

# **Quality Indicators for Home and Community-Based Services**

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## ■ Acknowledgements

Many people contributed much time and effort to this project. Members of the Maine Quality Technical Advisory Group (Quality TAG) met quarterly for three years and patiently and conscientiously learned about the many ways to define and measure quality for people receiving home and community-based services. Representatives from the HCBS Waiver programs and advocacy and consumer groups participated in the full Advisory Group meetings, as well as sub-group meetings, where the various quality measures were discussed, debated, revised, edited and finally selected for inclusion in this set of core quality measures. This work required patience, attention to detail and mutual respect for the variety of interests and perspectives represented in the group.

This work was also conducted at a time when there were many competing demands on department staff time. Staff from four Bureaus (representing three different Departments)<sup>1</sup> came together to participate in a number of meetings to review, comment and debate the inclusion or exclusion of these measures in a core set of indicators. Their continued commitment to the work and the goals of the project greatly contributed to the final product of this project.

Finally, we would like to acknowledge and thank Stuart Bratesman, Policy Analyst, Muskie School of Public Service, for his assistance in maintaining an exhaustive database of possible quality measures for consideration by the Quality TAG and its subcommittees. This database provided an invaluable tool for sorting quality measures according to the CMS Quality Framework and by Department.

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<sup>1</sup> The Departments represented included the Department of Behavioral and Developmental Disabilities (responsible for the MR/DD Waiver); the Department of Labor (responsible for the Consumer-Directed Waiver for Physically Disabled); and within the Department of Human Services, the Bureau of Elder and Adult Services (responsible for Older Adults and Adults with Disabilities Waiver), and the Bureau of Medical Services (the Medicaid operating agency). As of August 1, 2004, the Department of Human Services and the Department of Behavioral and Developmental Services merged into a single agency, called the Department of Health and Human Services.

## ■ Executive Summary

In 2001, the Maine Department of Human Services received a three year grant from the U.S. Department of Health and Human Service to improve services for people with disabilities. This grant was part of the Real Choice Systems Change Initiative funded by the Centers for Medicare & Medicaid. The grant funded work in four major areas: Person-centered services, Quality, Access, and Data Integration.

The goal of the *Quality* component of the Real Systems Change grant was to identify and/or develop a set of core quality indicators for home and community-based services across program areas. These core indicators provide a way for consumers, policy makers and other stakeholders to routinely and systematically assess the overall performance of the home and community-based service (HCBS) system and in particular the outcomes and satisfaction of people served by the HCBS Waiver Programs. The core measures are intended to provide a “high level” view of the quality of services and supports provided that will be helpful in identifying priority areas for quality improvement, will assess progress in meeting program goals and inform policy decisions.

Over the course of the project, these core quality measures have been called “dashboard” indicators. Like the lights on a car dashboard, they are intended to provide an easy and quick way to see how well the home and community-based service system is performing. They are not intended to replace or substitute for a more complete set of measures that any one program area may use to monitor and evaluate in more detail the workings of a particular program or service system. Instead they provide a way to take the pulse of the home and community-based services system and point to areas where further focus or improvement may be needed.

A Quality Technical Advisory Committee (Quality TAG) was formed to provide advice and guidance on the selection of a set of core quality indicators. Members of the Quality TAG included representatives of consumers, advocacy organizations, providers, other stakeholders, and department staff responsible for the administration of HCBS Waivers. Indicators were selected that could be used across programs and that were considered “very important” areas of quality of care or quality of life.

This report includes a final list of recommended “dashboard” indicators for use in assessing the quality of HCBS Waiver services. The indicators are organized according to the HCBS Quality Framework, a document developed by the Centers for Medicare & Medicaid (CMS), to provide a common frame of reference for conducting a “productive dialogue among all parties who have a stake in the quality of the services and supports provided to older people and people with disabilities.”<sup>2</sup>

The report includes recommendations for implementing the “dashboard” indicators, lessons learned throughout the project and a plan for sustaining the work of this grant.

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<sup>2</sup> This Framework includes seven areas of focus including: Participant Access, Participant-Centered Service Planning and Delivery, Provider Capacity and Capabilities, Participant Safeguards, Participant Rights and Responsibilities, Participant Outcomes and Satisfaction and System Performance.

## ■ Background

In 2001, the Maine Department of Human Services received a three year grant from the U.S. Department of Health and Human Service to improve services for people with disabilities. This grant was part of the Real Choice Systems Change Initiative funded by the Centers for Medicare & Medicaid. Called Quality Choices in Maine, the goals of the grant were to:

- make services and supports more consumer centered by incorporating greater choice and control for consumers in the system;
- ensure the quality of Maine's community-based living options by building community relevant quality management structures that incorporate the consumer perspective;
- focus attention on services and supports identified as weak links in the system; and
- facilitate inter-departmental collaboration by developing integrated data capacity

The grant funded work in four major areas:

- Person Centered Services
- Quality
- Access
- Data Integration

This report focuses on the work related to Quality and specifically the development of quality indicators for home and community-based services. The report includes recommendations for implementing a set of quality measures across program areas, lessons learned throughout the project and a plan for sustaining the work of this grant.

## ■ Goals

One of the overall goals of the Quality Choices grant was to improve the quality of care and services for people receiving home and community-based services and in particular to ensure that the consumer voice and perspective was included in assessing and monitoring quality. As stated in the original grant proposal, the quality indicators were to:

- consider the goals, preferences and choices of consumers including their satisfaction and experiences with services and supports;
- consider the health and welfare of consumers, access to services, and the outcomes of care and services; and
- provide a way to report on overall system performance.

In Maine, home and community-based services are provided to people with many different types and levels of disability and need. Services are administered, provided or financed by a number of different departments. Up until July 2004, these departments included the Department of Behavioral and Developmental Services, the Department of Labor, and the Department of Human Services.

The Department of Behavioral and Developmental Services administers programs for people with mental retardation and developmental disabilities (MR/DD), people with mental illness, and children with special needs. The Bureau of Elder/Adult Services, within Department of Human Services, administers home and community-based programs for older adults and adults with physical disabilities and administers the state Maine Care (Medicaid) program. The Department of Labor administers programs for adults with physical disabilities who self-direct their services.

As of July 2004, a number of changes were implemented in the administration of the home and community-based services. Most notably, as of July 1, 2004, the Departments of Human Services and the Departments of Behavioral and Developmental Services merged into a single agency, called the Department of Health and Human Services (DHHS). In addition, as of August 1, 2004, responsibility for the administration of the HCBS consumer directed waiver for people with disabilities was moved from the Department of Labor to the Bureau of Elder and Adult Services within DHHS.

