BROOKINGS

QUALITY. INDEPENDENCE. IMPACT.

Long-Term Care Quality Alliance

December 2008

Technical Appendices

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Appendix A:

Examples of Opportunities to Gather Person-Level Data on Functional Status or Diagnosis from Existing Sources

Appendix B:

Examples of Promising Measures and Measurement Areas

[a] The opinions expressed are those of the authors. No official endorsement by the Department of Health and Human Services or the Agency for Healthcare Research and Quality is intended or should be inferred.

Appendix A:

Examples of Opportunities to Gather Person-Level Data on Functional Status or Diagnosis from Existing Sources

This table is designed to answer the following questions:

- What are some of the options that exist to identify high-priority populations for participation in LTCQA pilots or demos?
- What are examples of data on functional status or diagnosis that are already available and maintained in the health care and supportive services systems?
- Where is functioning/health status data located?

Service/ Program Type	Description and Source of the Data	Eligibility-related functional and clinical status
Medicaid institutional level of care (LOC)		
Medicaid institutional level of care (LOC)	• Used by states to determine the "medical/functional eligibility" of persons for Medicaid institutional care. Requirements are in addition to financial eligibility requirements.	Institutional level of care defined in each Medicaid State Plan. There are three types of institutional care: – Nursing facility care[b] – Intermediate Care Facility for the Mentally Retarded (ICF-MR) – Hospital care
Nursing facility (NF) LOC as used by state Medicaid programs[1]	• Used to determine the medical/functional eligibility for Medicaid-paid nursing home care and some types of Medicaid 1915(c) home and community-based waiver services (e.g., elderly, physically disabled). • Data available from state agencies depending upon states' LOC administrative structure(s) (e.g., Medicaid agency/Medicaid enrollment records, agency responsible for LOC assessment (case managers, local area Agencies on Aging, physician medical records, etc.), providers of services)	• 3 states use clinical information (Alabama, Pennsylvania, Rhode Island) – e.g., Alabama's LOC criteria based on medical needs • 7 states use ADL information (Delaware, Idaho, Illinois, Iowa, Kansas, Oklahoma, Oregon) – e.g., Delaware uses a scoring system that is based on 4 areas of ADL ability (eating, transferring, mobility, and toileting); nursing facilities maintain this information monthly as part of resident's medical records • 40 states use both clinical and ADL information – e.g., Michigan assesses ADLs, cognitive skills, clinical instability, treatments and conditions, skilled rehab therapies, challenging behaviors, and requires ongoing services to maintain current functional status
Home- and community-based services		
Medicaid home and community-based services (HCBS) provided as a 1915(c) waiver services[2]	• Permits states to waive certain Medicaid requirements in order to furnish an array of home and community-based services (on a FFS basis) designed to promote community living for Medicaid beneficiaries and prevent institutionalization. There are more than 250 HCBS waiver programs across 49 states and DC.[c,3] • Data available from a variety of state agencies depends on state administrative structure(s) (e.g., Medicaid agency/Medicaid enrollment records,	• Eligibility requirements differ across states and programs. For example in New Mexico eligibility requirements include: – Aged & Disabled waivers: Elderly (65 or older), or individuals (all ages) with a disability (blind or disabled) who meets nursing facility level of care – Developmental Disability waiver: An individual who has a developmental disability or a specific related condition, was diagnosed prior to age 22, and meets

