in a relatively short time frame.

An implementation group, under Elder Affairs' leadership, could be a useful vehicle to facilitate the pilot test and subsequent state-wide roll out. As the current workgroup process has shown, incorporating stakeholders' input at key times can be valuable. This collaboration could be equally valuable during the pilot phase to ensure that resource availability and programmatic procedures align with any proposed data collection, analysis, and reporting guidelines. For example, having stakeholder involvement may help to ensure that the proper resources at ASAPs and Elder Affairs are identified for data collection and analysis and that data reporting activities meet Elder Affairs' and Medicaid's information needs (as well as ASAPs' needs for internal improvement). Therefore, some involvement by Elder Affairs, MassHealth, and ASAP staff in the pilot phase of operationalizing and implementing the selected

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[11] As noted, SIMS was first rolled at a few ASAPs in FY 2006 and is expected that all ASAPs will have the new information management system by mid-2007.

measures is recommended. In addition to this collaboration, another resource for the implementation team is the ASAP Quality Manager working group. Consultation with this group can promote a smooth transition from previous quality management systems to activities supporting this expanded quality framework.

It may also become important to involve consumers in the pilot phase and beyond. For example, consumers could provide feedback on participant satisfaction and outcome measures in development and rate the relative importance of measures/issues as they relate to the participant perception of quality of service, recognizing that the state and providers may still need data on outcomes that participants do not prioritize highly themselves. In addition, consumers could be brought together as a focus group to review and provide feedback on the reporting formats for reports made available to the public, if any.

### *d. Evaluation of Pilot Implementation of Measures*

After the pilot phase of measure implementation, the next step in the process is to study or evaluate the measures. Several key questions should be addressed:

<u>How will the measures be revised?</u> Once implementation questions have been explored through pilot testing, the measures will need to be reviewed and modified. The review should consider the importance of the measure, the ease of data collection, reliability and validity. To facilitate these decisions, the implementation workgroup may select a smaller team to review these measures.

<u>Are there benchmarks or targets?</u> The current workgroup has suggested that benchmarks would be determined in the first year. One idea to consider is to compare data with the weighted state (all ASAPs) average and with a baseline (Minnesota Department of Human Services & The Improve Group, 2006).

## VII. STATEWIDE IMPLEMENTATION

After the measures have been piloted and data collection/analysis guidelines and training have been revised, then the implementation team can proceed with the next phase of implementation: use of the measures for all ASAPs. This action phase could proceed as a staged roll out to ensure that staff members receive necessary training in the data collection guidelines. Once measures are implemented for all ASAPs, reports should be issued at least annually, coordinated by Elder Affairs.

A possible timetable for the implementation of these measures is necessarily complicated by the roll out of SIMS. Initial refinement of the measures and development of the initial specification manual could occur as final roll out of SIMS is occurring (e.g., in FY 2007). However, because much of the data collection is linked to SIMS capability, close consultation with Elder Affairs staff involved with SIMS is recommended to finalize the timetable for these measures. For example, the reporting capability of both Elder Affairs and ASAP staff, as staff learn the functionality of SIMS, will affect the data collection methods for these measures.

## VIII. QUALITY MANAGEMENT: REMEDIATION AND IMPROVEMENT

Remediation and improvement at the ASAP and Elder Affairs levels should be considered once pilot reports on the initial slate of measures are developed. Remediation and improvement methods already in place at the ASAPs should be used for ASAP-level quality problems identified during the pilot. For example, if participants' ADL/IADL unmet needs are not being addressed within the required timeframe, the individual ASAP may want to assess reasons for this. Identification of cross-ASAP issues may be more complicated because ASAPs serve different geographic locations and have access to different direct care providers. See Table 10 below for examples of how remediation methods can address a variety of issues.

**Table 10. Potential Issues for Specific Remediation Methods**

| Remediation Methods | Examples of Issues |
|---|---|
| Supervision/Case Management | • To address Information and Referral issues<br>• To ensure ADL/IADL and other participant needs are addressed<br>• To address concerns about service provision<br>• To ensure that service plans address risks |
| Staff Performance Evaluation and Training | • To ensure user-friendliness in Information and Referral<br>• To ensure that assessments are conducted in a timely manner<br>• To address ASAP capacity and capability issues<br>• To remediate certain system performance issues related to data collection, analysis and quality improvement in general |
| Focused Oversight through Corrective Action Plans | • To ensure providers start services in a timely manner and are responsive to participants' preferences<br>• To address provider capacity and capability issues<br>• To ensure financial integrity |

## IX. CONCLUSIONS

Quality measurement and improvement are complex and dynamic processes that take time and resources to plan and implement. Although much has been accomplished in past Elder Affairs and ASAPs' quality improvement efforts, new opportunities to standardize and build upon these efforts are presented by the roll out of SIMS and by the renewed interest of CMS in quality improvement.

Having noted these opportunities, Elder Affairs convened a workgroup composed of representatives from the ASAP network, Home Care program administrators, and elder waiver oversight staff at both MassHealth and Elder Affairs. With UMMS/CHPR facilitation, members explored current quality management practices and possible strategies for expanding quality management practices. As a result, this workgroup selected a prioritized slate of measures, partly from the existing set of measures, to serve as the basis for collecting standardized information to evaluate and remediate particular quality concerns. Thus, this initial slate of measures provides the foundation for next steps in strengthening the quality improvement structure for elder HCBS waiver services. A major next step will be developing a mechanism to evaluate the measures; one such mechanism, pilot testing, was recommended in this report.

As the initial slate of measures is evaluated, it will be crucial to maintain momentum so the initial measures can be refined and implemented and additional measures pilot-tested. To assist with future steps, Appendix H contains additional quality measures that could be incorporated into the quality management slate of measures.[12] As reliable information is gathered on a common set of measures during the pilot phase and beyond, it will be important to continue monitoring the quality data generated in routine and annual reports. In this way, quality improvement will be meaningfully sustained.

[12] The measures in Appendix H reflect measures from workgroup discussions and other sources. These measures include measures related to participant-reported outcomes and satisfaction and other measures that were deferred during the process of developing consensus on the initial slate.

## X. REFERENCES

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# Appendix A: CMS Waiver Assurances[13]

## I. Level of Care (LOC) Determination

Waiver applicants for whom there is reasonable indication that services may be needed in the future are provided an individual LOC evaluation.

Enrolled participants are reevaluated at least annually or as specified in the approved waiver.

The process and instruments described in the approved waiver are applied to LOC determinations.

The state monitors level of care decisions and takes action to address inappropriate level of care determinations.

## II. Plan of Care (POC)

POCs address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

The State monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of POCs.

POCs are updated/revised when warranted by changes in waiver participants' needs.

Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the POC.

Participants are afforded choice between waiver services and institutional care.

Participants are afforded choice between/among waiver services and providers.

## III. Qualified Providers

The state verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.

The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

The state identifies and rectifies situations where providers do not meet requirements.

