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, August 28, 2015. There were 273 (individuals attending the web meeting, representing a variety of stakeholder groups. An online archive of the web meeting is available for playback.

Welcome, Introductions, Review of Project Goals

Committee Co-Chair, Steve Kaye, began by welcoming participants to the webinar. Next, Margaret Terry, Senior Director, NQF, provided opening remarks, welcomed members and the public audience to the web meeting, and introduced the rest of the NQF Project Team and the HHS Project Team. Andrew Anderson, Project Manager, NQF conducted a roll call of Committee members (see Appendix A).

Next, Dr. Terry outlined the meeting objectives:

- Review highlights of the July 2015 Interim Report
- Discuss public comments received on the Interim Report and how to incorporate them into the work moving forward
- Provide guidance for ongoing environmental scan of HCBS measures and synthesis of evidence

Dr. Terry also reviewed the purpose of the project and the project timeline.

Overview of Comments Received, Operational Definition, and Characteristics of High-Quality HCBS

Mr. Anderson shared a general overview of the scope and themes of the comments received on the interim report. He began by acknowledging the high volume of participation in the public commenting period, and the thoughtfulness, diversity, and breadth of perspectives in the comments. Mr. Anderson noted that the NQF Project Team will be posting a document with the compiled comments and a cover page highlighting key themes and the Committee's responses to the HCBS project webpage. He also provided key points of clarification to respond to common questions and concerns:

- The project is setting a strategic direction and will produce short-term and long-term recommendations. It is not expected to immediately impact any program reporting requirements.
- Measures recommended by this project may or may not apply universally to all consumers, settings, or services.
- Prioritization involves making trade-offs. As we progress, the Committee will begin to focus more narrowly on specific areas of measurement; because a topic is out of scope does not mean that it is unimportant.

Mr. Anderson noted that overall the comments received were supportive of the Committee's work and approach, emphasizing the importance and urgency of work in this area. Many individuals shared personal experiences that highlighted important concepts in HCBS. Many suggested additions or

changes based on particular perspectives such as references to specific HCBS user populations, assistive technology, and measuring the reporting of abuse. Individuals also questioned the feasibility of data collection and made comments about barriers to accessing high-quality HCBS and clarifying terms such as *dignity of risk*.

Next, Mr. Anderson reviewed the operational definition of HCBS and characteristics of high-quality HCBS and highlighted comment themes on these aspects of the report. Many comments commended the Committee's consumer focused approach and broad parameters. Respondents, however, expressed concern about the term *integrated*. They also suggested adding "identifying and reducing barriers" to accessing HCBS; cost; workforce retention; consumer voice in data collection; engagement and strategies to reduce disparities; and linguistic competence to the characteristics. Next, Dr. Kaye facilitated Committee discussion on how to address the public comments. He asked the Committee to consider whether *independence*, *needs*, and *integrated* ought to be revised; and *self-determination*, *inclusion*, and *dignity* ought to be added.

Most Committee members supported *self-determination* as a stand-alone term about individuals having the opportunity to make choices and control their own lives. One member, however, raised a concern that this concept is foreign to stakeholders in the elder and persons with physical disabilities communities. A few members were hesitant to remove *independence* from the definition. Dr. Kaye asked what the Committee thought about qualifiers like: *as independent as possible* or *maximum attainable independence*. This led to a discussion about whether the Committee is trying to define HCBS or *high quality* HCBS. One member noted that the Committee should be creating a directional definition to move HCBS in the "right direction" toward how services ought to be.

The Committee discussed adding *inclusion* and what this term means in the HCBS context. One member spoke about inclusion as the antithesis of segregation. There was support for including the term but calling it *community inclusion*. Some Committee members spoke in favor of retaining the term *integrated*, particularly in light of new Federal rules and HCBS values. Others argued that individuals should be given the choice of an integrated setting, but may choose an isolated setting. One person expressed concern about including terms in the definition that are not universally understood and suggested a shorter definition with principles articulating the important elements of HCBS.

The Committee then considered whether *needs* was too broad given that all individuals have needs but they do not all need or use HCBS. Members discussed whether to address level of severity, duration, or disability. Members agreed that short-term needs are in the purview of post-acute care, whereas long-term needs are within HCBS. One member noted that the concept of long term is already captured in the definition by "an array of long-term services and support". The Committee agreed to allow Dr. Kaye to revise the definition based on the discussion and obtain their feedback after the meeting.

The next discussion was on the characteristics of high-quality HCBS, specifically the notion of a *person-driven system*, the degree to which people who use HCBS are socially connected to the community, the sufficiency of services, and the setting of service delivery. The Committee supported removing the examples from the characteristic of a person-driven system and adding life preferences after self-identified goals. One member also suggested revising the promoting social connectedness characteristic to include "*in accordance with individual preferences*". Although a few members questioned whether

sufficient was captured under *appropriate*, Committee members spoke in favor of moving it to the beginning of the list of adjectives. Individuals may be receiving services that are appropriate, but they may not have enough of them, they argued. There was also a discussion about whether *comprehensive* belongs in this list. Most members supported the term, but one noted that it brings up issues of affordability and needs to be discussed in more detail if Committee members feel strongly about including it.