The goal of this project was to identify and/or develop a set of core quality indicators for home and community-based services across program areas. These core indicators provide a way for consumers, policy makers and other stakeholders to routinely and systematically assess the overall performance of the home and community-based service system. The core indicators are intended to provide a “high level” view of the quality of services and supports provided that will be helpful in identifying priority areas for quality improvement, will assess progress in meeting program goals and provide information to inform policy decisions.

Over the course of the project, these core quality measures have been called “dashboard” indicators. Like the lights on a car dashboard, they are intended to provide an easy and quick way to see how well the home and community-based service system is performing. They are not intended to replace or substitute for a more complete set of measures that any one program area may use to monitor and evaluate in more detail the workings of a particular program or service system. Instead they provide a way to take the pulse of the home and community-based services system and point to areas where further focus or improvement may be needed.



# Quality Technical Advisory Group

## Membership and Composition

In January 2002, a Quality Technical Advisory Group (Quality TAG) was formed to provide advice and guidance on the development and selection of quality indicators for home and community-based services. Members of the Quality TAG were identified and recruited from a number of consumer, advocacy, and stakeholder groups. These included representatives from the following groups:

- Consumers
- Advocacy Organizations
- Providers
- Other Stakeholders
- Agencies and Departments responsible for home and community-based services

Staff from the Muskie School of Public Service at the University of Southern Maine provided ongoing support to the Quality TAG and maintained an extensive database of quality indicators for HCBS services. Staff from the Center for Community Inclusion at the University of Maine in Orono conducted focus groups and participated on the Quality TAG. A complete list of the members of the Quality TAG is included in Appendix A.

A number of members of the Quality TAG were also members of the Workgroup for Community-based Living.<sup>3</sup> This provided a way to promote communication between the work of the Quality TAG and the Community Living Workgroup. In addition, staff from the Muskie School were present at all the TAG meetings and the meetings of the Community Living Workgroup.

The membership of the Quality TAG has included a group of core members who have attended the meetings regularly and have remained interested and informed of the project activities. At the same time, a number of the original members of the Quality TAG have attended meetings less frequently or have not been able to continue to participate on the TAG. This has created some imbalances in the ongoing composition and mix of views represented on the TAG.

For the first two years of the Quality TAG, project staff chaired the Quality Workgroup. In January of the 2004, the Workgroup decided to select a chair of the TAG from its membership. In January 2004, Stephanie Crystal Wolfstone-Francis, a consumer member, was selected chair on a rotating basis.

In addition, in January 2004 the Quality TAG developed a more formal statement of mission. This was prompted in part by the new award of a second Real Choice Systems Grant to Maine to

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<sup>3</sup> The Workgroup for Community-Based Living was formed to develop a coherent plan, across departments and programs, to make certain that the State is providing services to people with disabilities in the most integrated setting appropriate to the needs and preferences of each individual. It includes members who represent all affected by disability. It includes state representatives from five departments that provide services to people with disabilities.

develop quality management structures for home and community-based services. The mission statement of the Quality TAG is included as Appendix B.

## **Roles and Responsibilities of Quality TAG members**

The Quality TAG met on a quarterly basis beginning in January 2002. Meeting materials were prepared and sent out at least one week in advance. Subcommittees of the Quality TAG also met on an as needed basis as particular issues arose. In addition to providing ongoing feedback, advice and consultation on project activities, the members of the Quality TAG have also:

- participated in and co-facilitated focus groups to identify important areas to be covered by the quality indicators;
- attended subcommittee meetings to select and prioritize cross-program quality indicators; and
- for a subset of members, participated on the Community Living Workgroup.

## **Selection of Quality Indicators**

In order to select and develop a set of core measures that could be used across HCBS program areas, the Quality TAG and staff conducted the following activities:

- Identified areas of focus or domains for defining important areas of HCBS quality
- Conducted an inventory of measures
- Selected a subset of measures
- Identified the target groups for the quality measures
- Identified gaps in available measures
- Developed a new version of the Participant Experience Survey for Consumer Direction
- Developed a final set of “dashboard” indicators

A summary of the timeline followed by the Quality TAG in conducting these activities is included in Appendix C. Each of these steps is discussed in more detail below.

## **Identify Areas of Focus**

The first step in the selection of a set of quality indicators was to identify the major areas of focus or domains of quality that should be covered by a set of core measures. Domains provide a conceptual framework for organizing quality measures. They also provide a way to assure that a set of quality measures are balanced and are representative of the areas of quality that are considered important by stakeholders.

In order to identify the major themes of quality that were important to the various stakeholder groups, the Center for Community Inclusion at the University of Maine in Orono conducted seven focus groups with consumers, policy makers and providers. The focus groups were conducted with:

- individuals over the age of 18 who receive MR/DD services;
- individuals over the age of 18 who receive mental health services;
- individuals over the age of 18 who receive independent living services;
- parents of children with disabilities who are receiving long term care services;
- elders receiving long term care services;
- providers of long term care services; and
- policy makers.

A participatory research design, in which university and lay investigators collaborated to obtain data, was used. Focus groups were conducted using a semi-structured approach. The focus groups were facilitated by two participants – a university project staff and a lay researcher that represented the interest group. All groups were asked to respond to the same set of questions. These questions were:

- How do participants define the quality of services they receive at home and in the community?
- How do services that people receive at home and in the community contribute to their quality of life?
- How can the services be improved?
- How can their quality of life be improved?

The findings from these focus groups were outlined in a report entitled: “Perspectives on Quality: How Long Term Care Users in Maine Define Quality Services”. The themes that were identified from the focus groups are included in Attachment D. These themes were used initially to categorize and organize a list of possible quality indicators.

These themes were very similar to but not exactly the same as the areas of focus that CMS identified in its HCBS Quality Framework that was released in draft form in the summer of 2002. The HCBS Framework provides “a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities.” The Framework focuses attention on participant-centered desired outcomes along seven dimensions. These areas and outcomes are as follows:

<b>Focus</b>	<b>Desired Outcome</b>
<b>Participant Access</b>	<i>Individuals have access to home and community-based services and supports in their communities.</i>
<b>Participant-Centered Service Planning and Delivery</b>	<i>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.</i>
<b>Provider Capacity and Capabilities</b>	<i>There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.</i>
<b>Participant Safeguards</b>	<i>Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.</i>
<b>Participant Rights and Responsibilities</b>	<i>Participants receive support to exercise their rights and in accepting personal responsibilities.</i>
<b>Participant Outcomes and Satisfaction</b>	<i>Participants are satisfied with their services and achieve desired outcomes.</i>
<b>System Performance</b>	<i>The system supports participants efficiently and effectively and constantly strives to improve quality.</i>

By the end of 2003, the HCBS Quality Framework had been updated and widely distributed to states. It was also becoming clear that CMS was using the HCBS Quality Framework to define and operationalize the quality management and quality improvement activities of state home and community-based waiver programs.