[13] CMS System Assurances on CMS Website

The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

### IV. Health and Welfare

On an ongoing basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

### V. Administrative Authority

The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

### VI. 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 waiver.

## Appendix B: Selected Elder Affairs Quality Goals, Objectives, or Measures for Aging Services Access Points (ASAPs) by CMS Quality Domains

### CONSUMER ACCESS

- Information & referral: Timely, comprehensive, and appropriate[14]
- Uniform intake process[14]
- Opportunity to apply for appropriate public benefits[14]
- Education of clients and providers about community long-term care services[14]
- Less than 10 business days between service request and service delivery[15]

### PERSON-CENTERED SERVICE PLANNING AND DELIVERY

- To conduct standardized long term care assessments to determine eligibility and develop and implement comprehensive service plans[14]
- To ensure eligible elders safely remain living in the least restrictive environmental through coordination, monitoring, and evaluation of formal and informal supports in accordance with available resources and elders' preferences[14]
- Appropriate program enrollment, home visit schedule, and records reflect interdisciplinary approach[14]
- Re-assessments reflect appropriateness of service plan[14]
- Monitor service plans and changes to effectively assist elders to maintain independent living[16]

### PROVIDER CAPACITY AND CAPABILITIES

- Awards of contracts to non-homemaker agencies must result from formal process of open competition every three years[14]
- Financial audits of ASAP statements[14]

### CONSUMER SAFEGUARDS

- To ensure eligible elders safely remain living in the least restrictive environmental through coordination, monitoring, and evaluation of formal and informal supports in accordance with available resources and elders' preferences[14]

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[14] Program Instruction (PI) 98-46
[15] 1997 RFP
[16] Waiver Program Guidance

- Timely and effective screening and investigation of elder abuse cases[17]

## CONSUMER RIGHTS AND RESPONSIBILITIES

- Demonstration of the distribution of materials informing applicants and clients of their rights and responsibilities[14]
- Number and type of complaints[14]
- Wait time for resolution of complaints[14]

## CONSUMER OUTCOMES AND SATISFACTION

- Annual surveys of clients who use ASAP services or programs[14]
- Clients' needs are met[14]

## SYSTEM PERFORMANCE

- ASAP profiling of linguistic and cultural community needs and provide capacity to serve non-English speaking, blind and deaf elders[14]
- Annual Quality Improvement Plan[18]
- Staff training on quality improvement philosophy, standing quality improvement committee, annual improvement plan[14]
- To ensure current and projected information needs are met to help manage agency operations efficiently and effective (HOMIS data is accurate) [14]

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[17] Program Instruction 98-37
[18] Program Instruction 98-48

# Appendix C: CMS HCBS Quality Framework[19]

## *Focus I: Participant Access*

**Desired Outcome:** *Individuals have access to home and community-based services and supports in their communities.*

### I.A Information/Referral

**Desired Outcome**: *Individuals and families can readily obtain information concerning the availability of HCBS, how to apply and, if desired, offered a referral.*

### I.B. Intake and Eligibility

#### I.B.1 User-Friendly Processes

**Desired Outcome**: *Intake and eligibility determination processes are understandable and user-friendly to individuals and families and there is assistance available in applying for HCBS.*

#### I.B.2 Referral to Community Resources

**Desired outcome***: Individuals who need services but are not eligible for HCBS are linked to other community resources***.**

#### I.B.3 Individual Choice of HCBS

**Desired Outcome**: *Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional services.*

#### I.B.4 Prompt Initiation

**Desired Outcome**: *Services are initiated promptly when the individual is determined eligible and selects HCBS.*

## *Focus II: Participant-Centered Service Planning and Delivery*

**Desired Outcome:** *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*

### II.A Participant-Centered Service Planning

#### II.A.1 Assessment

**Desired Outcome**: *Comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan.*

#### II.A.2 Participant Decision Making

**Desired Outcome**: *Information and support is available to help participants make informed selections among service options.*

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[19] CMS Website (http://www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf)

#### II.A.3 Free Choice of Providers

**Desired Outcome:** *Information and support is available to assist participants to freely choose among qualified providers.*

#### II.A.4 Service Plan

**Desired Outcome**: *Each participant's plan comprehensively addresses his or her identified need for HCBS, health care and other services in accordance with his or her expressed personal preferences and goals.*

#### II.A.5 Participant Direction

**Desired Outcome**: *Participants have the authority and are supported to direct and manage their own services to the extent they wish.*

### II.B Service Delivery

#### II.B.1 Ongoing Service and Support Coordination

**Desired Outcome**: *Participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.*

#### II.B.2 Service Provision

**Desired *Outcome***: *Services are furnished in accordance with the participant's plan.*

#### II.B.3 Ongoing Monitoring

**Desired Outcome**: *Regular, systematic and objective methods – including obtaining the participant's feedback – are used to monitor the individual's well being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals.*

#### II.B.4 Responsiveness to Changing Needs

**Desired Outcome**: *Significant changes in the participant's needs or circumstances promptly trigger consideration of modifications in his or her plan*.

## *Focus III: Provider Capacity and Capabilities*

**Desired Outcome:** *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*

### III.A Provider Networks and Availability

**Desired Outcome**: *There are sufficient qualified agency and individual providers to meet the needs of participants in their communities.*

### III.B Provider Qualifications

**Desired Outcome:** *All HCBS agency and individual providers possess the requisite skills, competencies and qualifications to support participants effectively.*

### III.C Provider Performance

**Desired Outcome:** *All HCBS providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's plan.*

## *Focus IV: Participant Safeguards*

**Desired Outcome**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*

### IV.A Risk and Safety Planning

**Desired Outcome**: *Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant.*

### IV.B Critical Incident Management

**Desired Outcome:** *There are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations.*

### IV.C Housing and Environment

**Desired Outcome**: *The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.*

### IV.D Restrictive Interventions

**Desired Outcome**: *Restrictive interventions – including chemical and physical restraints – are only used as a last resort and subject to rigorous oversight*.

### IV.E. Medication Management

**Desired Outcome**: *Medications are managed effectively and appropriately.*

### IV.F Natural Disasters and Other Public Emergencies

**Desired Outcome**: *There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.*

## *Focus V: Participant Rights and Responsibilities*

**Desired Outcome:** *Participants receive support to exercise their rights and in accepting personal responsibilities.*

### V.A Civic and Human Rights

**Desired Outcome**: *Participants are informed of and supported to freely exercise their fundamental constitutional and federal or state statutory rights.*

### V.B Participant Decision Making Authority

**Desired Outcome**: *Participants receive training and support to exercise and maintain their own decision-making authority.*

**V.C Due Process**

**Desired Outcome**: *Participants are informed of and supported to freely exercise their Medicaid due process rights.*

**V.D Grievances**

**Desired Outcome**: *Participants are informed of how to register grievances and complaints and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.*

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## *Focus VI: Participant Outcomes and Satisfaction*

**Desired Outcome:** *Participants are satisfied with their services and achieve desired outcomes.*

**VI.A Participant Satisfaction**

**Desired Outcome**: *Participants and family members, as appropriate, express satisfaction with their services and supports.*

**VI.B Participant Outcomes**

**Desired Outcome**: *Services and supports lead to positive outcomes for each participant.*

## *Focus VII: System Performance*

**Desired Outcome:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

**VII.A System Performance Appraisal**

**Desired Outcome**: *The service system promotes the effective and efficient provision of services and supports by engaging in systematic data collection and analysis of program performance and impact.*

