Assessing HCBS Providers' Performance: Candidate Measures for MN DHS

Final Report EXCERPT: Pages 1-12 and Appendix II

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I. Introduction and Background

As part of its long-term vision, the Minnesota Department of Human Services (DHS) is seeking to improve the quality and utility of the provider performance data it collects. The goal of doing so is to improve government and consumers' ability to make purchasing decisions based on meaningful performance metrics. These data could be used for public reporting to current and potential consumers to facilitate their decision-making and to influence provider behavior and quality improvement. As a first step in this process, DHS contracted with Thomson Reuters to propose a limited candidate list of cross-cutting measures for assessing and comparing individual providers, as well as an assessment of the feasibility of implementing these measures for an initial subset of HCBS provider types. The Provider Performance Measures task is one component of Minnesota's State Profiles Grant from CMS.

For this initial exercise, DHS identified five provider types to test the measures for "proof-of-concept." These include two categories of residential service providers - Adult Foster Care and Assisted Living - and three day services and employment providers: Supported Employment Services, Day Training & Habilitation programs, and Adult Day Care. All of these providers are subject to state statute and are licensed by the state, although only Assisted Living services, not facilities, require licensure. All licensed providers in these categories are eligible for Medicaid reimbursement through at least one or more Medicaid HCBS waiver program operated in Minnesota.

In developing the candidate list, the contractor was asked to select measures that met the following criteria:

- Applicable to all five providers
- Relevant across target adult LTC populations
- Acceptable to providers
- Meaningful to consumers
- Facilitate valid comparison and differentiation between providers
- Potentially apply to other HCBS provider types as well

An Expert Panel, comprising stakeholders from across the state, representing consumers, providers, the public sector, and associations knowledgeable and active in HCBS issues provided ongoing review and feedback on project activities. This Expert Panel was convened for the purpose of advising this task and the overall Long-Term Care Profile effort. Contractor staff participated in all the bi-monthly meetings of the Expert Panel, to update members on project activities and to obtain feedback on project findings and deliverables.

This final report outlines the work performed on this contract, presents a final candidate list of measures for the Department's consideration, overviews key findings with regards to the feasibility of implementing the candidate measures and includes recommendations for going forward.

II. Work Performed

A work plan for this effort was presented to Expert Panel in September 2008 and included six discrete activities. The work completed under each specific task is detailed below.

Task 1. Identify Measure Constructs

The first goal was to identify the constructs (broad areas for measurement) that project stakeholders believed were important dimensions of provider quality and meaningful for reporting purposes. In addition to discussions with the Expert Panel, project staff conducted a SNAP survey of Expert Panel members which asked them to rate measure constructs for importance as well as for provider accountability. The results of the SNAP survey were presented to the Expert Panel on November 21, 2008. The subsequent discussion was used to develop several categories or "buckets" of measure constructs that were considered important for assessing provider importance. These were:

- "Red Flags" or critical incidents
- Client/Participant Satisfaction
- Meeting State or Professional Standards
- Quality Outcomes
- Provider Characteristics

Together, these five domains specify a framework of important provider attributes and performance information that Panel members felt would be valuable to current and potential service recipients.

Task 2. Environmental Scan

The second major activity was to conduct an environmental scan of extant provider measures, including those used by other states, for HCBS and other long-term care providers that aligned with the constructs identified in Task 1. The environmental scan was conducted between December 2008 and February 2009. The results of that scan, along with summary observations and implications, were presented to the Expert Panel on February 27, 2009. Information about current use, relevant providers and populations, endorsement by the National Quality Forum and measure domain was included for each measure. An excerpt from the memo describing the scan findings and the measures reviewed are included in Appendix I.

Task 3. Candidate List of Potential Provider Measures

Team members used the findings of the environmental scan, along with feedback from DHS stakeholders to develop an initial list of candidate measures. This initial list, along with a proposal to group the measures by three tiers (applicable to all provider types; applicable to a group of provider types; applicable to one provider type) was presented in an on-site meeting on May 1, 2009. This initial list underwent revision as a result of DHS and stakeholder feedback. The final list of candidate measures is included in Appendix II.

Task 4. Gap Analysis for Measure Development

The initial candidate list of measures was reviewed against tested and reliable extant measures, to determine which measures would need to be developed, and which may be drawn from existing sources. This analysis was first addressed in the preliminary report, which is included as Appendix III. The "feasibility notes" in Appendix II identify where additional measure development may be needed. For a variety of reasons, many of which are discussed in the feasibility section below, nearly all the measures on the final candidate list will require some original development and testing.

Task 5. Gap Analysis for Data Collection

The second component of the gap analysis addressed the need for additional data collection or manipulation by DHS. The project team reviewed current and potential DHS data sources to determine which measures on the candidate list could be calculated from these sources, and which would require additional data collection, or modification to existing data sources. The notes in Appendix II and the "Recommendations" section below delineate where additional data collection or modification would be required to support the candidate measures.

Task 6. Feasibility Analysis

Finally, the project team outlined the pros and cons (feasibility) for each measure on the final candidate list, based on the gap analyses. The Preliminary Feasibility Report (Appendix III) explores feasibility based on the initial candidate list of measures. Feedback on that report resulted in the final candidate list included in Appendix II. Feasibility is addressed in both that Appendix, as well as the "Findings" and "Recommendations" sections below.