In January of 2004, the Quality TAG decided to adopt the HCBS Quality Framework and the areas of focus in the framework as the method of organizing and categorizing a set of core quality indicators for use in home and community-based services. (See Appendix E for a copy of the HCBS Quality Framework).

## **Conduct Inventory of Measures**

Once the major themes from the focus groups and the EMS Framework were identified, project staff researched, organized and created a database of over 500 quality measures that were currently in use in Maine and elsewhere. These included measures from consumer surveys, provider surveys, administrative and claims data, assessment data and measures used in managed care. The measures that are most commonly used in home and community-based services were included in a website that sorts the indicators by target group, CMS domain and developer. A database was also created that included all the measures. (See <http://qualitychoices.muskie.usm.maine.edu/qualityindicators/index.htm>.)

## **Select Measures**

In the spring and summer of 2003, the Quality TAG and a subcommittee of the Quality TAG met to review and prioritize possible quality measures. Project staff also interviewed staff from the various departments that administer home and community-based services to identify existing survey instruments, quality measures and other administrative data.

Project staff prepared a report that included a comprehensive list of possible quality indicators. The Quality TAG members were asked to rate possible quality indicators using two criteria:

- 1) the indicator was considered “very important”
- 2) the indicator could be used as a “cross program” measure.

In defining whether the indicator was important, the Quality TAG considered the following questions:

- Are people concerned about this area?
- Is it valuable in assessing a person’s quality of life?
- Is it valuable in assessing the quality of services and supports provided?
- Is it a meaningful way to assess the overall performance of the home and community-based care system?

After the Quality TAG rated the possible quality indicators, the list of possible indicators was reduced from over 500 possible indicators to 60 indicators. This list was further evaluated using the CMS Framework. In those areas, where no indicator had been identified using the above criteria, additional measures were added to the list of core measures to assure that there was at least one indicator in each focus area from the HCBS Quality Framework. The final set of recommended quality indicators includes at least one indicator for each of the focus areas in the HCBS Quality Framework.

## **Identify Target Groups**

In the course of reviewing the hundreds of possible quality measures, it became apparent that it would be necessary to define and limit the number and scope of the groups for which common quality measures would be identified. The possible target groups included adults with physical disabilities (including people receiving state funded HCBS services, Medicaid funded HCBS services and waiver services); adults with physical disabilities who self-direct services (including Medicaid and state funded services); people with mental illness, adults with MR/DD (served by a waiver and not served by a waiver program); children with MR/DD, autism or other special needs; people who are blind or deaf, people with brain injury. The task of identifying common measures for subsets of these groups was proving very challenging and the prospect of identifying common measures for all the groups was unwieldy.

For this reason, it was decided to focus, for the purpose of this project, on the identification of a set of “dashboard” indicators that could be used to monitor HCBS waiver programs.<sup>4</sup> The HCBS Waiver programs provide services to:

- People with mental retardation and developmental disabilities
- Adults with physical disabilities
- Adults with disabilities (over age 65)
- Adults with physical disabilities who self direct services

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<sup>4</sup> HCBS Waiver programs provide services to home and community-based services to people who meet the eligibility requirements for receiving services in an institution.

This does not preclude or diminish the responsibility of each program or department to develop and report on a wider range of quality measures for a broader population group. But in the spirit of starting with a realistic and attainable outcome, the scope of the project was refined. This was also consistent with the increased interest and focus of CMS on the quality of people served by HCBS waiver programs.

### **Identify Gaps in Data**

A number of gaps in the availability of data were identified as part of the inventory of possible measures. These gaps were as follows:

- The Department of Labor had no consumer survey for people with physical disabilities who were self-directing their services.
- A number of measures require linking Medicaid and Medicare data to compute the measures since many people on HCBS waivers are dually eligible for Medicaid and Medicare. A request was made to CMS for the use of Medicare data to construct quality measures for people who are dually eligible and served by the waiver programs.
- Data is generally only available for people who are “in” the system. Information on people who have tried to access services but are unable to get services is not generally available.

### **Develop a New Participant Experience Survey for Consumer Direction**

When the lack of a consumer survey for people with physical disabilities who direct their services was identified, project staff and department staff contacted the Medstat Group to provide assistance with the development of a survey of people with physical disabilities who self-direct their own services. The Medstat Group provides technical assistance to states at no cost under a contract with the Centers for Medicare and Medicaid. The Medstat Group had previously developed the Participant Experience Survey, a consumer satisfaction survey for elders and adults with disabilities and for people with MR/DD. However, no such survey had been developed for people who self direct services.

In the fall of 2003, project staff and department staff entered into an agreement with the Medstat Group to help develop a survey. This survey was pre-tested in the spring of 2004. Three rounds of cognitive interviews were conducted to test the how well consumers understood the questions, whether the survey questions were meaningful, and the length of the survey. A final version of the survey was completed in June 2004. The survey was conducted in the summer of 2004. Results will be available in the fall of 2004.

### **Develop Final Dashboard Indicators**

The final list of “dashboard” indicators for each of the HCBS waiver programs is provided in Appendix F, G, H. Appendix F lists the Dashboard Indicators that are derived from consumer surveys. Appendix G lists that Dashboard Indicators that are developed from Medicaid and/or Medicare claims. Appendix H lists the Dashboard Indicators that the Quality TAG Recommended by developed.

## ■ Challenges

The task of identifying a set of common measures across programs presented a number of challenges.

### **Consumer Surveys**

Each waiver program (Adults with physical disabilities, adults with MR/DD and adults with physical disabilities – consumer directed) has its own consumer survey instrument. The consumer surveys are administered differently, the sample sizes are different and the timeframe for collecting the information varies.

The Bureau of Elder and Adult Services administers two surveys – one to assess consumer satisfaction with the assessment process (as conducted by Gould Health Services) and one to assess consumer satisfaction with care management and other services provided by Elder Independence of Maine. These surveys are mailed to all those who receive either Medicaid funded and/or state funded home and community-based services. While it is possible to identify people who completed the surveys and are on the waivers, it is more difficult to determine whether the sample of people who responded include a representative sample. This survey does not have nationally comparable benchmarks.

The Participant Experience Survey-Consumer Direction, was designed to be conducted as an in-home survey. All the people on the Consumer Directed Waiver program will be asked to participate in this survey.

The National Core Indicator Survey is managed through the Department of Behavioral and Developmental Services. The consumer version of this survey is administered by providers. Each year BDS selects one third of adults receiving MR/DD services and trains providers to conduct the interviews with the consumers. Results are sent to BDS. This survey was developed by the Health Services Research Institute in collaboration with the National Association of State Directors of Developmental Disability Services. National comparison measures are available for comparison with the Maine results.