**VII.B Quality Improvement**

**Desired Outcome**: *There is a systemic approach to the continuous improvement of quality in the provision of HCBS.*

**VII.C Cultural Competency**

**Desired Outcome**: *The HCBS system effectively supports participants of diverse cultural and ethnic backgrounds.*

**VII.D Participant and Stakeholder Involvement**

**Desired Outcome**: *Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities.*

**VII. E Financial Integrity**

**Desired Outcome**: *Financial accountability is assured and* payments *are made promptly in accordance with program requirements.*

## Appendix D: Initial Slate of Quality Measures

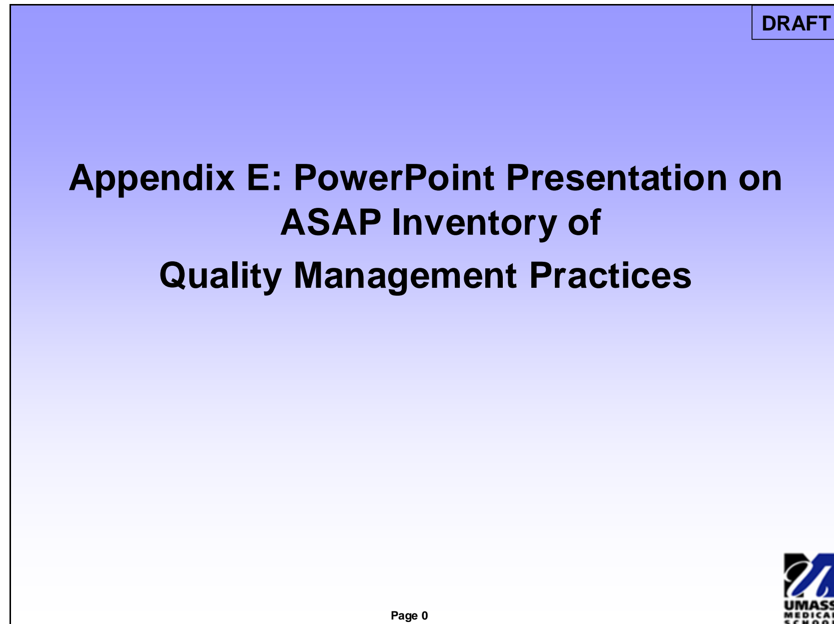
| Domain | Outcome | Measures |
|---|---|---|
| **Participant Access**:<br><br>Information and Referral | Individuals and families receive comprehensive information that meets their needs in a timely manner. | • % of individuals requesting information (current clients and elders/ families/ community members) who are provided information that is consistent with the type of information they requested |
| **Participant Access:**<br><br>User-Friendly Processes | Intake and eligibility processes are user-friendly. | • % of intake/assessment clients whose assessment is conducted, translated or facilitated in their primary language |
| **Participant Access**:<br><br>Individual Choice | Waiver applicants are aware of their choice between HCBS waiver services and nursing facility services. | • % of recipients of HCBS waiver services who have in their record a signed “Recipient Choice Form” in English at a reading level no higher than $6^{th}$ grade |
| **Participant Access**:<br><br>Prompt Initiation of Service | Applicants’ services are initiated in accordance with program time requirements. | • % of applicants whose eligibility for Medicaid Waiver have been assessed within 10 business days of their identified need |
| **Person-centered planning and delivery:**<br><br>Assessments/ Level of Care Evaluations | Assessments obtain comprehensive information to support the development of a personalized service plan, including information on informal caregivers’ level of support. | • % of Comprehensive Data Set assessments and re-assessments that are completed within timelines as determined by Elder Affairs standards |
| **Person-centered planning and delivery:**<br><br>Free Choice of Providers | Clients receive information on a wide range of service options. | • % of clients who received information on their right to choice in relation to service options and individual workers |
| **Person-centered planning and delivery:**<br><br>Service Plan | Service plans address clients’ assessed ADL/IADL needs either by waiver or other supports. | • % of clients’ unmet ADL/IADL needs, identified in the assessments, that are addressed within six months |

| Domain | Outcome | Measures |
|---|---|---|
| **Person-centered planning and delivery:**<br><br>Ongoing Service and Support Coordination/<br>Ongoing and Effective Monitoring | Enrolled clients are reevaluated according to their changing needs. | • % of service plans that are modified to reflect a change in functional status or informal support as identified in a re-assessment |
| **Person-centered planning and delivery:**<br><br>Service Provision | Services are furnished in accordance with the service plan. | • % of clients who receive:<br>o type of service<br>o unit of service<br>o duration of service<br>o frequency of service<br>from provider(s) as outlined in service plan |
| **Provider capacity and capabilities:**<br><br>Provider Qualifications/<br>Provider Performance | Clients are supported effectively by competent and qualified providers. | • % of ASAPs whose staff meet provider qualification standards<br>• % of providers with deficiencies whose corrective action plans address these deficiencies |
| **Provider capacity and capabilities:**<br><br>Provider Networks and Availability | There are sufficient providers to meet service needs. | • % of clients who received service in accordance with their service plans |
| **Safeguards:**<br><br>Risk and Safety Planning/<br>Natural Disasters and other Public Emergencies | System level safeguards exist to ensure clients' well-being. | • % of clients who received information on safeguarding their health and welfare in case of natural disasters and other public emergencies |
| **Safeguards:**<br><br>Critical Incident management | Critical incidents are assessed and managed. | • % of reports of critical incidents which are addressed appropriately |
| **Safeguards:**<br><br>Housing and Environment | Clients' housing environments are assessed for safety risks. | • % of clients assessed for housing environment safety |