[b] i.e., Care in a nursing home certified to receive Medicaid reimbursement

[c] Arizona operates HCBS services under Section 1115

Service/ Program Type	Description and Source of the Data	Eligibility-related functional and clinical status
	agencies responsible for LOC assessments and/or waiver program oversight (e.g., case managers, state aging agency, local Area Agencies on Aging), medical records, providers of HCBS services). • The Centers for Medicare & Medicaid Services (CMS) Form 372 (submitted by the states to CMS for each waiver program) contains aggregate data on the number of waiver participants.[4] • Individual recipients of waiver services can be identified in a state's MSIS data and through CMS' MSIS and MAX data. Identifying waitlisted individuals eligible for waiver services can be difficult.	ICF/MR LOC requirements. – Medically Fragile Waiver: An individual who has a developmental disability, a medically fragile condition, was diagnosed prior to age 22, and meets ICF/MR LOC requirements. • At a minimum, persons must meet medical/ functional eligibility requirements for a Medicaid institutional LOC as defined by the state (see above) *and* require one or more waiver services in order to function in the community (the latter is specific to a waiver). • States can target services to sub- populations and impose additional medical eligibility requirements specific to a waiver program. • States can also have more restrictive functional eligibility criteria than those used for institutional LOC. • In 2006, 7 waivers used more restrictive criteria – e.g., Alabama, California, Washington D.C., Florida, New York, Texas, and Utah[5]
Medicaid HCBS services provided under the Medicaid State Plan (either as an state optional service or a mandated State Plan service)	• In additional to waivers, Medicaid HCBS services can include: 1. Home health care (required in all states) 2. Personal assistant services (option in 30 states)[6] 3. Private duty nursing care (when provided at home or a community based setting) 4. Self-directed personal care option (1915(j); new option under the Deficit Reduction Act (DRA), only recently available.[7] 5. HCBS waiver services as a State Plan Option (1915(i); new under the DRA. • [Data available from sources as described in cell directly above.]	• Functioning/health status eligibility criteria, by program as articulated in each State's Medicaid State Plan: 1. Medicaid HH eligibility is defined as a Medicaid nursing facility LOC (see above)[8]; 2. Based on states' NF LOC 3. Based on states' NF LOC 4. Due to recently final CMS regulation, state specific details are not yet available. 5. Eligibility criteria for HCBS State Plan Option (1915(i) are needs-based eligibility criteria that could be based upon functional criteria, but must be "less stringent" than institutional and HCBS 1915c waiver LOC. Each state develops its own criteria.[9]
State-only funded home and community-based services [10]	• 48 states (including DC) have Medicaid state-only funded HCBS programs covering mostly elderly and/or physically disabled adults. • Data available from a variety of state agencies depending upon a state's administrative structure(s)	• Most states make eligibility available to individuals who do not meet the financial and/or functional eligibility requirements of Medicaid and/or individuals waiting placement on the Medicaid HCBS program or placement in a nursing home. • Several states use functional requirements to identify eligibility for certain services: – e.g. Arizona's eligibility is for individuals who do not meet the Arizona LTC system financial and medical eligibility requirements and need help with 2 ADLs/2 IADLs – e.g., California's Alzheimer's day care services (diagnosis of dementia or related disorder) and respite services (diagnosis of adult onset cognitive disorder)
AoA Title III and VII funded home and community-based	• National Family Caregiver Support Program and the Older Americans Act (OAA).[12] Funding provided as grants to the states.	• ADL/IADL: 12 states • ADL/IADL and diagnosis: 10 states

