NATIONAL QUALITY FORUM

Meeting Summary

Home and Community Based Services Quality Measurement Committee Web Meeting

The National Quality Forum (NQF) convened a committee web meeting for the Home and Community-Based Services (HCBS) Quality Measurement project on Friday, February 20, 2015. More than 500 individuals attended the web meeting, representing a variety of stakeholder groups. All members of the committee were in attendance (see Appendix A). An online archive of the web meeting is available for playback.

Welcome and Review of Webinar Objectives

Jamie Kendall, Director, Office of Policy Analysis and Development, Administration for Community Living began by welcoming participants to the webinar. Ms. Kendall remarked that this project is a collaborative effort across the Department of Health and Human Services (HHS) and will serve as a foundational effort for developing a comprehensive and robust quality measurement set for home and community-based services (HCBS). Wendy Prins, Vice President, NQF, also provided opening remarks, welcomed members and the public audience to the in-person meeting, and introduced Helen Burstin, Chief Scientific Officer, NQF, who conducted introductions and disclosures of interest for all committee members. Finally, Ms. Prins reviewed the meeting objectives:

- Build a shared understanding of the project objectives, activities, and the committee's role
- Introduce foundational information about quality measurement
- Begin to gather committee input in the development of an operational HCBS definition and conceptual measurement framework
- Request relevant sources for ongoing evidence synthesis and environmental scan of measures

Project Overview

Andrew Anderson, Project Manager, NQF, discussed the importance of HCBS quality measurement, the project objectives, deliverables, and the role of the committee. Mr. Anderson shared key points as to why it is essential to measure HCBS quality. As states continue to shift resources from institutional care to HCBS, there is an increased need to understand the quality of care that is being provided. A high-quality HCBS system is needed to support older adults and people with disabilities of all ages in order to optimize independence, good health, and quality of life. He added that there are existing frameworks and quality domains for evaluating long-term supports and services (LTSS) and HCBS, but the field lacks a unified picture of quality.

Mr. Anderson noted that this project will provide multi-stakeholder guidance on the highest priorities for measurement of HCBS. It will offer an opportunity to identify priority areas and address gaps in HCBS quality measurement through specific activities, including developing an operational definition of HCBS

and conceptual measurement framework, conducting a synthesis of evidence and environmental scan of measures and measure concepts, identifying the measurement gaps, and making recommendations for HCBS measure development. The creation of the operational definition will guide the development of a conceptual framework that incorporates the domains and sub domains of HCBS. This foundational work will then inform the identification of gaps in HCBS measures and priority areas for measure development. The final product will be a report with recommendations from the committee to HHS.

Mr. Anderson concluded by stating that this project will not emphasize a clinical point of view. The committee will be focusing on how to measure the quality of supports and services that enable community living. The committee will not be reviewing specific measures for endorsement; NQF endorsement is a separate formal process. The committee will examine existing quality measures and measure concepts, many of which are not endorsed by NQF, and identify a range of actions to increase the use of measures of HCBS.

"Crash Course" in Quality Measurement

Juliet Feldman, Project Manager, NQF, provided an overview of NQF and its role in the broader performance measurement enterprise. All NQF committees, including the HCBS committee, are purposefully balanced with stakeholders representing a wide variety of perspectives. NQF conducts its work in a transparent way to maximize stakeholder input. Ms. Feldman described how the HCBS project fits in the larger enterprise of performance measurement; it is upstream guidance.

Ms. Feldman presented foundational information about performance measurement to build a common understanding of terminology and basic measurement science.

- **Why Measure?** Measures can drive improvement, inform consumers and other stakeholders, and influence payment. It is important to remember that measurement is just a tool to help create change – it is not an end in itself. Careful deliberations are needed to determine what we should measure and how that information should be used; especially in the HCBS field where performance measurement is not yet systematic.
- **What is a Measure?** Measures allow for comparison against a standard or reference point. Essentially, measures offer a defined methodology for understanding quality in a fair and systematic way. A performance measure holds an entity accountable for a specific structure, process, or outcome. One form of outcome measurement is derived from information reported directly by consumers (person-reported outcomes or PROs). PROs can be the data source for performance measures (PRO-PMs) that assign accountability for achieving results.
- **Who can be measured?** Measures operate at various levels, including individual provider, facility, health plan, state, region, or nation.
- **How do measures drive change?** Accountability programs (e.g., public reporting and performance-based payment) tie rewards to performance on quality measures. When incentives such as payment, reputation, and market competition are on the line, measurement programs have more impact and also come under more scrutiny.