The original intent of this project was to identify a core set of measures that could be used across program areas. While the CMS Framework of domains provided a way to organize and structure the areas of interest, it was more difficult to select indicators that could be used across program areas. Many of the questions on each instrument are measuring similar themes but do not use the exact language. It is therefore difficult to compare the results of the surveys across program areas. The approach used for this project was to identify questions that were thematically similar even if the wording was not exactly the same. Where a program area did not have a question that captured that “theme”, it is recommended that the program area add or develop a question that is similar to that theme. This may be done by using a question from a survey used by another department.

The final report of measures identifies those measures that are currently used by a program area, those measures that exist and are recommended for adoption by a program area, and those measures that still need to be developed.

## **Medicare-Medicaid Claims Data**

Many of the people served on the HCBS waiver programs are dually eligible for Medicaid and Medicare services. In order to report some of the outcome measures (e.g. cancer screening rates), it is necessary to link Medicare and Medicaid claims data. The use of the Medicaid data alone results in significant under-reporting. The State of Maine has recently received permission to obtain and use the Medicare claims data in order to complete some of the analysis for the core indicators.

## **Recommendations**

The Quality TAG recommends the following:

- The HCBS Quality indicators identified in the appendices be adopted by the respective waiver programs as “dashboard” indicators. These indicators should be reported annually for each program.
- A HCBS Dashboard Indicator report should be made available to key stakeholder groups including senior quality management and program staff, the Quality TAG, the Community Living Workgroup and other constituencies as defined by each of the program areas, the Department and the Workgroup.
- In those instances where an indicator needs to be developed, an inter-program quality improvement plan should be prepared to develop common indicators. The plan would include a timeframe for developing the indicators and for data collection and analysis.
- Develop a way to measure or collect information from people who attempt to access services and are unable to do so because they are ineligible because services are not available or for other reasons.
- Develop or identify dashboard indicators for populations not considered part of the scope of the Quality TAG. This includes children, people with mental illness, people with substance abuse conditions, people who are blind or deaf.



## ■ Lessons Learned

### Quality TAG

The Quality TAG was formed at the same time that many other Technical Advisory Groups were being formed for the other components of the Systems Change Project. At the beginning of the project, the focus was on recruiting members and initiating the activities of the grant. Over the course of the project, the membership of the Quality TAG remained relatively stable although the participation of members in quarterly meetings varied. At the beginning of the third year of the project, a mission statement was developed for the Quality TAG and the scope, structure and functions of the TAG were clarified.

Some of the challenges faced by the Quality TAG have been reported on and articulated in the Road Map for Change: Maine's Response to the Olmstead Decision. These challenges include sustaining consumer involvement and consistently engaging state staff in the process. Consumer involvement is process and time intensive and requires an investment in educating consumers, being educated by consumers and building relationships. Engaging dedicated staff for collaboration often means finding time within very busy workloads and competing priorities. Some of the lessons learned from this project are:

- clarify the roles, responsibilities and mission of the group early in the process. Review the composition, membership and mission on an annual basis and recruit new members as necessary;
- provide more formalized ways to communicate activities of the Quality TAG to all departments, including executive team members, and the Community Living Workgroup. This is particularly important when people cannot attend meetings on a consistent basis;
- support the recruitment and training of consumers to participate on the Quality TAG. This includes meeting with new members, providing background materials and reviewing the scope and purpose of the Advisory Group with new members.

### Selection of Measures

In Maine, as in other states, home and community-based services include a wide range of services and supports for a variety of populations and individuals. These range from children with mental health needs to older adults with high levels of functional impairment and/or need for nursing services. When the project started, the goal was to identify possible common measures that were applicable to all populations. This task proved to be difficult and in some cases not possible. As mentioned earlier, we decided to limit the scope of the core quality measures to people served by the waiver programs. This provided a more realistic and manageable approach to the tasks. From this we learned:

- Define the target populations as a first step in the selection of common measures. This will help contain and focus the work. It also provides the basis for determining the “denominator” of the measures that are being developed.
- Define the services and/or source or data that will be used to develop the quality indicators. One criteria for selecting a measure is whether data is reasonably available

and can be collected in a cost efficient and timely manner. If a measure or indicator is considered very important but data is not available or it is difficult to collect such data, it is useful to keep a list of “desirable” measures that can be reviewed and evaluated at the end of the process.

## **■ Sustainability**

The work of the Quality TAG in identifying a set of core quality measures for home and community-based services is being sustained and continued in a number of ways.

### **Creation of Single Department of Health and Human Services**

The merger of the Department of Human Services and the Department of Behavioral and Developmental Services into the single Department of Health and Human Services (DHHS) creates organizational opportunities to coordinate the performance management and quality improvement activities of programs providing home and community-based services. While the final organizational structure of the Department is not final, a Deputy Commissioner of Policy and Performance has been named to provide leadership and direction in this area. This provides structure for a cohesive and coordinated approach to quality management and the ongoing reporting of HCBS quality measures.

### **Quality Choices II Grant**

In 2003, the Maine Department of Human Services was awarded a 3 year grant to develop an integrated quality management and improvement road map for home and community-based services. Building on the work of the Quality Choices I grant, this provides the opportunity to examine the quality assurance and improvement methods in place for home and community-based services and to use the reports and indicators generated from the “dashboard” indicators to focus on areas of quality improvement.

### **HCBS Internal Quality Workgroup**

As part of the Quality Choices II grant, an informal structure has been created to share information, build relationships, and leverage resources to develop stronger quality systems for home and community-based services. The HCBS Workgroup meets monthly, or as needed, to work on the activities of the grant and other quality related initiatives.

### **Dashboard Indicators**

Using existing data from consumer surveys and claims data, project staff are in the process of preparing a set of “dashboard” indicators for the HCBS waiver programs in Maine. Once the audience and report formats are developed, the definitions of the measures finalized and the data analyzed, it will be possible to more easily generate a standard set of reports each year.