Committee members then considered whether to add *coercion* and *restraint* to freedom from abuse, neglect, and exploitation. Most members supported adding these terms; although a few thought this made the sub-domain too wordy and argued that they fall under *abuse*. Next, the Committee discussed the HCBS workforce characteristic. Members supported replacing *trained* with *appropriately skilled* and supported including language here on *competence*. However, there was some concern about adding *linguistic competence*. They also spoke about supplying and supporting a well-prepared workforce, and supported adding the term *stable* which addresses high turnover and vacancy rates. Ultimately, the Committee acknowledged that this characteristic needs more work in order to get to consensus.

The Committee also supported adding the voice of designated representatives and consumer advocates in the design, implementation, and evaluation of HCBS, but emphasized that the consumer voice should be most prominent. Finally, the Committee supported addressing the social determinants of health in the statement about reducing disparities; emphasizing meeting consumer needs in the statement on coordinating and integrating resources; adding outcome-oriented to the statement on data; and creating another characteristic that addresses “adequate funding to deliver accessible and affordable services to those who need them”.

Measurement Domains and Subdomains

Sarah Lash, Senior Director, NQF, provided an overview of the HCBS domains and subdomains, and the public comments received on this section of the Interim Report. Overall, comments supported the emphasis on consumer goals and outcomes, and the importance of caregivers. There were many suggested additions, and little to no discussion that a concept was not important to measure. Several people questioned how particular domains and concepts would be measured. Ms. Lash clarified that this is an important question, but this level of detail may or may not be achieved in the life of the project.

Again, Dr. Kaye walked the Committee through the suggested changes. Dr. Kaye asked Committee members to consider adding *supports for consumers in directing services* to the domain of Choice and Control; adding *exploitation*, *coercion*, and *restraint* to the subdomain of freedom from abuse and neglect, and removing this from the domain of Health and Well-Being; adding something about educating people about their rights and how to exercise them; adding that services meet all applicable laws and regulations; and removing Providers from the title of the Workforce/Providers domain. Committee members supported removing Providers, but wanted it addressed in the sub-domains. They also liked the addition of support for people in exercising their choice, control, and rights. One Committee member suggested revising *promoting dignity and respect* to *upholding dignity* and *demonstrating respect*, recognizing that individuals come with dignity. Another highlighted the need to address the human and legal rights of the HCBS workforce as well as those of consumers.

Dr. Kaye asked Committee members if the subdomain of rebalancing should be moved to the domain of System Performance. He proposed removing the qualifier *full* from Full Community Inclusion and adding transportation as a sub-domain. Dr. Kaye also asked whether employment warranted its own domain and whether to add integration into the care team and education about system and legal supports to the Caregiver Support domain. The Committee supported removing "*full*" and adding transportation. A few members highlighted transportation as a means to accessing services and for inclusion in the community, and asked whether it belongs in multiple domains. One Committee member suggested replacing employment with adequate income or adequate income support. Finally, Committee members commented that the concept of caregiver integration in the care team was captured in the subdomain of caregiver and/or family assessment and planning.

Dr. Kaye then asked for Committee thoughts on adding appropriate assessment of need as a subdomain under Effectiveness/Quality of Services; removing housing from the Equity domain; including assistive technology and home modifications; and whether cost and financing warrants its own domain. Committee members supported adding needs assessment under the Effectiveness/Quality of Services domain. The Committee then discussed whether housing should be its own domain. Many Committee members commented that housing is one of the biggest issues within their communities. On one hand, this may be an opportunity to take the lead and incorporate an important issue to HCBS in a way that has not been previously incorporated. On the other hand, HCBS is, by definition, not a housing program and HCBS cannot necessarily address housing security. Recognizing that this issue would not be resolved during this meeting, Dr. Kaye suggested revising the housing discussion at a future date.

Conceptual Framework Illustration

Laura Ibragimova, Project Analyst, NQF, presented the illustration of the conceptual framework for measuring HCBS from the interim report. She noted that there were relatively few public comments on the illustration, but comments received suggested that the illustration offer more detail on measuring consumer outcomes, particularly about the intermediate steps of quality improvement activities linking quality measurement to improved consumer outcomes. A few comments were also related to the placement of domains in the overlapping circles. Ms. Ibragimova presented a revised illustration that demonstrates quality measurement and quality improvement leading to improved consumer outcomes.

One Committee member remarked that the revised illustration was an improvement, but wanted a more explicit demonstration of the progression from quality measurement to quality improvement to improved consumer outcomes. Another member questioned the placement of Choice and Control outside of the individuals circle given the Committee's long discussions about choice and control for persons receiving HCBS. Lastly, a Committee member suggested looking at visual representation of the Mobilizing for Action through Planning and Partnerships (MAPP) process for an example of another effort that demonstrates the cyclical approach to improvement.

Revisiting the Approach to the Environmental Scan of Measures and Synthesis

Mr. Anderson then presented NQF's plans for the environmental scan and evidence synthesis. The synthesis of evidence will provide the Committee and HHS with a comprehensive body of information on related efforts for improvement of the quality of HCBS. The product will be an annotated bibliography in the second Interim Report. NQF staff will evaluate each source based on the impact, improvability, and inclusiveness; and note whether the source contains measures or measure concepts. The final product

of the environmental scan will be a spreadsheet that captures key elements of existing measures and measure concepts. Measures and measure concepts will be evaluated using four criteria: 1) Scientific evidence and psychometric testing; 2) HCBS populations of interest; 3) Feasibility of data collection; and 4) Prevalence of use. NQF will assign a rating of superior, good, sufficient, or insufficient for the measure against each criterion.