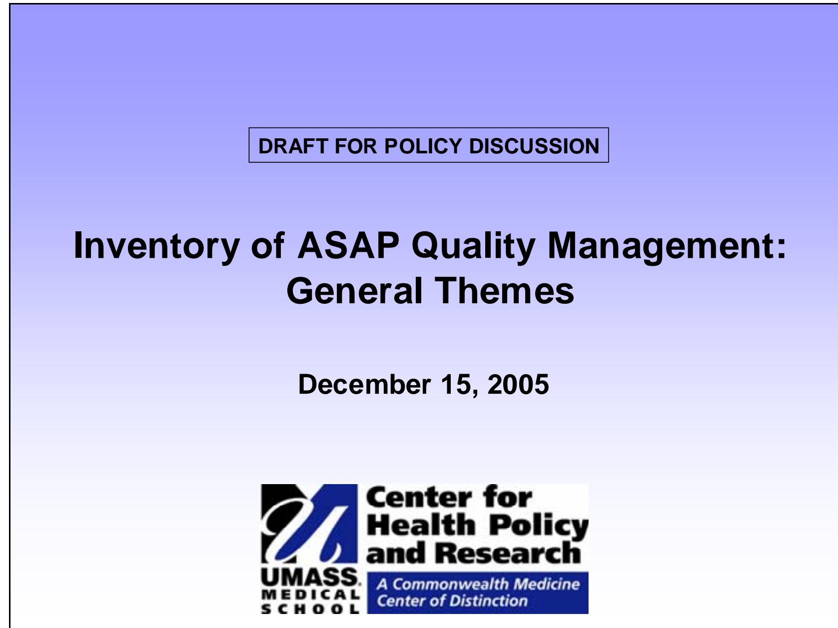
| Domain | Outcome | Measures |
|---|---|---|
| **Safeguards:**<br><br>Medication Management | Medication management is assessed and offered as needed. | • % of clients identified as needing medication management whose service plan addresses medication management supports |
| **Rights and Responsibilities:**<br><br>Civic and Human Rights | Clients are provided information and/or guidance regarding civic and human rights responsibilities and opportunities. | • % of clients who received information on civic and human rights |
| **Rights and Responsibilities:**<br><br>Medicaid Due Process | Clients are provided information about Complaint and Appeals process. | • % of clients given Appeals information at initial screening and Request for Fair Hearing Information with waiver eligibility notification |
| **Rights and responsibilities:**<br><br>Timely Grievance Resolution | ASAPS respond and follow up on grievances in a timely manner (to be defined). | • % of grievances showing evidence of appropriate resolution process follow-through and outcomes |
| **Participant Satisfaction and Outcomes:**<br><br>Satisfaction | Clients have the opportunity to express satisfaction with their services and supports. | • Annual client survey response rate |
| **Participant Satisfaction and Outcomes:**<br><br>Outcomes | Services and supports prevent or delay nursing home placement. | • Average duration of time receiving waiver services |
| **System Performance:**<br><br>Participant and Stakeholder Involvement in Quality Improvement | Clients participate in the development and management of quality management. | • % of ASAPs that have quality improvement action plans that address issues identified through stakeholder feedback |
| **System Performance:**<br><br>Financial Integrity | Services are billed in accordance with plan of care. | • % of waiver clients' claims that are coded correctly and paid in accordance with waiver reimbursement methodology |
| **System Performance:**<br><br>System Performance Appraisal via Systematic Data Collection | Medicaid/Elder Affairs/ASAPs work collaboratively to improve quality of services by, in part, conducting systematic and continuous data collection and analysis on their services and | • % of ASAPs that have a current annual plan to address quality improvement based on slate of measures |

| Domain | Outcome | Measures |
| --- | --- | --- |
| and Analysis/<br>Systematic Approach to Quality Improvement | system. | |
| **System Performance:**<br><br>Cultural Competency | System is sensitive to and addresses the ethnic, linguistic and cultural and accessibility needs of each individual client. | • % of ASAPs that have a written plan, including a Quality Improvement Plan, policies and procedures, and training in place to address any cultural, linguistic, and/or other accessibility barriers |

Slide 1




Slide 2



Slide 3

## Presentation Outline

- **CMS HCBS Quality Framework (CMS Framework)**
- **Comparison of CMS focus areas and desired outcomes with EOEA goals, objectives, and measures**
- **Inventory survey responses**
- **General themes from surveys: Discovery, remediation, and improvement methods**
- **Questions, comments, and next steps**

Slide 4

## CMS HCBS Quality Framework: Focus areas

- **Participant Access:** Individuals have access to home and community based services and supports in their communities
- **Participant-Centered Service Planning and Delivery:** Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community
- **Provider Capacity and Capabilities**: There are sufficient HCBS providers and they possess and demonstrate the capacity to effective service participants
- **Participant Safeguards**: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- **Participant Rights and Responsibilities:** Participants receive support to exercise their rights and in accepting personal responsibilities
- **Participant Outcomes and Satisfaction:** Participants are satisfied with their services and achieve desired outcomes
- **System Performance**: The system supports participants efficiently and effectively and constant strives to improve quality

Slide 5

## Comparison between CMS Framework and EOEA Quality Goals-Table 1

- In general, all CMS focus areas and most desired outcomes are addressed in EOEA quality goals, objectives, and measures (see table)
- CMS Framework outcomes are sometimes different, broader, or more outcome-oriented, than EOEA quality guidelines. For example:
  - I & R is readily obtainable vs. timely, comprehensive, and appropriate
  - Referral to community resources vs. public benefits
  - Consumers' positive outcomes vs. meeting needs
- Framework is specific to waiver quality while EOEA requirements apply to ASAPs' Home Care contract
- EOEA requirements form basis for ASAP quality management system

Slide 6

## Survey Responses

- 26 of 27 ASAP completed surveys
- 20 ASAPs provided additional documentation
  - Policies on quality roles and responsibilities
  - Sample consumer surveys
  - Record review checklists
- Some discrepancy because many ASAPs confused service delivery methods with discovery methods for quality management

Slide 7

## General Themes : Discovery Methods

**ASAPs as a group have discovery methods for all focus areas**

- **Vast majority of ASAPs have discovery methods to evaluate the following outcomes:**
  - **Information and referral (Access)**
  - **Level of care evaluations, assessments, re-assessments, service planning and service delivery (PCP)**
  - **Consumer satisfaction**
  - **Provider capabilities**
- **Less than half of all ASAPs have discovery methods to evaluate the following:**
  - **Information to make choices between NF and HCBS (Access)**
  - **Information to choose among providers (PCP)**
  - **Critical management and natural disaster risk management (Consumer safeguards)**
  - **Consumer rights and responsibilities**
  - **Stakeholder involvement in quality management and cultural competency (System performance)**

Slide 8

## General Themes: Discovery Methods

**A. ASAP Staff (Case Managers, Supervisors, and Senior Management):**

1. **Observation of vendor employees at consumers' homes (provider capabilities)**
2. **Interviews with and observations of consumers during home visits (provider capacity, client outcomes, and person-centered service planning and delivery)**
3. **Interdisciplinary case conferences (most focus areas)**
4. **Record review of case manager progress notes, assessments, and service plans (person-centered service planning and delivery)**
5. **HOMIS data analysis (person-centered service planning and delivery, provider capacity)**
6. **Surveys of ASAP staff (provider capabilities)**

Slide 9

## General Themes: Discovery Methods

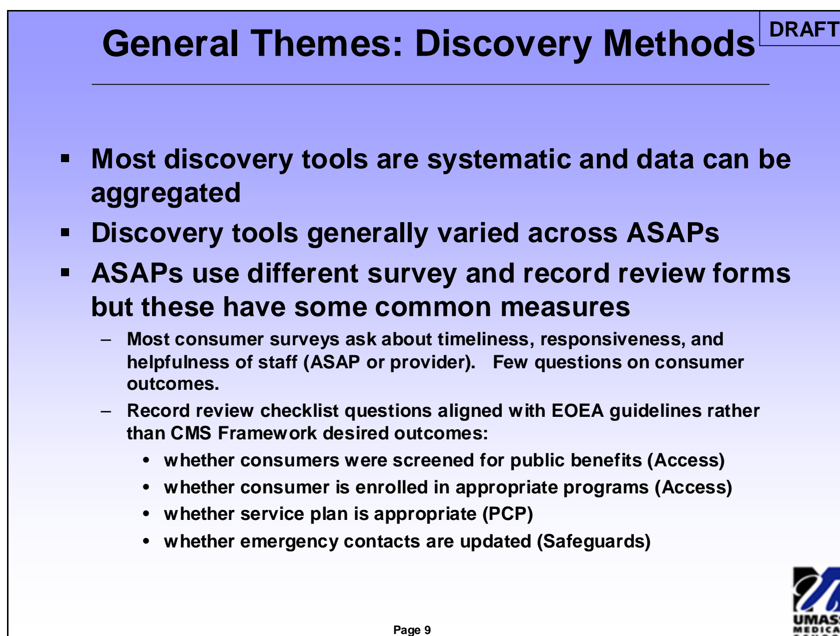
**B. ASAP Vendors:**

1. Incident reports completed by providers re: provider employees and consumers (safeguards and provider capabilities)
2. On-site vendor monitoring (provider capabilities)