# **■ Appendices**

**Appendix A: Quality TAG Members**

**Appendix B: Quality TAG Mission Statement**

**Appendix C: Timeline of Quality TAG Activities**

**Appendix D: Themes from Focus Groups**

**Appendix E: HCBS Framework**

**Appendix F: HCBS Dashboard Indicators – Consumer Surveys**

**Appendix G: HCBS Dashboard Indicators – Claims Data**

**Appendix H: HCBS Dashboard Indicators - Other**



## Appendix A: Quality TAG Members

- Kathy Adams, Alpha One
- Pamela Allen, Seniors Plus
- John Baillargeon, BEAS
- Mollie Baldwin, BEAS
- Maureen Booth, Muskie School of Public Service
- Taryn Bowe, Muskie School of Public Service
- Carolyn Briggs, New England Family Health Care
- Margaret Chandler, AARP
- Deb Chapman, Eastern Area Agency on Aging
- Marcia Cooper, Disability Rights Center
- Stephanie Crystal Wolfstone-Francis, Consumer/Advocate
- Charlotte Cushman, New England Center Deafblind Project
- Melinda Davis, Advocacy Initiative Network of Maine, Inc.
- Donna Dwyer, Sweetser's Partners in Disability
- Sharon Forester, Elder Independence of Maine
- Deb Gilmer, Center for Community Inclusion
- Karen Glew, BDS, Mental Retardation
- Eileen Griffin, Muskie School of Public Service
- Linda Huff, Developmental Disabilities Center
- Patricia Hunt, Family Network of Maine
- Jeffrey Jones, Division for the Blind and Visually Impaired
- James Leonard, DHS BMS/QI
- Louise Olsen, Muskie School of Public Service
- Kathryn Pears, Maine Alzheimer's Association
- Sharon Sandstrum, BDS- Office of Quality Improvement
- Katharine Storer, Office of Consumer Affairs for Region 3
- Julie Tosswill, Bureau of Medical Services
- Danny Westcott, Muskie School of Public Service
- Patten Williams, Division of Vocational Rehabilitation



## **Appendix B: Quality TAG Mission Statement**

### **MISSION** **MAINE HCB QUALITY** **TECHNICAL ADVISORY GROUP (TAG)**

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#### **Background and History**

In 2000, Maine established a Work Group for Community Living to make certain that the State is providing services to people with disabilities in the most integrated setting appropriate to the needs and preferences of each individual. Four technical advisory groups (TAGs) were subsequently formed to advise the Work Group on issues relating to access, person-centered care, quality and data integration. The TAGs are responsible for developing an agenda for action, including solicitation of external grant funding to promote the design and implementation of innovative solutions to service integration and improving service outcomes.

#### **Purpose**

The HCB Quality TAG was established to provide a formal mechanism for assessing and improving the quality of services and outcomes in the home and community-based (HCB) setting. Its purpose is to develop consensual standards for measuring quality and to provide guidance on the performance of the system, including barriers and opportunities for improvement.

#### **Scope**

Current funding and support for the HCB Quality TAG is provided under the federal Real Choices Systems Change Grants for Community Living. Work is divided into two phases. Phase I of the HCB Quality TAG's work focuses on improving the quality oversight and outcomes of Maine's four home and community-based waiver programs serving older persons and persons with disabilities. Phase II will more broadly define home and community-based services to encompass the array of services and programs aimed at supporting all persons with disabilities in their homes and communities. Throughout its work, the TAG will be advised of federal and state rules and regulations governing the state's responsibility for quality oversight.

#### **Functions**

The HCB Quality TAG promotes quality improvement through the following activities:

- Select and analyze measures that assess the impact of HCB services on the quality of care, quality of life, and wellbeing of consumers.
- Identify opportunities and strategies for the development of more consistent and effective approaches to quality management and oversight of HCB services.
- Foster quality improvement through sponsorship and support of specific projects and demonstrations.
- Report on the performance of the HCB system in ways that are useful to state policymakers, providers, and consumers of care.

**Structure**

The HCB Quality TAG is composed of no more than 30 members appointed with the approval of the Work Group for Community-Based Living, or its designee. The members will include: (i) representatives from the Department of Human Services, Behavioral and Developmental Services, Department of Labor, and the Department of Education; (ii) consumers; (iii) advocacy organizations; (iv) individual and institutional care providers; and (v) health care workers. At least one member of the HCB Quality TAG will also serve on the Work Group. Members may elect a Chair who will serve a one-year term.

At its discretion, the HCB Quality TAG may establish sub-committees to address focused topics. The sub-committees may include non-members with expertise in the area. All sub-committees will include at least one-overlapping member with the HCB Quality TAG.

The HCBS Interagency Work Group will be established to support the work of the HCB Quality TAG on an operational level. Composition of the HCBS Interagency Work Group will include persons from state agencies with responsibilities for quality management and oversight of HCB services.

**Administration**

The Muskie School of Public Service will provide technical support to the HCB Quality TAG under terms of its Cooperative Agreement with the State.

**Meetings**

Meetings of the HCB Quality TAG will be held as often as is necessary but no less frequently than once every three months. The HCBS Interagency Work Group will meet monthly, or as is necessary to conduct its work.

**Compensation**

Consumer members may receive a stipend or reimbursement for travel to meetings of HCB Quality TAG.



## Appendix C: Timeline of Quality TAG Activities

1/02	Quality TAG convened and goals of project introduced and discussed
3/02-9/02	Conducted focus groups and identified themes
1/03	Reviewed final report from focus groups.
3/03	Three Quality TAG sub-committees met and reviewed potential quality measures within three broad categories: Consumer Experience, Provider Capacity, and System Performance. The Quality TAG subcommittee members reviewed the indicators and added new indicators or ideas. In March and April, all Quality TAG members were asked to rate the indicators using the criteria “very important” and “cross program”.
4/03	A list of all indicators that received at least 5 votes was created. Quality TAG met and further refined the core list of indicators.
7/03	Preferred “Core measures” of consumer experience indicators provided to the Quality TAG. Inventory of consumer satisfaction and other measures used by DHS and BDS completed and presented to Quality TAG.
10/03	Additional health and wellness indicators identified. Gaps in indicators identified. (Bureau of Labor did not have a consumer survey instrument.) Differences in definitions and instruments across departments discussed. Possible action – develop some measures that could be added to survey instruments of the various programs.
1/04	Quality TAG decided to organize the Quality indicators according to the CMS Framework and to focus on HCBS waiver programs.
12/03-3/04	New Survey instrument for consumer directed physically disabled waiver developed.
3/04-4/04	Subcommittee of a Quality TAG met to review and finalize “dashboard indicators”.
7/04-10/04	Draft report circulated to Quality TAG, Community Living Workgroup, and DHHS senior staff for review and comment.