Developing HCBS Definition and Conceptual Framework

Sarah Lash, Senior Director, NQF, began by describing the purpose of the operational definition and conceptual framework. To support development of the definition, staff reviewed 200+ sources and identified 27 definitions for HCBS and LTSS. Ms. Lash explained that while these definitions contained many useful phrases, they do not meet the needs and scope of this project. Ms. Lash then suggested an approach the committee could take when developing the definition. For example, the definition should be person centered; use positive language; and contain the components of goal, recipients, services. She reminded the committee that this definition is not meant to replace existing guidance or regulations. Ms. Lash invited discussion on the approach to developing a definition of HCBS and the committee members offered the following suggestions:

- Focus on the three W's of HCBS (i.e., what is HCBS, who are these services for, and what is the goal)
- Be inclusive of everyone that benefits from HCBS, including children, people with behavioral health needs, family members, and caregivers
- Look at various initiatives such as work on eLTSS that are also working to define HCBS
- Goals of HCBS should be positive (e.g., "allow people to thrive in their communities" rather than "help keep people out of institutions")
- Emphasize person-centeredness
- HCBS link people to myriad other services and supports, including medical care
- Describe a "spectrum of available HCBS services" rather than listing each one

Each committee member was asked to submit a draft definition of HCBS by February 27, 2015. The definitions will be compiled and synthesized into a single draft definition for further refinement at the April meeting.

Opportunity for Public Comment

Throughout the web meeting, public participants had the opportunity to provide comments and ask questions. Participants' comments were generally focused on issues of project scope, related policy, and suggestions for developing the definition of HCBS. Comments from the chat are listed with responses from NQF in Appendix B.

Call to Action and Next Steps

Ms. Lash noted that NQF welcomes the committee's submission of the following items to the project team at HCBS@qualityforum.org:

- Submit draft definition by February 27th
- Sources to consult for HCBS operational definitions, conceptual measurement frameworks, the synthesis of evidence, and/or the environmental scan of measures

In closing, Ms. Lash thanked the committee members and the public for participating in the meeting. NQF will convene the next committee meeting on April 29-30, in Washington, DC.

Appendix A: Committee Members in Attendance

Name	Organization
Joe Caldwell, PhD (Co-chair)	National Council on Aging
H. Stephen Kaye, PhD (Co-chair)	University of California San Francisco
Robert Applebaum, MSW, PhD	Miami University of Ohio
Kimberly Austin-Oser, MS	SEIU Healthcare
Suzanne Crisp	National Resource Center for Participant Directed Services
Jonathan Delman, PhD, JD, MPH	University of Massachusetts Medical School
Camille Dobson, MPA, CPHQ	National Association of States United for Aging and Disabilities
Sara Galantowicz, MPH	Abt Associates, Inc.
Ari Houser, MA	AARP Public Policy Institute
Patti Killingsworth	Bureau of TennCare
K. Charlie Lakin, PhD	Retired, Formerly with National Institute on Disability and Rehabilitation Research
Clare Luz, PhD	Michigan State University
Sandra Markwood, MA	National Association of Area Agencies on Aging
Barbara McCann, MA	Interim Health Care
Sarita Mohanty, MD, MPH, MBA	Kaiser Permanente Northern California
Gerry Morrissey, MEd, MPA	The MENTOR Network
Ari Ne'eman	Autistic Self Advocacy Network
Andrey Ostrovsky, MD	Care at Hand
Mike Oxford	Topeka Independent Living Resource Center
Lorraine Phillips, PhD, RN	University of Missouri
Mary Smith, PhD	Illinois Division of Mental Health
Anita Yuskauskas, PhD	Pennsylvania State University