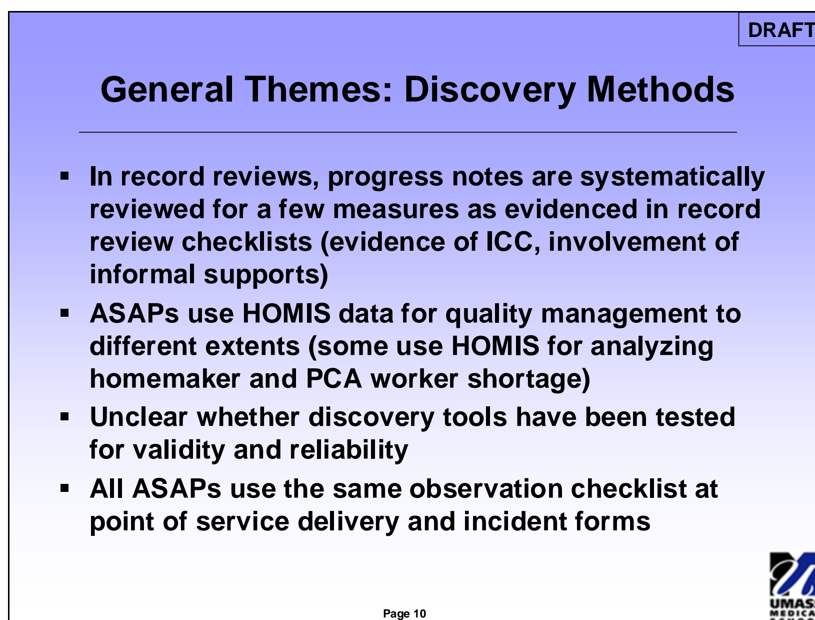
**C. Consumers:**

1. Consumer complaints
2. Consumer surveys of ASAP Information and Referral Services, case management, and specific services (consumer satisfaction/outcomes and provider capabilities)

Slide 10



Slide 11




Slide 12

## General Themes: Roles and Responsibilities for Remediation

**In general, ASAP remediation responsibilities are generally decentralized and distributed as follows:**

- Information and Referral department is responsible for I and R remediation
- Individual consumer issues are addressed by case managers, supervisors, and contracts manager
- Contract managers handle remediation for day-to-day vendor related issues
- Individual ASAP staff issues are addressed by supervisors

Slide 13

## General Themes: Roles and Responsibilities for Improvement

- Multiple entities within each ASAP have responsibilities for addressing "systemic" consumer, provider, and ASAP staff issues
  - Home Care or senior management
  - Assistant Directors
  - Executive Directors
  - Quality committees
  - Vendor/Ethics/Complaints Committees
  - Board of Directors
- Quality data from discovery methods is usually reported to multiple entities whose level of involvement in quality management differ across ASAPs
- Critical incidents or consumer safety issues appear to have higher priority and are handled by Home Care or senior management and Assistant Directors at some ASAPs

Slide 14

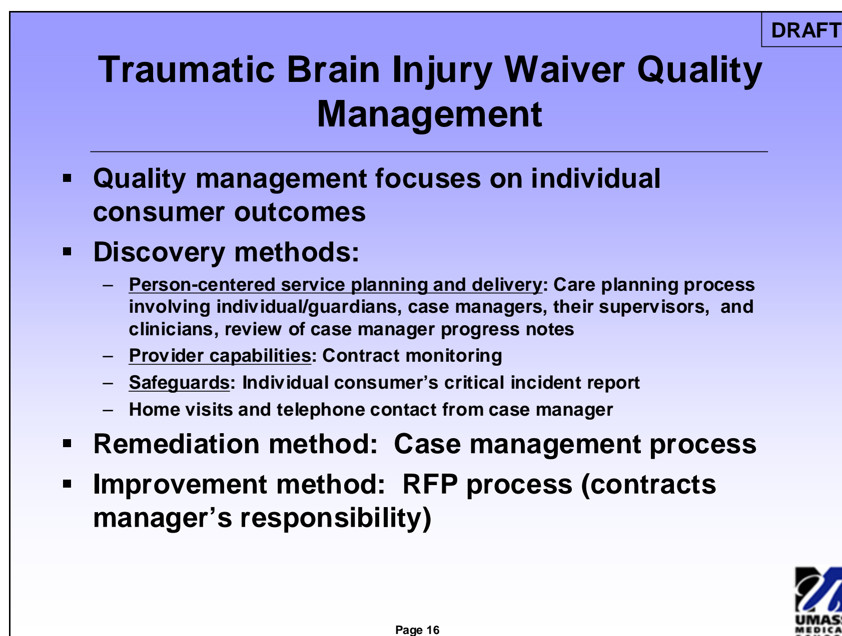
## General Themes: Remediation and Improvement Techniques

- ASAPs use the following techniques to make remediation of specific issues and system improvements:
  - Supervisor oversight
  - Staff performance evaluation
  - Interdisciplinary case management
  - Policy or process modification
  - Staff training
  - Vendor corrective action plans or RFP process
  - Internal Review Committee

Slide 15

Slide 16

Slide 17




Slide 18

## Next Steps

- Any questions, comments, etc?
- What criteria to select ASAPs for in-depth interviews?
  - Timing of interview
  - Objectives of interviews
- Realignment to CMS Framework
- Slate of measures
- Revisit timeline
- Other next steps?

## Appendix F: ASAP Inventory's Discovery Methods by Outcome

Key:
√ : More than half of survey respondents indicated this discovery method was used
O : Half or less than half of survey respondents indicated this discovery method was used
Direct Observ. by CM or Sup: Direct observation by case manager or supervisor
ICC/ Sup. Overs.: Interdisciplinary Case Conferences/Supervisory Oversight
Rec Rev: Record review
Appeals or Compl: Appeals or complaints

Note: Survey responses were verified against documentation when available. Therefore, some discovery methods are not checked off for some desired outcomes in this document even though they were checked off on survey responses.