## ■ Appendix D: Themes from Focus Groups

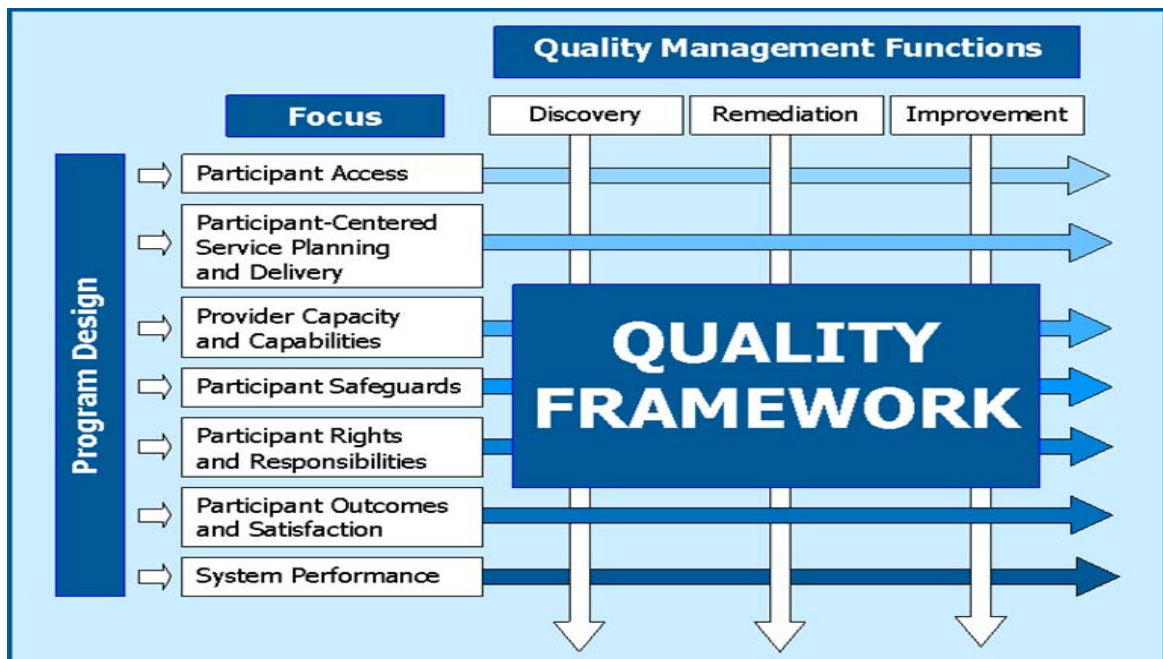
1. Person First: “Don’t Fit Me In”
2. Civil Rights
3. Services Facilitating Life
4. Options
5. Nature of Services
6. Geographic Equity
7. Stewardship



## Appendix E: HCBS Framework

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered desired outcomes along seven dimensions.

Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).



Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

<b>Focus</b>	<b>Desired Outcome</b>
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 capability to effectively serve 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 constantly strives to improve quality.

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

## HCBS Quality Framework: Domains

The Home and Community-Based Services (HCBS) Quality Framework is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports for people with disabilities. The Framework focuses attention on the desired outcomes of HCBS quality management and improvement efforts. The Framework is not regulatory. It is not expected that every state or provider would be engaged in actively monitoring each and every sub-domain. The Framework identifies seven broad quality domains and associated sub-domains:

Domain	Associated Sub-domains
I. Participant access	A. Information/referral B. Intake and Eligibility <ol style="list-style-type: none"> <li>1. User-friendly processes</li> <li>2. Eligibility determination</li> <li>3. Referral to Community Resources</li> <li>4. Individual choice of HCBS</li> <li>5. Prompt Initiation</li> </ol>
II. Participant-centered service planning and delivery	A. Participant-centered service planning <ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Participant decision making</li> <li>3. Free choice of providers</li> <li>4. Service plan</li> <li>5. Participant direction</li> </ol> B. Service delivery <ol style="list-style-type: none"> <li>1. Ongoing service and support coordination</li> <li>2. Service provision</li> <li>3. Ongoing monitoring</li> <li>4. Responsiveness to changing needs</li> </ol>
III. Provider capacity and capabilities	A. Provider networks and availability B. Provider qualifications C. Provider performance
IV. Participant safeguards	A. Risk and safety planning B. Critical incident management C. Housing and environment D. Behavior interventions E. Medication management F. Natural disasters and other public emergencies
V. Participant rights and responsibilities	A. Civic and human rights B. Participant decision making authority C. Alternate decision making D. Due process E. Grievances
VI. Participant outcomes and satisfaction	A. Participant satisfaction B. Participant outcomes
VII. System performance	A. System performance appraisal B. Quality improvement C. Cultural competency D. Participant & stakeholder involvement E. Financial integrity

# HCBS Quality Framework Domains & Desired Outcomes

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## DOMAIN I: Participant Access

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

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### 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 Eligibility Determination

**Desired Outcome:** *Each individual's need and eligibility for HCBS are assessed and determined promptly.*

#### I.B.3 Referral to Community Resources

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

#### I.B.4 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.5 Prompt Initiation

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

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## Domain 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*

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### 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.*

#### 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.*

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## **Domain III: Provider Capacity and Capabilities**

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

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### **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.*

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## **Domain IV: Participant Safeguards**

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

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#### **IV.A Risk and Safety Planning**

**Desired Outcome:** *Participant risk and safety considerations are identified and potential interventions considered that promote 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 Behavior Interventions**

**Desired Outcome:** *Behavior 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.*

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### **Domain V. Participant Rights and Responsibilities**

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

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#### **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 Alternate Decision Making**

**Desired Outcome:** *Decisions to seek guardianship, surrogates or other mechanisms that take authority away from participants are considered only after a determination is made that no less intrusive measures are or could be available to meet the participant's needs.*

#### **V.D Due Process**

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

#### **V.E 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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## **Domain VI Participant Outcomes & Satisfaction**

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

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### **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.*

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## **Domain VII. System Performance**

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

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### **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:** *Payments are made promptly in accordance with program requirements.*



## ■ Appendix F: HCBS Dashboard Indicators – Consumer Surveys

# **Dashboard Quality Indicators for Maine Home & Community Based Services Waivers**

## **Part I: Consumer Surveys**

**Recommendations of the Maine Quality Technical Advisory Group (TAG)**

**Including Quality Indicators from the:**

- **BEAS Consumer Satisfaction Surveys (MeLTC);**
- **Participant Experience Survey: Consumer Direction (PES-CD);**
- **the National Core Indicators (NCI); and**
- **additional indicators recommended by the TAG (TAG)**

**December 2004**

# Dashboard Quality Indicators for Maine Home & Community Based Services Waivers: Consumer Surveys

Elders and Persons with Physical Disabilities <sup>1</sup>

Persons with Physical Disabilities: Consumer-Directed <sup>2</sup>

Persons with MR/DD <sup>3</sup>

## 1. Participant access

### A. Information/referral

MeLTC: The nurse who did the assessment explained what services I could get.

PES-CD: How did you first learn about the consumer-directed waiver services you receive through Alpha One?

NCI: The proportion of families/consumers who report they are informed about the array of existing and potential resources (including information about their family member's disability, services and supports, and public benefits), in a way that is easy to understand.