Service/ Program Type	Description and Source of the Data	Eligibility-related functional and clinical status
services[11]	• Data available from state and local agencies that comprise the Aging Network (e.g., state aging agency, local Area Agencies on Aging) • Aggregate data on program participants, by state and program type, are submitted to AoA as part of the National Aging Program Information System (NAPIS) State Program Reports (SPR) on the Home and Community Based and Nutrition Services and Elder Rights (Titles III and VII)[13]	• Diagnosis only: 2 states • OAA guidelines: other states • No functional status requirement: 11 states
"One Stop" Aging Disability Resource Centers (ADRC)	• The Aging and Disability Resource Center (ADRC) Grant Program, a cooperative effort of the AoA and CMS, was developed to assist states in their efforts to create a single, coordinated system of information and access for individuals seeking long term support to minimize confusion, enhance individual choice, and support informed decision-making. To date grants have been awarded to 41 states and the DC.[14] – To streamline operations, some states have already moved their LOC determinations and/or case management functions to the ADRCs, others are in the process.	• The LOC eligibility criteria for Medicaid, state-only HCBS programs and AoA Aging programs are the same as other HCBS described above. • However, where and/or how eligibility information is stored and used is centralized within the ARDCs.
Managed Care Plans		
Managed Care Plans	There are several types of managed care plans relevant to individuals that are assessed for functional and cognitive abilities, identified with particular diagnoses or risk factors, and/or in need of (or using) long-term services and supports. These plan types can include: – Medicaid (and Medicare) Managed Care Plans – Medicaid Managed LTC Plans – Medicaid (and Medicare) Integrated Care Plans – Medicaid (and Medicare) Disease Management Plans – Medicare Special Needs Plans (SNPs) – Private managed care plans	Examples are illustrated in the next few rows.
Medicaid Managed LTC Plans (MMLTC)[15] and Medicaid and Medicare Integrated Care Plans	• A program of coordinated LTC services whereby a contractor accepts the financial risk for the coordination and provision of services through a capitated payment of long-term care benefits to Medicaid beneficiaries. • Services are provided directly by the contractor or are sub-contracted. Some MMLTC programs only provide LTC services (e.g., Wisconsin Family Care), others include all Medicaid services (e.g., Texas Star+Plus), while others provide all Medicare and Medicaid services (e.g., Massachusetts Senior Care Options, New Mexico Coordinated Long -Term Services and Wisconsin Family Care Partnership).[16]	• In most cases, the criteria are associated with Medicaid nursing facility level of care.
Medicare Special Needs Plans (SNP's)[17]	• There are three types of Medicare SNP's (all provide routine medical care and Medicare post-acute care). SNPs provide: 1. Services for individuals in "institutional" settings	• In addition to being a Medicare beneficiary, individuals must meet the below SNP specific criteria, which may provide some information on functioning/health status: 1. **Institutional SNPs**

Service/ Program Type	Description and Source of the Data	Eligibility-related functional and clinical status
	- Individuals in a nursing home or ICF-MR - Includes people who receive Medicaid HCBS 2. Services for beneficiaries who are dual eligibles (Medicare and Medicaid) 3. Medicare services for individuals with "chronic and disabling conditions"[18] • For data source, see adjacent column.	- Individuals residing in Medicare or Medicaid certified nursing home; functioning/health status information available in the NH Resident Assessment data (MDS) captured on all NH residents at least quarterly - Individual residing in a Medicaid ICF-MR; functioning/health status information available in data on institutional LOC determination and in subsequent resident assessments - Persons receiving Medicaid HCBS services; functioning/health status information available in data on institutional LOC and in yearly HCBS assessments performed as part of the case management function **2. Dual Eligible SNPs** - Functioning/health status data may be available in medical records. Persons medically eligible for Medicaid HCBS services, but on a waiting list for services will have an institutional LOC determination in state Medicaid data. **3. Chronic and Disabling SNPs** - Functioning/health status data maybe available in medical records. Persons medically eligible for Medicaid HCBS services, but on a waiting list for services will have an institutional LOC determination in state Medicaid data. - Beginning in 2010, SNPs that serve Medicare beneficiaries with chronic conditions must have at least one of 15 chronic conditions (shown in Attachment B of the report).[19]
Programs of All-inclusive Care for the Elderly (PACE)[20]	• PACE provides an alternative to institutional care for persons aged 55 or older who require a nursing facility level of care. PACE enrollees can be Medicare and/or Medicaid beneficiaries (CMS administers the program as a Medicare program). Regardless of the source of payment, PACE programs receive capitated payments in accordance with the PACE agreement. • There are 53 PACE programs; names and contact information for PACE organizations are available on the CMS web site.[21] • Aggregate data on PACE programs are submitted to CMS and state administering agencies by individual PACE programs. State agencies responsible for determination of an individual's NF LOC contain functioning/health status data on enrollees. Medicare and Medicaid enrollees are identified in applicable enrollment files (CMS and state Medicaid).	• Nursing facility level of care is determined using the same requirements (and administrative procedures) as the state's Medicaid nursing facility LOC (see above). Other than the NF LOC determination, PACE enrollee information on functioning and health status of individual enrollees is maintained by the PACE organization. • PACE regulations require that an initial comprehensive assessment (including functioning and health status) of a PACE enrollee "must be completed promptly following enrollment." • PACE organizations licensed by a state as a managed care organization are required to collect state required managed care participant information (e.g., could include HEDIS and NCQA functioning/ health status data). PACE organizations licensed by a state as a home health agency are not required to collect OASIS assessment data unless the PACE organization is