| **CMS Focus Areas & Desired Outcomes** | **Discovery Methods** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **ASAP Staff** | | | | | | **Providers** | **Consumers** | |
| | Home Visits | Direct Observ. by CM or Sup. | ICC/ Sup. Overs. | Contract Monitoring | Analysis of HOMIS/ other statistics | Rec Rev | Incident Reports | Survey | Appeals or Compl. |
| ***CONSUMER ACCESS*** | | | | | | | | | |
| Information & referral process | O | O | O | | √ | O | | √ | |
| Intake & eligibility determination process (user-friendly and understandable) | | O | | | O | √ | | O | |
| Referral to community resources | O | | √ | | O | √ | | O | |
| Individual choice of HCBS and NF | | | O | | O | O | | | |
| Prompt Service Initiation | O | | O | O | √ | √ | O | O | O |
| ***PERSON CENTERED SERVICE PLANNING AND DELIVERY*** | | | | | | | | | |
| Comprehensive re/assessments | | | √ | | √ | √ | | | |
| Comprehensive and responsive service plans *(all of client's needs,* | √ | | √ | | O | √ | | | |

| **CMS Focus Areas & Desired Outcomes** | **Discovery Methods** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **ASAP Staff** | | | | | | **Providers** | **Consumers** | |
| | Home Visits | Direct Observ. by CM or Sup. | ICC/ Sup. Overs. | Contract Monitoring | Analysis of HOMIS/ other statistics | Rec Rev | Incident Reports | Survey | Appeals or Compl. |
| *personal goals, and preferences)* | | | | | | | | | |
| Free choice of providers and service options | | O | | O | | | | | |
| Service provision in accordance to service plans | √ | √ | √ | √ | √ | √ | O | √ | |
| ***PROVIDER CAPACITY AND CAPABILITIES*** | | | | | | | | | |
| Provider availability, qualifications, and performance | √ | √ | O | √ | O | O | √ | √ | |
| ***CONSUMER SAFEGUARDS*** | | | | | | | | | |
| Assessments of client health risk and safety considerations and appropriate interventions | | | √ | | | √ | O | | |
| Critical incident management | | | O | | | | √ | | |
| Safety and security of housing and environment is assessed and modifications are offered | | | √ | | | √ | O | | |
| Medication management | √ | | √ | | | O | O | | |
| Safeguards for natural disasters and other public emergencies, including inclement | | | O | | O | O | | | |

| **CMS Focus Areas & Desired Outcomes** | **Discovery Methods** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **ASAP Staff** | | | | | | **Providers** | **Consumers** | |
| | Home Visits | Direct Observ. by CM or Sup. | ICC/ Sup. Overs. | Contract Monitoring | Analysis of HOMIS/ other statistics | Rec Rev | Incident Reports | Survey | Appeals or Compl. |
| weather. | | | | | | | | | |
| ***CONSUMER RIGHTS AND RESPONSIBILITIES*** | | | | | | | | | |
| Participant decision-making authority training and support | | | | | | O | | | |
| Medicaid due process rights information and support | | | | | | O | | | |
| Grievance registration process information and support and timely resolution of grievances | | | | | | O | | | |
| ***Consumer Outcomes and Satisfaction*** | | | | | | | | | |
| Satisfaction with their services and supports | √ | √ | | | | O | O | √ | O |
| Services and supports lead to positive outcomes | √ | O | O | | √ | √ | | O | |
| ***System Performance*** | | | | | | | | | |
| Cultural competency of HCBS system | | | O | | O | | O | O | |
| Client and stakeholder involvement in program design, performance appraisal, and quality improvement activities | | | | | | | | | |

Source: ASAP Inventory Survey Responses

## Appendix G: Implementation Considerations for the Initial Slate of Measures

As discussed in the report, there are a number of general implementation considerations. In order to collect consistent data across ASAPs, there is a need to define the following:

- Population and/or sample: Who is eligible to be in the denominator? Is the measure only for Waiver clients or for Waiver and Home Care clients?
- Measurement period: What is the time period being reviewed?

There is a need for further refinement and specification of the measure itself such that data are collected appropriately and consistently. All terms within each measure should be clearly defined. Other implementation considerations and issues are suggested in the table below.

| Domain | Measures | Implementation Considerations |
|---|---|---|
| **Participant Access**:<br><br>Information and Referral | • % of individuals requesting information (current clients and elders/ families/ community members) who are provided information that is consistent with the type of information they requested | • Types of information may be defined to allow for easier data collection. Then for each individual, a checklist of request versus provided information could be developed.<br>• However, it may be important to keep in mind that what people request and what they end up needing is often unconnected. |
| **Participant Access:**<br><br>User-Friendly Processes | • % of intake/assessment clients whose assessment is conducted, translated or facilitated in their primary language | • See Table 9. Possible Specification Information for Measure.<br>• Some clarity is needed about the population: are intake clients and assessment clients two separate populations? If so, it might be easier to create two separate measures.<br>• Is English as a primary language documented or is primary language most often only documented for non-English speakers? In the second case, missing data may be difficult to interpret and guidelines need to be developed to consistently handle this occurrence. |
| **Participant Access**:<br><br>Individual Choice | • % of recipients of HCBS waiver services who have in their record a signed "Recipient Choice Form" in English at a reading level no higher than 6th grade | • Reading level will need to be addressed and measured. |
| **Participant Access**:<br><br>Prompt Initiation of | • % of applicants whose eligibility for Medicaid Waiver have been assessed within 10 business days of their identified | • Definitions and guidelines are needed for exactly when to begin the 10 business day count and what constitutes their identified need. These guidelines could simply follow current ASAP/Elder Affairs practice. |

| Domain | Measures | Implementation Considerations |
|---|---|---|
| Service | need | • A flow chart with exact ideal times between events would be helpful with all timeliness measures. |
| **Person-centered planning and delivery:**<br><br>Assessments/ Level of Care Evaluations | • % of Comprehensive Data Set assessments and re-assessments that are completed within timelines as determined by EOEA standards | • If an individual can have both an assessment and a re-assessment during the same measurement period, then make this two separate measures.<br>• Review tool for exact language if there is a need to be more descriptive.<br>• The CDS tool may need to go through further field-testing to determine if it is the right tool for assessments.<br>• The MassHealth clinical team could provide valuable input with this measure. |
| **Person-centered planning and delivery:**<br><br>Free Choice of Providers | • % of clients who received information on their right to choice in relation to service options and individual workers | • Specification related to exactly how clients receive information is needed. |
| **Person-centered planning and delivery:**<br><br>Service Plan | • % of clients' unmet ADL/IADL needs, identified in the assessments, that are addressed within six months | • Guidelines must specify the definition for unmet need and what is acceptable proof that an unmet need was addressed.<br>• One possible data collection option is to create a list unmet needs, with a column for "yes" or "no" as to "addressed within 6 months."; If the answer is "no," then there could be a comments section for "why not". |
| **Person-centered planning and delivery:**<br><br>Ongoing Service and Support Coordination/ Ongoing and Effective Monitoring | • % of service plans that are modified to reflect a change in functional status or informal support as identified in a re-assessment | • The denominator should be specified as number of persons with changes in functional status or informal support.<br>• Guidelines should address the documentation required for this measure. |
| **Person-centered planning and delivery:**<br><br>Service Provision | • % of clients who receive:<br>o type of service<br>o unit of service<br>o duration of service<br>o frequency of service<br>from provider as outlined in service plan | • These should be broken down into four separate measures.<br>• One possibility is to use the existing financial reporting measures. |
| **Provider capacity and capabilities:**<br><br>Provider Qualifications/ | • % of ASAPs whose staff meet provider qualification standards | • Very detailed provider qualification statements are necessary to ensure that this measure is adequate.<br>• Other reporting decisions should be considered including whether or |