Dr. Kaye asked the Committee for questions and comments on NQF's approach. One Committee member asked NQF to group the measures in such a way to help the Committee prioritize their review and suggested organizing the measures by those that receive the highest rating across criteria. Other members asked how NQF would address multiple measures embedded in instruments or surveys. Mr. Anderson replied that NQF staff would extract relevant measures. Another member expressed concerns that important measures may be overlooked because they cannot be psychometrically tested such as measures that are a proportion of services received. Mr. Anderson recognized that some measures will have more testing than others, and that NQF will be including as much information on each measure as possible. Further, Dr. Kaye emphasized that there is more to reliability and validity than psychometric testing, and NQF agreed that staff will be looking at scientific evidence more broadly.

Opportunity for Public Comment

Public participants had the opportunity to provide comments and ask questions throughout the meeting. Many participants wrote in their responses through the chat feature (See Appendix B for participant messages). The Committee received one public comment asking them to emphasize that HCBS be consistent with the legal rights of consumers.

Call to Action and Next Steps

The meeting concluded with Ms. Ibragimova detailing the next steps for the project:

- NQF will conduct the environmental scan of measures and synthesis of evidence.
- The 2nd Interim Report with scan and synthesis results will be posted for public and NQF member comment by mid-November.
- NQF will convene a 2-day Committee in-person meeting in March 2016, in Washington, DC.

Mr. Anderson committed to sending the Committee a list of sources, organizations, and initiatives that are currently being reviewed as part of the environmental scan. Dr. Kaye asked Committee members to review this list and suggest additional sources for NQF to consult.

In closing, Dr. Terry and Dr. Kaye thanked the committee members, NQF staff, and the public for participating in the meeting.

Appendix A: Committee Members in Attendance

Name	Organization
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
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

Each comment has been reviewed and will be shared with the Committee. Public and member feedback is essential to our process and we encourage continued participation throughout the life of this project. All materials from the meeting, including the slide deck and transcripts, are available on the project's webpage. The next opportunity for public comment will begin on November 17, 2015 for the draft report on the environmental scan and synthesis of evidence. NQF staff encourages the public and NQF members to subscribe to project alerts on the NQF HCBS Project webpage.

Participant Comment
we use as independent as they choose
The term 'choices' is a universal word that the general public would understand.
Autonomy, in place of self-determination, could be an option as well.
Can independence be asterisked with a definition that says "as defined by the person"?
I'm on, have been from the start, and not on mute. Not sure why I can't be heard. I agree that the word promote implies maximum independence just as it promotes maximum well-being and choice, terms that are also open to interpretation. Clare Luz
Keep Integrated!!
yes! it removes the medical model- the focus on curing the individual. HCBS is based on functional needs.
What about"...promote inclusion and optimal self-empowerment (or independence),well-being, and choices of an individual.. provided in the home or within community settings."Self-empowerment would suggest personal and professional development.Would agree that the time frame is already implied.
Appropriate can be viewed as a value judgement. Who is determining what is appropriate for the individual?
try, "promote health and wellness"
Suggestion related to slide 17:"...includes a scope of services that are person-centered and sufficiently accessible, dependable, and timely...""Person-centered services" implies flexible and appropriate.
how about Voice of the Customer (VotC) instead of consumer voice
System Performance might include the idea that the system will begin to focus on "diversion" so that PWDs don't ever have to enter a SNF or other type of institution.

Participant Comment
James Gallant, Marquette County Suicide prevention Coalition. I'm specifically concerned about the fidelity of the voting process and parliamentary procedure as it relates to the National Quality Forum's approved Bylaws (2014). Please consider a special meeting to review the NQF Bylaws and gain a consensus (60% vote) of the committee on the "Rules of Order" and the voting requirements for this NQF HCBS Standing Committee. Thank You.
should be included Level of Care is not going away for eligibility.
Regarding housing, it would not seem appropriate to put it under "Equity" as that might imply all participants will or should have similar housing. Those living in their own homes or family homes already live in diverse situations.
How does this project plan to work with the Centers for Medicare & Medicaid Services (CMS), the Assistant Secretary for Planning and Evaluation (ASPE), and Mathematica Policy Research's current work to develop quality measures for Medicaid fee-for-service beneficiaries using home- and community-based services (HCBS)?
In regard to the list of qualities of services as being flexible, adequate, etc., I would suggest you also add "acceptable." Given the importance of choice and control, services should be acceptable to the individual. A choice among multiple unacceptable services is no real choice at all.
A financing domain would be an essential addition to the domains, and the subdomains should include the adequacy of funding, the use of multiple funding streams and the efficient and effective use of funding resources. Thank you for all your hard work!
choices and control for person supported is the central feature of HCBS. can the person with ID/ cognitive/physical/emotional needs be supported in learning to make responsible decisions (considering consequences of choices) would help. Any consideration for it?
James Gallant, Marquette County Suicide Prevention Coalition. Will the HCBS Standing Committee please consider amending NQF's working definition of Person and Family-Centered Care to include the phrase 'legal rights' to ensure services are responsive to and consistent with the consumers current legal rights including court ordered custody/parenting time rights. All HCBS services are currently required to be provided in a manner consistent with the person's legal rights. Right? Thank You.
In the environmental scan, please focus on identifying additional research that may be needed to support building evidence in domains where evidence is lacking.

Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living

Committee Web Meeting

August 28th, 2015

NATIONAL QUALITY FORUM

NQF Project Staff

- Margaret Terry, RN, PhD
  - Senior Director
- Rachel Roiland, RN, PhD
  - Senior Project Manager
- Andrew Anderson, MHA
  - Project Manager
- Kim Ibarra, MS
  - Project Manager
- Laura Ibragimova, MPH
  - Project Analyst

HHS Project Team

- Jamie Kendall, ACL
- Coretté Byrd, CMS
- Ellen Blackwell, CMS
- Mike Smith, CMS
- Venesa Day, CMS
- D.E.B. Potter, ASPE
- Lisa Patton, SAMHSA

HCBS Quality Committee

Staff will roll call Committee members who are not logged into the webinar.

- Joe Caldwell (Co-Chair)
- Stephen Kaye (Co-Chair)
- Robert Applebaum
- Kimberly Austin-Oser
- Suzanne Crisp
- Jonathan Delman
- Camille Dobson
- Sara Galantowicz
- Ari Houser
- Patti Killingsworth
- Charlie Lakin
- Clare Luz
- Sandra Markwood
- Barbara McCann
- Sarita Mohanty
- Gerry Morrissey
- Ari Ne'eman
- Andrey Ostrovsky
- Mike Oxford
- Lorraine Phillips
- Mary Smith
- Anita Yuskauskas

Webinar Objectives

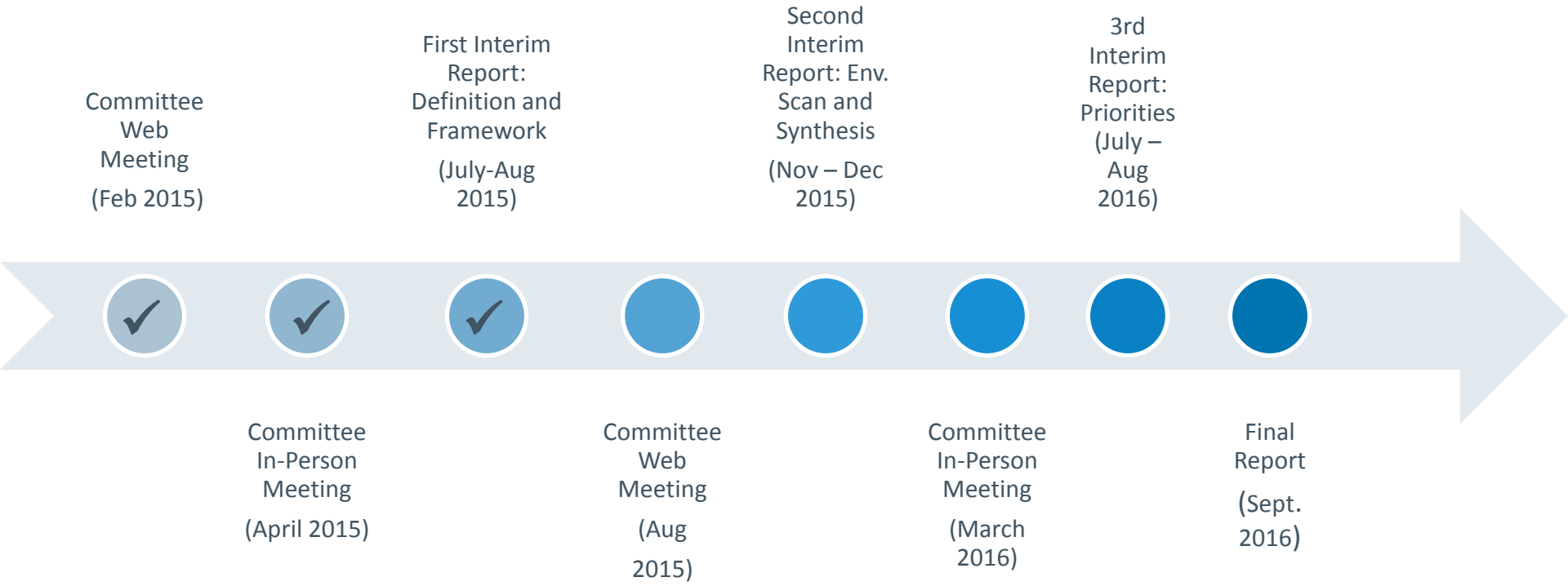
- Review highlights of the July 2015 Interim Report
- Discuss public comments received on the Interim Report and how to incorporate them into the work moving forward
- Provide guidance for the ongoing environmental scan of HCBS measures and synthesis of evidence

Measuring HCBS Quality Project

Provide multistakeholder guidance on the highest priorities for measurement of home and community-based services that support high-quality community living

- Offers an opportunity to address the gaps in HCBS measurement and provide direction for future performance measurement
- Will maintain a broad and inclusive orientation to community living and maximize opportunities for public input. Will NOT endorse individual measures.

Project Timeline 2015-2016



Interim Report and Public Comments

Interim Report Public Comments

- NQF received 100+ comments from dozens of organizations and individuals across the country
- NQF will post the comments to the project page with a cover letter highlighting and responding to key themes

- Points of clarification:
  - This project is setting a strategic direction and will produce both short-term and long-term recommendations. It is not expected to immediately impact any program reporting requirements, particularly for states.
  - Measures suggested by this project will not apply universally (to all consumers, all settings, or all services).
  - Prioritization involves making trade-offs. Out of scope ≠ unimportant.