Service/ Program Type	Description and Source of the Data	Eligibility-related functional and clinical status
		also certified as a Medicare or Medicaid home health Agency. • A PACE program can chose to collect participant assessment data with the "Core Outcome and Comprehensive Assessment – Basic (COCOA-B) Data Set".[22]
Providers of Services		
Nursing Homes[23,24]	• Over 98 percent of all nursing homes (NH) are certified by CMS for Medicare and/or Medicaid reimbursement.[25, 26] • All certified NH are required to collect NH Resident Assessment data on all NH residents; these data are to be used by NH's in developing a plan of care for an individual. • Data are collected using the CMS mandated electronic Minimum Data Set form (MDS; currently version 2). • NH's are required to submit individual MDS data to the states and to CMS quarterly.	• A wide range of functioning/health status data are collected upon admission to the NH as part of the MDS data collection. • MDS data are also collected on individuals quarterly, annually and upon a significant change in an individual's health status. • Persons admitted to the NH with Medicare as the source of payment also have a Medicare MDS at 3 or 5 days post admission and again at 15 and 30 days post admission.[27]
Home Health Agencies (HHA)	• Home health care includes skilled nursing care, as well as other skilled care services (e.g., physical and occupational therapy, speech-language pathology (therapy) services). • About 92 percent of all HHAs are certified as a Medicare and/or Medicaid HHA.[28] About 86 percent of certified HHAs (9,200 in 2007)[29] are Medicare certified and also accept Medicaid, and 4 percent are Medicaid only. • Certified HHAs are required to collect outcome and assessment data on all individuals receiving services. Data are collected with the CMS mandated Outcome and Assessment Information Set (OASIS; currently version B). • HHAs are required to submit aggregate OASIS information to the state and CMS; HHAs are also required to submit person-specific OASIS data to the state and CMS for individuals in which Medicaid and/or Medicare are a source of payment (respectively).	• Functioning/health status data are collected as part of the OASIS data collection at the start of the home health episode of care. • During the course of care these data are updated to reflect changes in an individual's functioning/health status. • Several of the quality measures posted on the Medicare.gov Home Health Compare web site are derived from functioning/health status OASIS data (and are available for each certified HHA).
Long-Term Care Hospitals (LTCH) [30, 31]	• LTCHs provide care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions) and who need a hospital-level care for relatively extended periods. • Medicare is the predominant payer for LTCH services, accounting for about 70 percent of LTCH discharges. In 2007 there were 394 LTCH certified by Medicare. • LTCH must meet the conditions of participation applicable to acute care hospitals and have an average length of stay greater than 25 days for its Medicare patients. • The top 15 long-term care diagnoses made up more than 60 percent of all discharges from LTCHs in 2006.[32]	• Beginning January 1, 2008, LTCHs must have a screening process to help ensure the appropriateness of patient admissions and stays.[33] • Functioning/health status eligibility is based upon a person needing a hospital level of care. • Medical records are the only source of health care assessment data other than.