| Domain | Measures | Implementation Considerations |
|---|---|---|
| Provider Performance | <br><br><br><br><br>• % of providers with deficiencies whose corrective action plans address these deficiencies | not data would be provided, for each ASAP, on what % of staff were below standard.<br>• To facilitate review, one possible data collection tool is to create a list of the standards for each type of provider and a “met” and “unmet” column.<br><br>• Guidelines should address how decisions about whether plans address deficiencies are made.<br>• Decisions should also address which providers are being evaluated (ASAPs and/or direct care providers). |
| **Provider capacity and capabilities:**<br><br>Provider Networks and Availability | • % of clients who received service in accordance with their service plans | • Definitions and decisions are necessary around whether this is a yes/no measure or a measure about how much (%) service clients receive and also around how to ensure that this measure provides data about provider availability (for example, data could be collected on the reasons that clients do not receive service). |
| **Safeguards:**<br><br>Risk and Safety Planning/<br>Natural Disasters and other Public Emergencies | • % of clients who received information on safeguarding their health and welfare in case of natural disasters and other public emergencies | • Specification related to exactly how clients receive information is needed.<br>• Clarification on the type and nature of the information may be needed. |
| **Safeguards:**<br><br>Critical Incident management | • % of reports of critical incidents which are addressed appropriately | • Definitions and specifications are needed for “critical incidents” and “appropriateness.” One suggestion is to follow CMS guidelines related to critical incidents. |
| **Safeguards:**<br><br>Housing and Environment | • % of clients assessed for housing environment safety | • Guidelines about proper documentation of assessment(s) are necessary. |
| **Safeguards:**<br><br>Medication Management | • % of clients identified as needing medication management whose service plan addresses medication management supports | • Further refinement is needed:<br>• Two primary questions are: 1) What are the criteria for "needing" medication management? and 2) What constitutes "medication management supports"?<br>• Further clarification is also needed as to what extent medication management is a home care service. |
| **Rights and Responsibilities:** | • % of clients who received information | • Specification related to exactly how clients receive information is |

| Domain | Measures | Implementation Considerations |
|---|---|---|
| Civic and Human Rights | on civic and human rights | needed. |
| **Rights and Responsibilities:**<br><br>Medicaid Due Process | • % of clients given Appeals information at initial screening and Request for Fair Hearing Information with waiver eligibility notification | • This may actually be two separate measures.<br>• Specification related to exactly how clients receive information is needed. |
| **Rights and responsibilities:**<br><br>Timely Grievance Resolution | • % of grievances showing evidence of appropriate resolution process follow-through and outcomes | • This may be two separate measures: one on follow-through and one on outcomes.<br>• Specification is needed around the evidence of appropriateness. |
| **Participant Satisfaction and Outcomes:**<br><br>Satisfaction | • Annual client survey response rate | • The number of clients who are sent surveys and the number of clients responding to surveys should be presented. |
| **Participant Satisfaction and Outcomes:**<br><br>Outcomes | • Average duration of time receiving waiver services | • A flow chart representing events (hospitalizations, nursing home admission) involved with receiving and then not receiving waiver services will be useful to ensure that data are collected for the correct periods of time |
| **System Performance:**<br><br>Participant and Stakeholder Involvement in Quality Improvement | • % of ASAPs that have quality improvement action plans that address issues identified through stakeholder feedback | • Guidelines must be established to ensure that criteria are applied consistently with regards to who are stakeholders, what is feedback, and how the plan addresses issues measured.<br>• Perhaps Elder Affairs should suggest some standard way it wants ASAPs to gather “stakeholder feedback” on quality improvement plans. |
| **System Performance:**<br><br>Financial Integrity | • % of waiver clients’ claims that are coded correctly and paid in accordance with waiver reimbursement methodology | • Specification about how to determine whether the coding is correct should be given.<br>• This may be two separate measures. |
| **System Performance:**<br><br>System Performance Appraisal via Systematic Data Collection & Analysis Systematic Approach to | • % of ASAPs that have a current annual plan to address quality improvement based on slate of measures | • Decisions about how to measure ASAPs with regards to addressing some, but not all, measures in a plan must be made. One possibility is to categorize ASAPs in the following way: % of ASAPs that have a plan; % that have a plan but not fully compliant; and for those not fully compliant, % of measures addressed in the plan. |

| Domain | Measures | Implementation Considerations |
|---|---|---|
| Quality Improvement | | |
| **System Performance:**<br><br>Cultural Competency | • % of ASAPs that have a written plan, including a Quality Improvement Plan, policies and procedures, and training in place to address any cultural, linguistic, and/or other accessibility barriers | • One consideration is whether this measure can be partially met (e.g., what if an ASAP has a plan and policies and procedures, but no training?). |

## Appendix H: Recommendations for Additional/Potential Outcomes and Measures

These are recommendations from the Center for Health Policy and Research about additional quality measures that could be incorporated into the quality management system. These measures include measures related to participant-reported outcomes and satisfaction and other measures that were deferred during the process of developing consensus on the initial slate. They highlight potential areas for further development. The measures can build upon those developed by the workgroup and thus provide an even stronger foundation for future quality measurement and improvement.

Analysis and selection of these measures by the implementation workgroup is warranted and encouraged to explore the feasibility of data collection. It will be necessary for selected measures to go through the same suggested pilot-testing process, including the creation of definitions and specifications, to address implementation considerations. Additional considerations involve the identification of data sources for these and any other measures; data sources may include MassHealth data and Medicare claims data.

| Domain | Outcome | Measures[20] |
|---|---|---|
| **Participant Access**: Information and Referral | • Individuals and families can readily obtain information concerning the availability of HCBS, how to apply and, if desired, are offered a referral. | • % of families/consumers who reported that they receive the information as quickly as they had needed<br>• Number of calendar days for ASAP to complete information request (average, range and median) |
| **Participant Access:** User-friendly Processes | • Intake and eligibility determination processes are understandable and user-friendly to individuals and families and there is assistance availability in applying for HCBS. | • % of families/consumers who report that they understood intake and eligibility determination processes for services<br>• % of individuals requesting assistance with the process of applying for HCBS services during intake and eligibility determination processes who receive such assistance |

[20] Sources, where appropriate, are in parentheses: NCI= National Core Indicators; Maine= Maine Long-Term Care Consumer Satisfaction Survey; Muskie= Muskie School of Public Service, Community Living Exchange Collaborative (2005); HCSM= Home Care Satisfaction Measure. National Core Indicators, Maine Long-Term Care Consumer Satisfaction Survey and Home Care Satisfaction Measure from the Home & Community Based Services & Supports Quality Indicator Database (University of Southern Maine Muskie School of Public Service, n.d.).