### B. Intake and Eligibility

## 2. Participant-centered service planning and delivery

### A. Participant-centered service planning

MeLTC: The nurse who did the assessment asked me what I wanted for services.

PES-CD: Did you participate as much as you wanted to in developing your plan of care?

NCI: The proportion of families/consumers reporting that their support plan includes or reflects things that are important to them.

PES-CD: Did you participate as much as you wanted to in developing your plan of care?

### B. Service delivery

MeLTC: I need more hours of home care services.

NCI: The proportion of people who report that services/supports are flexible to meet their changing needs.

NCI: The proportion of people reporting that service coordinators help them get what they need.

MeLTC: I know who my Care Coordinator is at EIM.

Q-18 *If you ask for something, does s/he help you get what you need?*

MeLTC: I need more help from my Care Coordinator than I get.

PES-CD: Can you talk to an Alpha One staff person when you need to?

NCI: The rate at which people report that "needed" services were not available.

NCI: The proportion of people who report that services/supports are flexible to meet their changing needs.

Q-48 *Do you get the services you need?*

NCI: The proportion of people who report that services/supports are flexible to meet their changing needs.

<sup>1</sup> Primary source of Indicators is the BEAS consumer satisfaction survey

<sup>2</sup> Primary source of indicators is the Participant Experience Survey: Consumer Direction Version

<sup>3</sup> Primary source of Indicators is the National Core Indicators

## 2. Participant-centered service planning and delivery

### B. Service delivery

## 3. Provider capacity and capabilities

### A. Provider networks and availability

MeLTC: During this past month the worker didn't show up: (Once this past month; 2-3 times; More than 3 times; A worker always showed up this past month).

PES-CD: What is the longest time it has taken you to find and hire a PA?

PES-CD: In the past year did you find it difficult to keep PAs?

PES-CD: In the last 60 days, have you ever been unable to complete a personal care task, such as bathing or eating, because you didn't have someone to assist you?

PES-CD: What task(s) were you unable to do because no one was there to help you?

### B. Provider qualifications

MeLTC: The worker who comes to help knows what to do

PES-CD: Do you have any medical or other needs, such as catheter care, ventilator care, or use of Hoya lift, where your PA needs special training?

MeLTC: The worker who comes to help knows what to do

NCI: The proportion of individuals who report that staff are competent to provide services and supports.

NCI: The proportion of individuals who report that staff are competent to provide services and supports.

### C. Provider performance

MeLTC: The worker who comes to help does things the way I want them to be done.

PES-CD: In the past year, have you ever been unhappy with the way your PAs perform their work?

MeLTC: The worker who comes to help does things the way I want them to be done.

MeLTC: The worker who comes to help takes an interest in me as a person.

PES-CD: With which aspects of your PAs' performance have you been unhappy?

NCI: The proportion of people indicating that most support staff treat them with respect.

Q-02 *Do you have staff who help you there? Is s/he nice and polite to you?*

PES-CD: Do your PAs treat you respectfully in your home?

Q-08 *Do you have staff who help you where you live? Is s/he nice and polite to you?*

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1 Primary source of Indicators is the BEAS consumer satisfaction survey

2 Primary source of indicators is the Participant Experience Survey: Consumer Direction Version

3 Primary source of Indicators is the National Core Indicators



## 4. Participant safeguards

### A. Risk and safety planning

MeLTC: If the worker doesn't show up, I (Call my family; Call the agency; Call EIM, Go without help; A worker always shows up).

TAG: Do you know who to call if you have a serious problem?

PES-CD: Have you ever felt unsafe because you did not have a PA present?

PES-CD: Have you ever had to use your back-up system?

PES-CD: How did it work?

PES-CD: Have you ever felt unsafe because you did not have a PA present?

PES-CD: Have you ever been injured by any of your PAs?

NCI: The proportion of people who report that they feel safe in their home and neighborhood.

Q-06 *Are you ever afraid or scared when you are at home?*

Q-07 *Are you ever afraid or scared when you are out in your neighborhood?*

TAG: Do you know who to call if you have a serious problem?

### B. Critical incident management

### C. Housing and environment

PES-CD: Have you ever talked with anyone about any special equipment, or changes to your home, that might make your life easier?

PES-CD: What equipment or changes did you talk about?

PES-CD: Did you get the equipment or make the changes you needed?

PES-CD: Would additional adaptive equipment or assistive technology allow you to be more independent?

PES-CD: Have you ever talked with anyone about any special equipment, or changes to your home, that might make your life easier?

PES-CD: What equipment or changes did you talk about?

PES-CD: Did you get the equipment or make the changes you needed?

PES-CD: Would additional adaptive equipment or assistive technology allow you to be more independent?

PES-CD: Have you ever talked with anyone about any special equipment, or changes to your home, that might make your life easier?

PES-CD: What equipment or changes did you talk about?

PES-CD: Did you get the equipment or make the changes you needed?

PES-CD: Would additional adaptive equipment or assistive technology allow you to be more independent?

### D. Behavior interventions

### E. Medication management

### F. Natural disasters and other public emergencies

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<sup>1</sup> Primary source of Indicators is the BEAS consumer satisfaction survey

<sup>2</sup> Primary source of indicators is the Participant Experience Survey: Consumer Direction Version

<sup>3</sup> Primary source of Indicators is the National Core Indicators

## 5. Participant rights and responsibilities

### A. Civic and human rights

PES-CD: Do your PAs respect your privacy in your home?

PES-CD: Do your PAs respect your privacy in your home?

NCI: The proportion of people who report satisfaction with the amount of privacy they have.

Q-05 *Can you be alone if you want to? (Can you have privacy?) Here we are looking at privacy (e.g. going in a room and closing the door), not the person's need for supervision (e.g. staying home alone).*

### B. Participant decision making authority

MeLTC: I wish I had more say in who was going to help me.

Q05 *I would like more choices about the services I get.*

PES-CD: Did you choose your main PA from among more than one applicant?

NCI: The proportion of families/consumers who report they choose, hire and manage their service/support providers.

TAG: Did you choose or pick who helps you at home?

NCI: The proportion of families/consumers who report they choose, hire and manage their service/support providers.

### C. Alternate decision making

TAG: Proportion of people with guardians or advocates who are satisfied with the person making the decision

TAG: Proportion of people with guardians or advocates who are satisfied with the person making the decision

### D. Due process

MeLTC: The nurse told me I could file an appeal if I disagreed with the assessment.

PES-CD: Have you ever received information on how to file an appeal?

### E. Grievances

TAG: I know who to call if I have a complaint

PES-CD: Do you know whom to contact if you have a complaint about Alpha One?