Service/ Program Type	Description and Source of the Data	Eligibility-related functional and clinical status
Inpatient Rehabilitation Facilities (IRF)[34]	• Hospitals and units within hospitals that provide intensive inpatient rehabilitation services, including physical, occupational, and speech therapy. • Beneficiaries must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in a rehabilitation hospital or unit, also called inpatient rehabilitation facilities (IRFs). • Relatively few Medicare beneficiaries use these services, although 70 percent of discharges were for Medicare reimbursed services. [35]	• Functioning/health status data are collected as part of Inpatient Rehabilitation Facility–Patient Assessment Instrument[36]
Ambulatory Care Settings and Health Care Delivery Organizations	• Used by physicians and other clinicians as part of the process for care assessment and subsequent development of a plan of care. • Several clinical assessment tools are available containing functioning and health status assessment information. – Tools include the Short-Form 36 Health Survey (SF-36), the Patient Health Questionnaire (PHQ)[37], the Mini Mental State Examination (MMSE), and Katz Index of Activities of Daily Living (ADL).[38]	• Health care assessment data are part of the medical record. • For some large health delivery organizations information may be available in administrative/ claims data. • Health assessment data are also available for some types of insurance plans (e.g., disease management plans, chronic disease plans).
Medicaid coverage based on a disability (Presumptive Medicaid Disability)[39,40]		
Medicaid coverage based on disability	• To receive Medicaid coverage based on disability, the individual must be determined blind or disabled according to the Social Security Administration's (SSA) standards. • The SSA makes a determination of disability or blindness as part of the eligibility determination for SSI or SSDI benefits. Individuals receiving either Social Security Disability benefits or SSI based on disability have met the necessary disability standard. SSA will not make a disability determination if the individual is not eligible for a cash payment from SSI or SSDI.[41]	• Presumptive Medicaid Disability criteria as determined by SSA standards: – Definition of Disability (Medicaid): The inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months or result in death. – Definition of Blindness (Medicaid): Central visual acuity of 20/200 or less in the better eye with the use of correcting lens which has lasted, or is expected to last, for a continuous period of not less than 12 months or result in death.

Appendix B:

Examples of Promising Measures and Measurement Areas

This outline briefly describes several additional examples of potential measures and related data systems that could be used to support new pilots or demonstrations as part of the Long-Term Care Quality Alliance. This list is not exhaustive, but it covers a broad range of domains including outcomes measures, resource use, experience/satisfaction with care, client functioning, and program performance.

QUALITY OUTCOMES AND ADVERSE EVENTS

- **National Core Indicators System (NCI)**[42]
  - The NCI system consists of multi-state data collection and performance assessment tools and outcomes measures used to inform performance improvement for services provided for persons with developmental disabilities.
    - Serious reportable events (e.g., incidence of serious injuries reported among people with mental retardation and developmental disabilities (MR/DD) in the course of service provision in the past year; incidence of serious injuries resulting from abuse and neglect, the use of constraints)
  - In addition to health and safety outcomes and adverse events information, the NCI includes consumer, family, systemic, and cost outcomes. Sources of information include consumer surveys (e.g., empowerment and choice issues), family surveys (e.g., satisfaction with supports), provider surveys (e.g., staff turnover), and state systems data (e.g., expenditures, mortality).

- **Agency for Healthcare Research and Quality Measures**
  - AHRQ is currently developing several measures useful for numerous settings in long-term care, including serious accidents in nursing homes and home and community-based services (HCBS) measures related to client functioning, client satisfaction, and program performance.

- **Minimum Data Set (MDS)**[43]
  - The MDS is a tool for implementing standardized assessment and for facilitating care management in Medicare and Medicaid nursing homes. Medicare and state agencies also use MDS items in their nursing home (NH) payment methodologies.
  - MDS 2.0 supports the quality measures that are publicly reported.
  - The MDS 3.0 (planned for implementation October 2009) will respond to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns.
    - Short- and long-stay resident measures (e.g., percent of residents given influenza vaccination during the flu season; percent of low- and high-risk residents who have pressure ulcers)
  - Some NH Compare quality measures will require modifications as a result of the MDS 3.0.