| Domain | Outcome | Measures[20] |
|---|---|---|
| | • Intake and eligibility process is conducted in a timely manner. | • % of families/consumers who reported that the intake and service eligibility processes were conducted promptly<br>• Number of calendar days between intake to service eligibility determination (average, range and median) |
| **Participant Access:** Referral to Community Resources | • Individuals who need services but are not eligible for HCBS are linked to other community resources. | • % of individuals not eligible for waiver services who are referred to other available resources for which they may be eligible |
| **Participant Access**: Individual choice | • Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional services. | • % of applicants who report that they received enough information to allow them to make a choice between HCBS and institutional services |
| **Participant Access**: Prompt initiation of service | • Services are initiated promptly when the individual is determined eligible and selects HCBS. | • Number of calendar days between service eligibility determination and service initiation (average, range and median) |
| **Person-centered planning and delivery:** Assessments/ Level of care evaluations | • Comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan. | • % of clients whose assessment contains information about:<br>o Preferences<br>o Personal goals<br>o Needs and abilities<br>o Health status<br>o Level of informal caregiver support |
| | • Assessment is conducted in a timely manner. | • Number of days between intake (initial contact) and assessment completion (average, range and median) |
| **Person-centered planning and delivery:** Participant Decision-Making | • Information and support is available to help participants make informed selections among service options. | • % of clients who report that they were given information that was useful in selecting service options and providers |
| **Person-centered planning and delivery:** Free Choice of Providers | • Information and support is available to assist participants to freely choose among qualified providers. | • % of clients wanting a choice in providers who report that they were able to choose among providers<br>• % of clients requesting a change in providers who were given assistance to change providers<br>• % of clients requesting a change in providers whose request was granted |
| **Person-centered planning and delivery:** | • Each participant's plan comprehensively addresses his or her identified need for HCBS, | • % of clients who report that their plan includes or reflects things that are important to them *(NCI)* |

| Domain | Outcome | Measures[20] |
|---|---|---|
| Service Plan | health care and other services in accordance with his or her expressed personal preferences and goals. | |
| **Person-centered planning and delivery:** Participant direction | • Participants have the authority and are supported to direct and manage their own services to the extent they wish. | • % of clients who were provided with the option to direct and manage their own services |
| **Person-centered planning and delivery:** Ongoing service and support coordination | • Participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living. | • % of clients who report that on the whole, their case manager does a good job setting up services and supports for them *(HCSM)*<br>• % of clients who report that it would be a waste of time to call their case manager if they had a problem *(HCSM)* |
| **Person-centered planning and delivery:** Service provision | • Services are furnished in accordance with the participant's plan. | • % of clients who received less services than in plan *(Muskie)* |
| **Person-centered planning and delivery:** Ongoing and effective monitoring | • Regular, systematic and objective methods – including obtaining the participant's feedback – are used to monitor the individual's well-being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals. | • % of clients who report that they were asked, at least once a year, about how their services are meeting their goals |
| **Person-centered planning and delivery:** Responsiveness to Changing Needs | • Significant changes in the participant's needs or circumstances promptly trigger consideration of modifications in his or her plan. | • % of clients who report that their services/supports changed as needs changed *(Muskie)* |
| **Provider capacity and capabilities:** Provider qualifications | • All HCBS agency and individual providers possess the requisite skills, competencies and qualifications to support participants effectively. | • % of clients who report that staff were knowledgeable about needs<br>• % of clients who report that staff had necessary skills to meet needs |
| **Provider capacity and capabilities:** Provider Performance | • Clients are supported effectively by competent and qualified providers. (same outcome as in initial slate) | • % of clients who report that worker does not show up *(Muskie)*<br>• % of clients who report that most staff treat them with respect *(NCI)* |
| **Provider capacity and capabilities:** Provider Networks | • There are sufficient providers to meet service needs. (same outcome as in initial slate) | • % of clients who report that they are getting all the hours in their plan (*Maine)*<br>• % of clients who report that "needed" services are not available |

| Domain | Outcome | Measures[20] |
|---|---|---|
| and Availability | | *(NCI)*<br>• Vacancy rate (proportion of direct service provider positions that were vacant as of a specified date) *(Maine)* |
| **Participant Safeguards:** Risk and Safety Planning | • Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant. | • % of clients whose assessment contains information about risks and safety<br>• % of service plans that include services that address risk and safety needs as identified in assessments |
| **Participant Safeguards:** Critical incident management | • There are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations. | • % of ASAPs with written policies addressing critical incidents and other life-endangering situations<br>• Mortality rate |
| **Participant Safeguards:** Housing and Environment | • The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home. | • % of clients who report that they feel safe in their homes |
| **Participant Safeguards:** Restrictive Interventions | • Restrictive interventions – including chemical and physical restraints – are only used as a last resort and subject to rigorous oversight. | • % of ASAPs with a policy related to restrictive interventions |
| **Participant Safeguards:** Medication Management | • Medications are managed effectively and appropriately. | • % of clients who report that they are able to manage their medicines effectively<br>• Number of reported adverse medication events |
| **Participant Safeguards:** Natural Disasters and other public emergencies | • There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies. | • % of clients with documented service back-up plans in place |
| **Participant Rights and Responsibilities:** Civic and Human Rights | • Participants are informed of and supported to freely exercise their fundamental and federal or state statutory rights. | • % of clients who report that they were given information about their rights |
| **Participant Rights and Responsibilities:** Participant Decision Making | • Participants receive training and support to exercise and maintain their own decision-making authority. | • % of clients who report that they make their own decisions about services and supports to the extent they want |

| Domain | Outcome | Measures[20] |
|---|---|---|
| Authority | | |
| **Participant Rights and Responsibilities:** Medicaid Due Process | • Participants are informed of and supported to freely exercise their Medicaid due process rights. | • % of clients who report that they were given information about their Medicaid due process rights<br>• % of clients requesting assistance related to their Medicaid due process rights who receive assistance<br>• Number and % of Medicaid due process appeals |
| **Rights and Responsibilities:** Grievances | • Participants are informed of how to register grievances and complaints and supported in seeking their resolution. | • % of clients who report that they know what to do to register a grievance or complaint<br>• % of clients who are satisfied with the grievance/complaint process |
| | • Grievances and complaints are resolved in a timely fashion. | • Number of calendar days between grievance/complaint filing and follow up with individual registering grievance/complaint (average, range and median)<br>• Number of calendar days between grievance/complaint filing and resolution (resolution may not mean resolution in favor of individual) (average, range and median) |
| **Participant Satisfaction and Outcomes** Satisfaction | • Participants and family members, as appropriate, express satisfaction with their services and supports. | • % of clients who report being satisfied with their services and supports |
| **Participant Satisfaction and Outcomes** Outcomes | • Services and supports prevent or delay nursing home placement. (same outcome as in initial slate) | • % of clients who report that they believe HCBS services and supports are the main reason they are not in a nursing home<br>• % of individuals screened through CSSM (Comprehensive Services and Screening Model) who are in the community at 6 months |
| **System Performance** Participant and Stakeholder Involvement | • Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities. | • % of ASAPs with consumers participating in quality improvement activities (quality improvement teams, quality councils, advisory boards) |
| **System Performance:** Financial integrity | • Financial accountability is assured and payments are made promptly in accordance with program requirements.<br>• The most cost effective and appropriate health and homecare services are provided | • % of clients whose services provided are equal to services authorized |
| **System Performance:** System Performance | • ASAPs conduct systematic and continuous data collection and analysis on their services and system. | • % of ASAPs who collect and analyze data on specified quality measures |

| Domain | Outcome | Measures[20] |
|---|---|---|
| Appraisal | | |
| **System Performance:** Quality Improvement | • There is a systemic approach to the continuous improvement of quality in the provision of HCBS. | • % of ASAPs that have a plan to address quality improvement areas as identified through quality measures.<br>• % of ASAP-identified quality issues with evidence of improvement within one year<br>• % of ASAPs that update the quality improvement plan annually |
| **System Performance**: Cultural Competency | • The HCBS system effectively supports participants of diverse cultural and ethnic backgrounds. | • % of clients who report that staff or translators are available to provide information, services and supports in their primary language or method of communication *(NCI)*<br>• % of clients who report that providers are sensitive to and respectful of their culture |

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