Appendix B: Webinar Chat Report with NQF Responses

Message from Participant	Response from NQF
Will these performance standards affect Older American funded programs under Title III?	The committee has been tasked with identifying high quality HCBS measures and gaps in HCBS measurement. The committee will also provide recommendations to HHS for measure development. The recommendations will be general and it is not foreseeable that they will have an immediate impact on Title III or any programs.
Although I think this was alluded to in suggesting it might be a % or ratio, the distinction between measures and instruments is not always clear (e.g., NCI, PES have been mentioned, but are instruments, not measures per se--perhaps to some extent collections of measures, but not really as focused as "composites"). Some instruments are very widely used and there may be important consideration of measures that are imbedded in these instruments so as not to disrupt or dissuade use of broader scale effort. Also it seems important to consider the units of analysis (providers vs. systems). These have implications related to methods and demands of sample size or population surveys. It may also suggest that there are benefits to looking for measures within instruments so as not to disrupt broad scale use and associated benefit of the quality-related instruments.	The committee will take care to note the distinction between an instrument and a measure when conducting their review. The committee may also review instruments that contain questions that might be converted into stand-alone measures to ensure a complete picture of existing quality measures.
Is there any plan to address the issue of the increased costs that will be experienced by HCBS when they're asked to implement new and/or additional measurement tools and analyses?	This is an important question and the committee will consider costs and feasibility when evaluating measurement opportunities. However, projecting the cost of implementing measurement in HCBS is outside the scope of this project.
A participant raised the question of provider, individual, proxy provided information. That's really important. Beyond that, there are questions of response bias-especially among persons with cognitive limitations. Another issue is the discriminative vale of some measures. Many of widely used instruments items (or "measures") are 85%-90% positive. They are important items, but don't show much variation for discriminating quality.	This is an important point. During the prioritization process, the committee will consider the strength of potential measures based on these and other considerations.

Message from Participant	Response from NQF
In terms of transparency would there be some utility in identifying which members are consumers - it seemed like if a member was a consumer they had a position in an organization versus a "community member"	The committee was carefully selected to include representation from many stakeholders. Several committee members are consumers or have family members that use HCBS. However, this will not be designated on the roster.
What about including measures related to social determinants of health?	The committee will determine if measures related to social determinants of health are a priority, if any suitable measures currently exist, and if so how they might be implemented.
Can you confirm what programs will be used in collecting this information? This would be helpful for someone like me who is not in a public program.	The committee has been tasked with identifying high quality HCBS measures and gaps in HCBS measurement. The committee will also provide recommendations to HHS for measure development. The recommendations will be general and it is not foreseeable at this time what data collection strategies may be necessary.
How will independent organizations be using measurements/processes NQF endorses? How will we be notified of endorsements? Will these endorsements be given to funding sources to require NPs to complete, or are these voluntary suggestions?	The recommendations of the committee will be general and it is not foreseeable at this time how measurement will be implemented at the provider level. This project is well upstream of the policy and processes you describe. For reference, all NQF-endorsed measures can be found in the Quality Positioning System (QPS) on the NQF website. However, this project will not endorse individual measures.
How are we proposing to overcome limitations posed by state databases in terms of data entry and reporting capabilities?	Data infrastructure is an important factor to consider when determining the feasibility of adopting measures for HCBS. The committee may make recommendations about how to strengthen current capacity.
I would propose that we need to understand the elements of the HCBS before we can discuss scope or outcomes.	The first task of the committee is to develop an operational definition of HCBS to frame the committee's discussions.
States vary in terms of budgets, which can affect quality of care. Example: New Hampshire told me a max of 40 hours/week of home care services is available to an elder on the HCBW. Another state is more liberal in terms of available services. This would impact quality of care/satisfaction.	HCBS recipients differ in many ways; risk-adjustment and stratification of measures likely need to be used to enable fair comparisons. This is an important point that the committee will weigh when making its recommendations.