TAG: I know who to call if I have a complaint

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1 Primary source of Indicators is the BEAS consumer satisfaction survey

2 Primary source of indicators is the Participant Experience Survey: Consumer Direction Version

3 Primary source of Indicators is the National Core Indicators

## 6. Participant outcomes and satisfaction

### A. Participant satisfaction

MeLTC: I would recommend my worker to a friend who needed the same kind of help.

TAG: I would recommend the services and supports I get to a friend who needed the same kind of help.

PES-CD: Would you recommend your main PA to a friend who needed the same kind of assistance?

PES-CD: Would you recommend the services and supports you get from the consumer-directed waiver to a friend who needed the same kind of assistance?

MeLTC: I would recommend my worker to a friend who needed the same kind of help.

TAG: I would recommend the services and supports I get to a friend who needed the same kind of help.

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1 Primary source of Indicators is the BEAS consumer satisfaction survey

2 Primary source of indicators is the Participant Experience Survey: Consumer Direction Version

3 Primary source of Indicators is the National Core Indicators

## 6. Participant outcomes and satisfaction

### B. Participant outcomes

MeLTC: I am able to go places when I need to.

MeLTC: In general, my health is: (Excellent; Very Good; Good; Fair; Poor)

TAG: Can you always get to the doctor's office when you need to?

TAG: Do the services you are receiving add to the quality of your life?

PES-CD: Is there anything you want to do outside your home that you don't do now?

TAG: Do the services you are receiving add to the quality of your life?

PES-CD: Can you always get to the doctor's office or grocery store when you need to?

PES-CD: Is there anything you want to do outside your home that you don't do now?

PES-CD: How would you rate your current health overall? Would you say excellent, very good, good, fair, or poor?

NCI: The proportion of people who participate in everyday integrated activities in their communities.

Q-26 *Do you (does this person) go shopping? (What do you go shopping for? Examples: groceries, clothing, house-wares, tapes/CDs.)*

Q-27 *Do you (does this person) go out on errands or appointments? (Where do you go? Examples: doctor, dentist, bank, post office, hair dressers/barber.)*

Q-28 *Do you (does this person) go out for entertainment? (Where do you go? Examples: movies, library, plays, concerts, museums, art galleries.)*

Q-29 *Do you (does this person) always eat at home, or do you sometimes go out to eat? (What restaurants do you go to?)*

Q-30 *Do you (does this person) go to religious services? (Where do you go? Examples: church, synagogue, or other place of worship.)*

Q-31 *Do you (does this person) go to clubs or other community meetings? (Where do you go? Examples: non-religious clubs, social groups or community organizations.)*

NCI: The proportion of people who report having adequate transportation when they want to go somewhere

Q-22 *When you want to go somewhere, do you always have a way to get there? (Can you get a ride when you need one?)*

TAG: Do the services you are receiving add to the quality of your life?

PES-CD: Is there anything you want to do outside your home that you don't do now?

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1 Primary source of Indicators is the BEAS consumer satisfaction survey

2 Primary source of indicators is the Participant Experience Survey: Consumer Direction Version

3 Primary source of Indicators is the National Core Indicators

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Elders and Persons  
with Physical Disabilities <sup>1</sup>

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Persons with Physical  
Disabilities: Consumer-Directed <sup>2</sup>

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Persons with MR/DD <sup>3</sup>

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## **7. System performance**

**A. System performance appraisal**

**B. Quality improvement**

**C. Cultural competency**

**D. Participant & stakeholder involvement**

**E. Financial integrity**

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<sup>1</sup> Primary source of Indicators is the  
BEAS consumer satisfaction survey

<sup>2</sup> Primary source of indicators is the Participant  
Experience Survey: Consumer Direction Version

<sup>3</sup> Primary source of Indicators  
is the National Core Indicators

**Appendix G: HCBS Dashboard Indicators – Claims Data**

# **Dashboard Quality Indicators for Maine Home & Community Based Services Waivers**

## **Part II: Claims-Based QIs**

**Recommendations of the Maine Quality Technical Advisory Group (TAG)**

**Including Quality Indicators from the:**

- **MaineCare Quality Indicators (MC-QI);**
- **MaineCare Chronic Care Indicators (MC-CCI);**
- **the National Core Indicators (NCI); and**
- **additional indicators recommended by the TAG (TAG)**

**December 2004**

# Dashboard Quality Indicators for Maine Home & Community Based Services Waivers: Claims-Based

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## 3. Provider capacity and capabilities

### C. Provider performance

MC-QI: Cervical cancer screening

MC-QI: Breast Cancer Screening

MC-QI: Diabetes-Retinal Exams

MC-QI: Diabetes-HgbA1c

MC-QI: Diabetes-Lipids

## 4. Participant safeguards

### E. Medication management

MC-CCI: Inappropriate prescriptions for elderly patients

NCI: The proportion of people taking psychotropic medications.

TAG: Use of psychotropic medications without an appropriate diagnosis

TAG: Use of 9-or-more different medications

## 6. Participant outcomes and satisfaction

### B. Participant outcomes

MC-QI: Average Number of ER Visits

MC-QI: Potentially Avoidable Hospitalization Conditions

## 7. System performance

### A. System performance appraisal

TAG: Expenditures per person (Medicaid + Medicare)



**Appendix H: HCBS Dashboard Indicators - Other**

# **Dashboard Quality Indicators for Maine Home & Community Based Services Waivers**

## **Part III: All Other QIs**

**Recommendations of the Maine Quality Technical Advisory Group (TAG)**

**Including Quality Indicators from the:**

- **the Mental Health Performance Indicators (MHPI); and**
- **additional indicators recommended by the TAG (TAG)**

**December 2004**

# Dashboard Quality Indicators for Maine Home & Community Based Services Waivers: All Other QIs

## 1. Participant access

### B. Intake and Eligibility

TAG: Timeliness of intake/eligibility process

TAG: Timeliness of service initiation

## 3. Provider capacity and capabilities

### A. Provider networks and availability

TAG: Availability and retention of staff

### C. Provider performance

TAG: Worker satisfaction

## 4. Participant safeguards

### B. Critical incident management

TAG: Number and type of critical incidents/complaints

TAG: Timeliness in responding to and resolving cases

### D. Behavior interventions

TAG: Staff training re: Difficult behaviors

### F. Natural disasters and other public emergencies

TAG: Care plans include planning for emergencies

## 7. System performance

### A. System performance appraisal

TAG: Waiting lists

### B. Quality improvement

TAG: Quality improvement project (y/n)?

### C. Cultural competency

TAG: Staff/provider training in another language

### D. Participant & stakeholder involvement

MHPI: Consumer/Family member involvement in policy development, quality assurance & planning