General Comments

- Overall, very supportive of the Committee's work and approach
  - Recognized importance and urgency
- Personal experiences highlighted important concepts
- Comments were generally thoughtful and nuanced, often suggesting that additional details or perspectives be specifically mentioned, such as:
  - References to specific populations that use HCBS
  - Use of technology in the home
  - Measurement of reporting of abuse
- Questions related to data availability and system interoperability
- Descriptions of barriers to receiving high-quality HCBS
- Requests to further clarify "dignity of risk"

HCBS Operational Definition

The term “home and community-based services” (HCBS) refers to an array of long-term supports that promote the independence, well-being, and choices of an individual of any age who has physical, cognitive, and/or behavioral health needs and that are delivered in the home or other integrated community setting.

Characteristics of High-Quality HCBS

- Provides for a person-driven system that optimizes individual choice and control in the pursuit of self-identified goals (e.g., employment, enjoying life)
- Promotes social connectedness by including people who use HCBS in the community to the same degree as people who do not use HCBS
- Includes a flexible range of services that are accessible, appropriate, effective, sufficient, dependable, and timely to respond to individuals' strengths, needs, and preferences
- Integrates healthcare and social services to promote well-being

Characteristics of High-Quality HCBS

- Protects the individual's human and legal rights, including privacy; dignity; freedom from abuse, neglect, and exploitation; respect; and independence
- Ensures each individual can achieve the balance of personal safety and dignity of risk that he or she desires
- Utilizes and supports a workforce that is trained, adequate, and culturally competent
- Supports family caregivers
- Engages individuals who use HCBS in the design, implementation, and evaluation of the system and its performance

Characteristics of High-Quality HCBS

- Reduces disparities by offering equitable access to and delivery of services
- Coordinates and integrates resources to maximize affordability and long-term sustainability
- Supplies valid, meaningful, integrated, aligned, and accessible data
- Fosters accountability through measurement and reporting of quality and outcomes

Operational Definition and Characteristics : Comment Themes and Committee Discussion

Definition and Characteristics: most comments agreed

- "integration" – not all HCBS are fully integrated, yet these services should not be excluded from the definition.
  - Does the committee want to modify the definition to mention "most integrated setting appropriate" or mention "maximizing capabilities"
- Suggestions that Characteristics should mention: identification and reduction of barriers, more about cost, worker availability/retention, consumer voice in data collection, engagement and disparities, linguistic competence
  - Does the committee want to make any additions?

Discussion: HCBS Operational Definition

The term "home and community-based services" (HCBS) refers to an array of long-term services and supports that promote the independence, well-being, ~~and choices~~ self-determination, [inclusion?,] [and dignity?] of an individual of any age who has physical, cognitive, and/or behavioral health needs and that are delivered in the home or other integrated community setting.

- "Independence": Does this apply to all HCBS users? Is the intent misinterpreted by some readers?
- "Needs": It's positive (a plus) but is it too broad?
- "Integrated": Does this exclude some forms of HCBS? What about emphasizing choice or preference?

Discussion: Characteristics of High-Quality HCBS

- Provides for a person-driven system that optimizes individual choice and control in the pursuit of self- identified goals ~~(e.g., employment, enjoying life)~~ [and life preferences?]
- Promotes social connectedness by including people who use HCBS in the community to the same degree as people who do not use HCBS
- Includes a flexible range of services that are accessible, appropriate, effective, sufficient, dependable, and timely to respond to individuals' strengths, needs, and preferences [something about settings?]
- Integrates healthcare and social services to promote well-being [and …]

Discussion: Characteristics of High-Quality HCBS

- Protects the individual's human and legal rights, including privacy; dignity; freedom from abuse, neglect, ~~and~~ exploitation [, coercion, and restraint?]; respect; and independence
- Ensures each individual can achieve the balance of personal safety and dignity of risk that he or she desires
- ~~Utilizes and supports~~ [Ensures? Promotes?] a workforce that is trained [appropriately skilled?], adequate, [stable?], and culturally [and linguistically?] competent
- Supports family caregivers
- Engages individuals who use HCBS [, their designated representatives, and consumer advocates] in the design, implementation, and evaluation of the system and its performance

Discussion: Characteristics of High-Quality HCBS

- Reduces disparities by offering equitable access to and delivery of services [and…]
- Coordinates and integrates resources to [best meet consumer needs and] maximize affordability and long-term sustainability
- [Does cost/financing need its own bullet? E.g.: Receives adequate funding to deliver accessible and affordable services to those who need them.]
- Supplies valid, meaningful, integrated, aligned, accessible, outcome-oriented data to all stakeholders
- Fosters accountability through measurement and reporting of quality and outcomes

HCBS Domains and Subdomains

Domain	Subdomains
Workforce/Providers	Sufficient numbers and appropriately dispersed; dependability; respect for boundaries, privacy, consumer preferences, and values; skilled; demonstrated competencies when appropriate; culturally competent, sensitive, and mindful; adequately compensated, with benefits; safety of the worker; teamwork, good communications, and value-based leadership
Consumer Voice	Meaningful mechanism for input (e.g., design, implementation, evaluation); consumer-driven system; breadth and depth of consumer participation; level of commitment to consumer involvement; diversity of consumer and workforce engagement; and outreach to promote accessible consumer engagement
Choice and Control	Choice of program delivery models and provider(s) including self-direction, agency, particular worker(s), and setting(s); personal freedoms and dignity of risk; achieving individual goals and preferences (i.e., individuality, person-centered planning); self-direction; shared accountability