- **Outcome and Assessment Information Set (OASIS)**[44]
  - The OASIS is a federally mandated instrument/data collection tool that is used to collect and report performance data by home health agencies for outcome-based quality improvement. Data are made available through public reports and private reports available to providers only.
  - These data form the basis of patient case mix profile reports and patient outcome reports that are used by home health agencies for quality improvement and quality monitoring purposes and by state survey staff in the certification process. Home health agency quality measures that appear

on the CMS Home Health Compare website are also based on OASIS data, and the data are used for case-mix adjustment of per-episode payment.
  - CMS is adding process measures in OASIS C in an attempt to measure whether providers are engaging in best practice methods and utilizing evidence-based care, and to determine whether this has any effect on re-hospitalizations.

- **Serious Reportable Events in Health Care**[45]
  - The 2006 consensus report by the National Quality Forum (NQF) identified 28 serious reportable events (SRE) in one of six categories: surgical, product of device, patient protection, care management, environment, or criminal.
  - SREs as defined by the NQF refer to care provided in a health care facility including LTC facilities.
  - 27 states have SRE systems and typically require hospitals, but not LTC facilities, to report on them.
  - Beginning October 2008, CMS will reduce treatment payments for a list of complications considered preventable with good care. Many of these complications are included on NQF's SREs list (e.g., pressure ulcers, injurious falls). Some states have passed similar Medicaid regulations.

- **Adverse Event/Critical Incident Reporting Systems**[46]
  - Most states have multiple regulations governing adverse event systems that are (in part) an outgrowth of the Protection and Advocacy (P&A) System for persons with developmental disabilities, abuse and neglect systems for children and elders, Adult Protective Systems the elderly, P&A for Individuals with Mental Illness (PAIMI) and P&A for Individuals with Traumatic Brain Injury (PATBI), among others.
  - Many of these systems are specific to the vulnerable and LTC populations whose health care is financed by Medicaid and other state programs.
  - Many states have incident systems for persons with developmental disabilities and a different system for persons with mental illness. Only recently (as a result of the Money Follows the Person Demo) have these systems been required for Medicaid elderly HCBS populations.
  - Harmonization across states does not exist, and public reporting is minimal (e.g., number of deaths).
  - Event investigation for quality improvement needs to be improved.

CARE TRANSITIONS

- **Care Transitions Measure (CTM)**[47]
  - The Care Transitions Program established a 15-item and 3-item set.
  - The CTM3 has been endorsed by the NQF to assess the quality of care transitions to support the concept of patient-centeredness across multiple health care settings.
  - The CTM measures the extent to which patients are being prepared to participate in post-acute self-care activities (e.g., patients' understanding of their self-care role in the post-hospital setting; medication management; whether their preferences were incorporated into the care plan).

- **Assessing Care of Vulnerable Elders (ACOVE)**
  - Developed by RAND and UCLA, the ACOVE items examine whether certain tasks regarding communication across settings were achieved.
  - A composite score is used to reflect the completeness (but not the accuracy) of information transfer.

- Initially designed to assess the completeness of home health referrals, ACOVE has expanded to include other care settings.

PREVENTABLE HOSPITALIZATIONS

- **"Bounce-Back" Measures**
  - Home Health Compare, a tool developed by CMS that provides consumers and families with information on home health agency performance, includes a basic bounce-back measure. CMS is considering refinements in this measure that would seek to attribute re-hospitalizations to home health agencies (home health episode [7 days] plus 60 days [episode definition for payment purposes]).
  - New home health re-hospitalization measures are being developed by CMS and AHRQ in collaboration with other partners for conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.[48]
  - Other efforts include the QIO Program 9th Statement of Work, which has demonstrations in 14 states examining whether bounce-back rates are related to care transition efforts.[49]
  - Medicare and private insurance claims databases.

CLIENT AND FAMILY EXPERIENCE

- **CAHPS® Nursing Home Survey**[50]
  - The CAHPS Nursing Home Surveys consist of a set of instruments to provide information on the experiences of nursing home residents and their family members.
  - Three questionnaires are in development: two instruments to gather information on the experiences of nursing home residents and one designed for family members of residents.
  - Once finalized, the Nursing Home Surveys will enter the public domain so that they may be used in monitoring programs designed to improve both care quality and patient satisfaction.