Message from Participant	Response from NQF
With person centered planning focus, Is it correct for the State to dictate to a client to state in their plan of care what days they are able to travel to destinations? (i.e. Doctor's appointments, grocery store, shopping for a 6 month timeline)	A person-centered approach increases the ability of an individual to choose when, where and how they receive their services. Policies that hinder ability to choose would be considered less than person- centered, but must be weighed against other practicalities. This level of detail is beyond the scope of the committee's deliberations.
One slide mentioned measures influence payment. To the extent states have autonomous ability to identify their own measure criteria, this goal seems incompatible unless a methodology is developed that takes this into consideration.	This committee's work is intended to provide the framework and guiding principles that would support more standardization of measurement across states.
How will the committee respond to the variability in impact, for purposes of this point, after traumatic brain injury in terms of injury severity and consequences, since no 2 injuries result in the same challenges?	HCBS recipients differ in many ways. Prioritization of measurement opportunities is likely to favor the measures that are cross-cutting and relevant to the most consumers.
There is already a list of things that must be present in order to qualify for a setting that qualifies for federal funding of waivers of HCBS	The committee will be using the settings rule, and other sources, while crafting the operational definition for this project. The definition will not conflict with the rule, but the rule is intended for a different use.
One of challenges in avoiding the "laundry list" of services is that many service recipients are served by multiple providers and those multiple providers offer specific services. Also many would argue that high quality in services would differ in content for persons with different types of impairments.	The committee is creating a high level definition of HCBS for the purposes of this project. It is intended to provide broad guidance on what high-quality HCBS is.
I feel many HCBS actually DO provide Health Care; the problem is one of nomenclature; services provided by physicians is MEDICAL CARE; HCBS services that provide nutrition, exercise, etc. keep people healthy, and therefore really do deserve the health care label, even though they are not traditionally thought of as such.	For purposes of this project, we regard HCBS as including both clinical and non-clinical services. The committee will be cognizant of differences in nomenclature surrounding HCBS when making its recommendations.
I think that HCBS includes supports that are not services like new technologies that obviate the need for a caregiver's help and that should be included here - also virtual monitoring or therapeutic meeting kinds of supports. (I would add to the third column heading in slide 38)	Thank you for the suggestion. The committee may discuss this when refining its definition of HCBS and creating domains and subdomains for measurement.
There is a really great broad definition that was just created here:	This source is now included in the project references.

Message from Participant	Response from NQF
http://wiki.siframework.org/eLTSS+Glossary	
I think it's great to build on existing efforts as much as possible to avoid duplication of efforts	Taking advantage of existing efforts is in line with our effort to create a complete and unified picture of HCBS quality measurement
The committee might need to distinguish between the push to respond to or modify the environment, universal design vs the need for comprehensive services including quality	The built environment may be considered in the committee's prioritization of measurement opportunities.
Increasingly, HCBS service options for frail older adults will be offered through integrated care options, such as PACE and managed care, which also incorporate primary and acute care services alongside with community based supports. How will this project address the quality of services in fully integrated care models, such as PACE.	The committee will be reviewing a variety of existing measures and measurement opportunities through the environmental scan. If a gap is identified in the measurement of HCBS through integrated care models, the committee may consider recommendation for development in this area.
I want to let the Committee know that CMS through the TEFT program, is maintaining the ties between eLTSS and the work of this committee	Thank you for the comment. This project is tracking a variety of related efforts and will coordinate to the extent possible.
When I hear comments like: "Availability of services should be mentioned as well as consumer choice," I worry that "choices" might be limited to what is available rather that when is actually needed. The success of the HCBS hinges on the independence and integrity of the person centered plan.	Thank you for the comment. This issue may be addressed during the committee's discussions of priority domains and sub-domains for potential measurement.
Also wanted to mention that it would be helpful to include administrative data as a source of important and valuable information	The committee will consider all credible and reliable sources of data when considering the feasibility of HCBS quality measures.
Please next time emphasize the connection to the e-LTSS which has been discussed several times	We have included the e-LTSS glossary in our list of research sources. The committee will reference it when developing the operational definition and conceptual framework.