HCBS Domains and Subdomains

Domain	Subdomains
Human and Legal Rights	Consumer engagement; participatory program design; reliability; publicly available data; appropriate and fair resource allocation based on need; primarily judged by the aggregate of individual outcomes; waiting lists; backlog; financing and service delivery structures; availability of services; efficiency and evidence based practices; data integrity
System Performance	Sufficient numbers and appropriately dispersed; dependability; respect for boundaries, privacy, consumer preferences, and values; skilled; demonstrated competencies when appropriate; culturally competent, sensitive, and mindful; adequately compensated, with benefits; safety of the worker; teamwork, good communications, and value-based leadership
Full Community Inclusion	Enjoyment or fun; employment, education, or productivity; social connectedness and relationships; social participation; resources to facilitate inclusion; choice of setting; accessibly built environment

HCBS Domains and Subdomains

Domain	Subdomains
Caregiver Support	Training and skill-building; access to resources (e.g., respite, crisis support); caregiver well-being (e.g., stress reduction, coping); caregiver and/or family assessment and planning; compensation
Effectiveness/Quality of Services	Goals and needs realized; preferences met; health outcomes achieved; technical skills assessed and monitored; technical services delivered; team performance; rebalancing
Service Delivery	Accessibility (e.g., geographic, economic, physical, and public and private awareness or linkage); appropriate (e.g., services aligned with needs and preferences, whether goals are assessed); sufficiency (e.g., scope of services, capacity to meet existing and future demands); dependable (e.g., coverage, timeliness, workforce continuity, knowledge of needs and preferences, and competency); timely initiation of services; coordination (e.g., comprehensive assessment, development of a plan, information exchange between all members of the care team, implementation of the plan, and evaluation of the plan)

HCBS Domains and Subdomains

Domain	Subdomains
Equity	Reduction in health and service disparities; transparency of resource allocation; access or waiting list; safe, accessible, and affordable housing; availability; timeliness; consistency across jurisdictions
Health and Well-Being	Physical, emotional, and cognitive functioning; social well-being, spirituality; safety and risk as defined by the consumer; freedom from abuse, neglect, and exploitation; health status and wellness (e.g., prevention, management of multiple chronic conditions); behavioral health

Measurement Domains and Subdomains: Comment Themes and Committee Discussion

- Numerous suggested additions to the list of domains/subdomains, relatively few comments that a concept was not important to measure
  - Workforce supply, Inclusion, Equity vs. Equality, etc.
- Generally appreciative and supportive of the domains' emphasis on consumers' goals and outcomes as well as the important role of all types of caregivers.
- Noting the "subjective" nature of some of the measurement domains and how measurement thresholds will be determined
  - "Who will judge when _____ is sufficient?"

Discussion: HCBS Domains

- Workforce~~/Providers~~:
- Consumer Voice:
- Choice and Control:
  - Add supports for consumers in directing services?
- Human and Legal Rights:
  - Add exploitation/coercion/restraint to “freedom from abuse & neglect,” remove from Health & Well-Being?
  - Something about education about rights and exercising them?
  - Add: services meet all applicable laws and regulations?