- **CAHPS® Ambulatory Care Home Health Care Surveys**[51]
  - The CAHPS program offers several surveys that assess the experiences of health care consumers in various ambulatory settings, including health plans, managed behavioral health care organizations, home health care agencies, and clinician and group practice settings.
  - The CAHPS® Home Health Care Survey is intended to provide a standard basis by which organizations can assess the quality of home health care providers.
  - The Home Health survey is strictly driven at consumers. Questions are currently going through the development and testing process, with voluntary submission beginning in 2009 and mandatory submission by 2010.

- **Participant Experience Survey (PES)**[52]
  - The PES is a consumer survey instrument that provides state officials with information about program participants' experience with the services and supports they receive under the Medicaid HCBS waivers. The PES provides indicators of program participants' experience in four priority areas: access to care, choice and control, respect and dignity, and community integration/inclusion.
  - There are three versions of the surveys with some common items; each targets a different population: PES/ED (frail elderly and adults with physical disabilities), PES/MRDD (adults with mental retardation and developmental disabilities); and adults with brain injuries. The survey covers the following areas:

- Change in daily activity function (e.g., improvement on waiver; clients who can do more for themselves now)
- Availability of assistance with everyday activities (e.g., measures regarding unmet needs in ADLs/IADLs)
- Employment (e.g., satisfaction and choice in current job/daily activity; unmet demand for employment or other day activities)
- Community inclusion (e.g., participants reporting unmet need for community involvement)

- **Home Care Satisfaction Measure (HCSM)**[53]
  - The HCSM is a 60-item survey developed by the Boston University School of Social Work that measures consumer satisfaction across five types of home care services: homemaker, home health aide, home delivered meals, grocery service, and care management. The survey can be used to measure an overall satisfaction score, individual scores for each type of service, and multiple dimensions of quality within each service.
    - e.g., availability and assistance with everyday activities (e.g., adequacy and reliability of grocery service, home-delivered meals)

- **National Core Indicators (NCI) Consumer and Family Surveys**[54]
  - As referenced above, the NCI is a multi-state data collection and performance assessment tool and outcomes measurement system used to inform performance improvement for services provided for persons with developmental disabilities.
  - The NCI Consumer and Family surveys also include information on client and family experience with care.
    - Availability of assistance for everyday activities when needed (e.g., access to services)
    - Employment (e.g., community-integrated employment; proportion of individuals receiving day-time supports; percent of people satisfied with their job or day activities)
    - Maintenance of family relationships (e.g., proportion of people able to see friends and family when they want)
    - Community connections

- **CAHPS® Children with Chronic Conditions**[55]
  - The CAHPS Consortium adopted an extensive set of items to enable users to assess the experiences of this population with health plans and health care services. This supplemental set allows sponsors to compare the experiences of children with special health care needs with those of similar children in other health plans and/or the general population of children in the same plan.
    - Opportunity to make choices about services (e.g., parent's experience with shared decision-making)
    - Care coordination (e.g., parent's experience with coordination of their child's care)

COST/RESOURCE USE

- **The Continuity Assessment Record and Evaluation (CARE) Tool**[56]
  - CMS and RTI International are developing a site-independent assessment instrument for post-acute care that will measure the health and functional status of Medicare acute discharges and changes in severity and other outcomes for post-acute care patients (SNF nursing homes, home health agencies, inpatient rehab and LTC hospitals).
  - This will provide a standardized way of summarizing information on patient health and functional status linked to data on resource use for any post-acute setting.

- The tool will account for health, functional, and cognitive impairments and for social factors that may affect resource use and outcomes.
- The tool builds on the MDS, OASIS and FIM measures.

OTHER

- **Staff turnover measures**
- **Severity adjustment measures**
- **State rebalancing measures**

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[3] In additional to any financial eligibility requirements.

[4] For participant numbers see Table 5: Kaiser Commission on Medicaid and the Uninsured. "Medicaid Home and Community-Based Service Programs: Data Update." December 2007. (Available at: http://www.kff.org/medicaid/upload/7720.pdf).

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