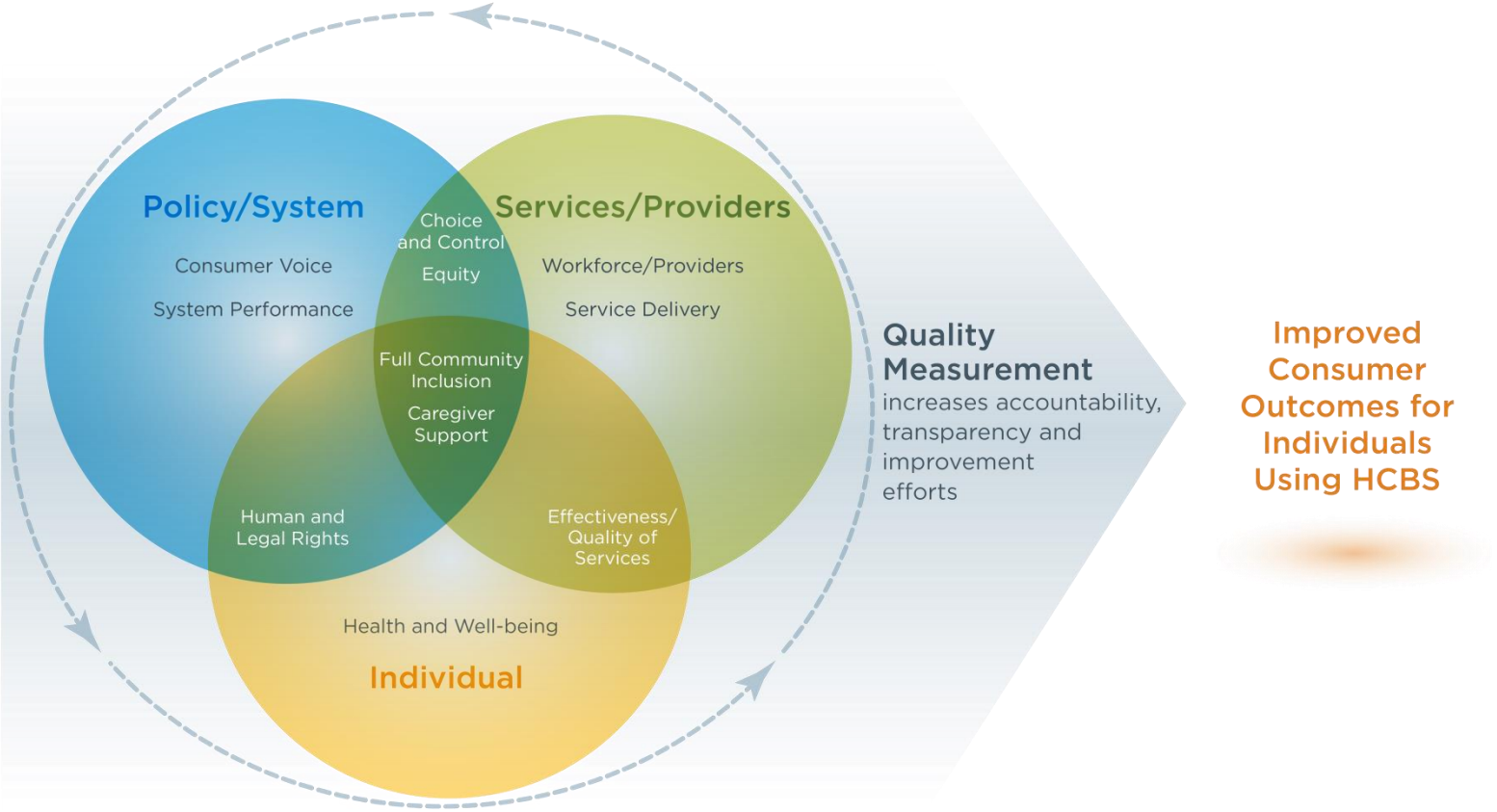
Discussion: HCBS Domains

- System Performance:
  - Move “rebalancing” from Effectiveness to here?
- ~~Full~~ Community Inclusion: The level to which individuals who use HCBS are integrated into their communities and are socially connected
  - Mention transportation in subdomain?
  - Is the employment subdomain sufficient?
- Caregiver Support:
  - Add: Integration into care team?
  - Add: Education about system and legal supports

Discussion: HCBS Domains

- Effectiveness/Quality of Services:
  - Add appropriate assessment of need?
- Service Delivery:
- Equity:
  - Remove housing?
- Health and Well-Being:
- Where does housing go, if anywhere?
- Do we need to include assistive technology, home modifications, etc.? Where?
- Domain on cost/financing?

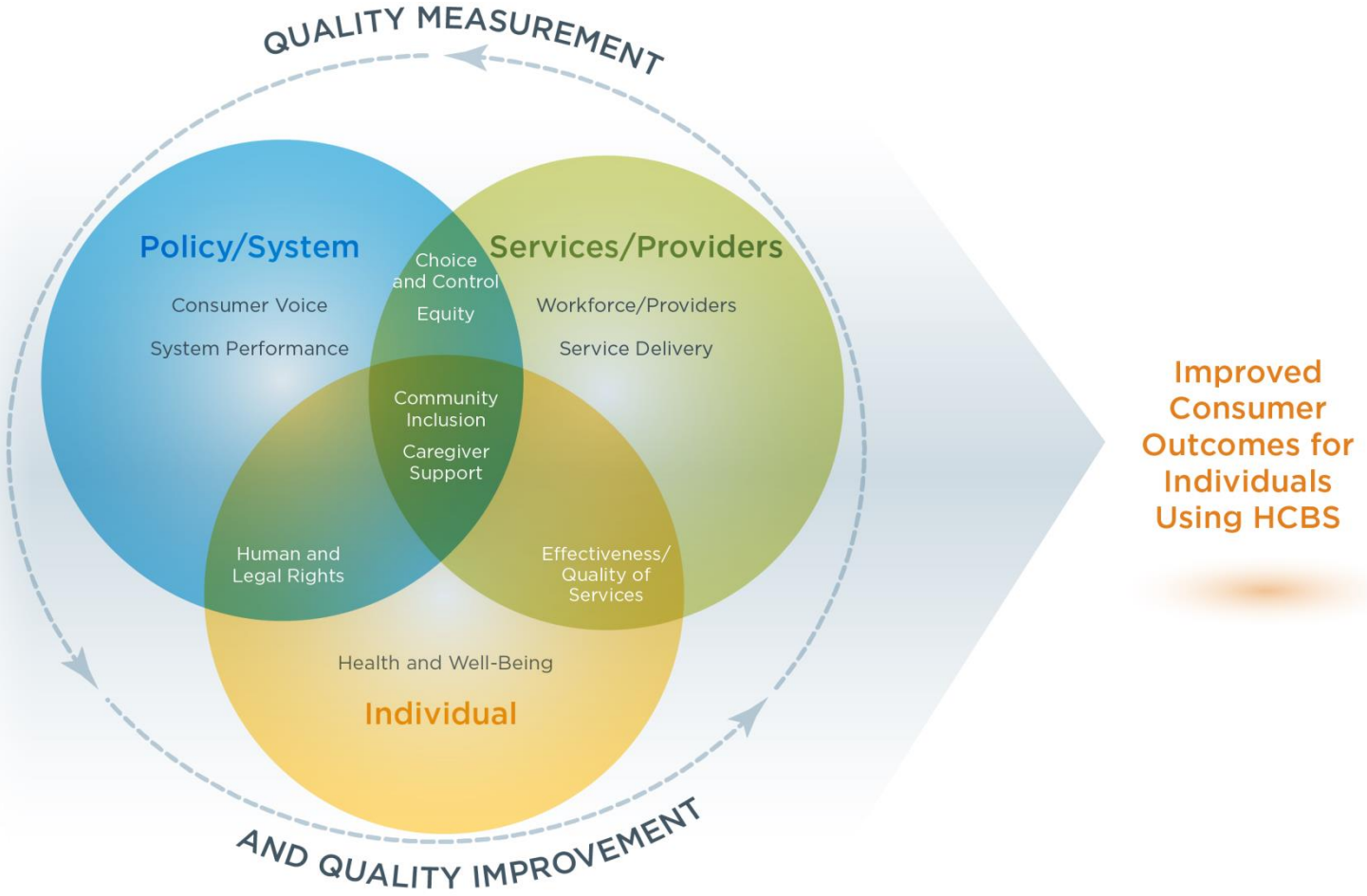
Illustration of Conceptual Framework for Measuring HCBS



Conceptual Framework: Comment Themes and Committee Discussion

- Relatively fewer comments about the illustration
- Placement of the arrow linking quality measurement to improved consumer outcomes
  - Highlight the intermediate step: quality measurement **informs quality improvement actions** which lead to improved outcomes?
- Continue to receive questions and comments about the placement of domains within the three circles.
  - Is the conceptual framework meaningful without the domains?
  - How can they be better communicated?

Revised Illustration of Conceptual Framework for Measuring HCBS



Opportunity for Public Comment

Environmental Scan and Synthesis of Evidence

Synthesis of Evidence

Objectives:

- Collect information sources relevant to the HCBS project and its ultimate goal of prioritizing measurement opportunities
- Sources have already informed the development of the operational definition, domains/subdomains, and conceptual framework
- Feed the scan of measures and measure concepts applicable to HCBS
- Inform the prioritization of measurement gaps

Source Evaluation Criteria

- **Product = annotated bibliography**
- NQF staff will evaluate each source based on three criteria first described by the Institute of Medicine*:*
  - **Impact:** Magnitude of the quality issues, both to the HBCS consumer/family and the system
  - **Improvability:** Existence of a performance gap and opportunity to narrow it through measurement.
  - **Inclusiveness:** Extent to which the quality issue is relevant to a variety of HCBS consumers and the ability to generalize findings to other areas

Citation List Data Elements

- Title
- Author
- Publication Year
- Evidence Type
- Abstract/Description
- Service Type(s)
- Target Population(s)
- Evaluation Criteria Ratings
- Framework Domain(s)
- Framework Subdomain(s)
- Formatted citation

Environmental Scan of Measures

Objectives:

1. Identify existing measures applicable to HCBS, with an emphasis on those that maps to the list of domains and subdomains
2. Identify example(s) of HCBS quality measures to guide Committee discussion of implementation barriers and mitigation strategies
3. Identify measure concepts and ideas that should be further developed into future performance measures

Environmental Scan of Measures

- **Product format = spreadsheet**
- Ongoing collection from information sources
  - Literature review of both grey and peer-reviewed articles, reports, websites
  - Measure inventories/databases
  - Specifically search for measures within domains/subdomains identified by the Committee

Data Elements for Each Measure or Concept

Measures List	
• Title	• Service Setting
• Description	• Level of Analysis
• Numerator and Denominator	• Data Source
• Measure Type	• Unique numerical identifier
• Service Type(s)	• Reliability Testing (Y/N)
• Target Population(s)	• Validity Testing (Y/N)
• Payer(s)	• Information Source Citation
• Measure Development Lifecycle Stage	• Evaluation Criteria Ratings
• Measure Developer/Steward	• Framework Domain(s)
• NQF endorsement status	• Framework Subdomain(s)

Measure and Measure Concept Evaluation Criteria

Criteria	Rating Scales
Scientific evidence and psychometric testing	A: Reliability and validity testing B: Evidence of some instrument testing I: There is either: • Documented evidence that the measure was developed in collaboration with stakeholders • No documented evidence of psychometric testing
HCBS populations of interest	A: Designed/tested for more than one HCBS population B: Designed/tested for one HCBS population I: The measure was: Designed/tested for the general population not receiving HCBS Designed/tested for persons receiving institutional care
Feasibility of data collection	A: Requires administrative/clinical data collection from single organizational source B: Requires survey data collection from a single survey respondent or chart review C: Requires administrative/clinical data from multiple organizational courses I: Requires survey data collection from multiple responses to construct the measure about a single person
Prevalence of use	A: Use or intended use by a federal government agency or national entity B: Use or intended use by two or more programs/entities (including state/local) C: Use or intended use by one program/entity I: No Indication of use in the field of HCBS

Committee Discussion

- What other elements, if any, would the Committee like to be captured:
  - During the synthesis of evidence?
  - During the environmental scan of measures?
- In what format would the Committee most like to review the results?
- What other organizations and/or key informants should NQF contact regarding measures or measurement initiatives?

Next Steps

- NQF will conduct the environmental scan of measures/measure concepts and synthesis of evidence
- The 2nd Interim Report with the results of the scan and synthesis will be posted for public and NQF member comment by mid-November
- 2-day Committee in-person meeting in March 2016 to review the results of the scan, synthesis, and comments
  - Committee will conduct prioritization of measurement opportunities at this meeting

Opportunity for Public Comment

Adjourn

Thank you for participating!