III. Findings Regarding Feasibility

As noted in the Preliminary Feasibility Report from June 2009, Minnesota has an opportunity to capitalize on extant performance measures and its current and potential data sources to publish information on individual HCBS provider performance and characteristics. This report identified a "three-tiered" approach to measure development and reporting that included some cross-cutting measures, some specific to groups of providers (residential or day) and some relevant to a single provider type only, e.g. Supported Employment Services. Subsequent revisions resulted in the elimination of the middle tier for provider groups, leaving the mixture of cross-cutting measures and provider-specific ones included in Appendix II.

There are several aspects of both this task and the state's structure for reviewing and monitoring providers which impact the feasibility of implementing the candidate list, or really any list, of provider performance measures. These have been discussed throughout the project, and are summarized below, in order to provide context for the recommendations which follow.

The five proof-of-concept providers serve disparate populations with a wide array of services

The five provider types chosen for this review offer very different services to their clients, which means they share few, if any, common outcomes. Adult Foster Care must meet the daily living needs of adults during the evening and overnight hours, including meals, hygiene and mobility, along with supporting community integration. In contrast, Supported Employment Services provide supports specific to obtaining and fulfilling paid employment. This variability in services, staffing and goals is even greater when all HCBS providers are considered, a long-term goal of this initiative. By necessity, the feasibility of cross-cutting measures of provider characteristics and impact is limited to more generic outcomes.

A related issue is the mix of public and private pay clients served by the proof-of-concept providers. Day Training & Habilitation providers, for example, serve virtually only Medicaid recipients. In contrast, assisted living providers serve large numbers of private pay clients. The feasibility of gathering information on this latter group is limited, and subject to their cooperation. At the same time, measures based solely on the experience of public pay clients will not provide a comprehensive view of provider performance.

Finally, individual HCBS recipients are often served by more than one provider type. An individual may reside in an adult foster care home, attend day training classes and receive supported employment services. This has implications for the feasibility of holding any one provider accountable for outcome measures, as well as assessing consumers' experience. Measures that are specific to a service type, or reference a single provider, will be more feasible from a respondent's perspective and more accurate in describing a particular provider's performance.

Provider licensing responsibility falls to two different Departments, and standards are specific to provider type and clients served.

Four of the proof-of-concept provider types (Adult Foster Care, Adult Day Care, Day Training & Habilitation, and Supported Employment Services) are licensed by DHS. Assisted Living facilities are not licensed per se, but the providers who offer services in these sites are licensed by the Minnesota Department of Health (MDH). Even within DHS' licensing function, some provider types are reviewed directly by state staff, while others are reviewed at the county level. This means that providers, such as adult foster care providers, that operate in more than one county can be subject to multiple reviews captured in multiple documents. Furthermore, the licensing requirements in stature for each provider type are different, although some basic themes and expectations do cut across all five. And, for some providers, only the services provided to a subset of their clients, specifically those who are on the states Developmental Disabilities waiver, are reviewed. Finally, there are key differences in how often reviews are conducted by MDH and DHS, as well as which data are captured electronically, what findings trigger conditional licensure, when fines are assessed and how remediation is monitored.

The feasibility of using licensing data for provider measures is limited, therefore, by this variability and the obstacles it poses to valid comparisons between provider types. Furthermore,

our review found that much of the information obtained during a licensing review, especially that related to service quality, is not captured electronically. The feasibility of producing future measures based on licensing data will hinge in part on efforts and investments in automating more of the review findings.

Minnesota does not currently implement a standard consumer assessment or feedback tool for HCBS recipients.

Unlike nursing home residents, whose Report Card was a model for this project, there is no single tool currently used to assess individuals' needs or to capture their feedback on services and supports received. Periodic assessment data and consumer surveys are two powerful sources for measuring provider performance. DHS does have two surveys that were developed specifically for groups of Medicaid HCBS waiver participants: the Consumer Experience Survey for Elder Waiver participants and the Participant Experience Survey, MN Version, for participants on the Developmental Disabilities, Traumatic Brain Injury, CAC and CADI waivers. Neither tool was developed specifically for the purpose of assessing individual provider performance, although each contains several items that align with the measure constructs endorsed by the Expert Panel. However, the large number of HCBS providers in the state poses significant sampling challenges for collecting sufficient responses to support individual provider profiles. This factor, combined with the resource-intensive nature of collecting consumer data in person, means that cost is an appreciable constraint on feasibility. The disparate nature of the current assessment tools also limits the feasibility of using assessment data for cross-cutting measures. Implementation of the standardized COMPASS assessment tool will facilitate using these data for measuring provider performance, particularly given the planned 100 percent sample of waiver participants. If COMPASS were leveraged to gather consumer experience data as well, this would make several measures on the candidate least more feasible to implement.

Most proof-of-concept providers serve a very small number of individuals, particularly public pay clients, each.

There are a large number of small providers who deliver HCBS services and supports to individuals with disabilities in Minnesota. This fact makes it more difficult to gather sufficient data from service recipients to support valid comparisons between individual providers. In most cases, nearly one hundred percent of service recipients would need to be sampled to support statistically significant comparisons. And, any reported rates, even if drawn from administrative data, may be misleading for very small providers: one substantiated complaint from five total residents translates to 20 percent, while one complaint per 100 day services participants equals only one percent. As noted above, the small numbers of clients per individual provider and the large number of provides overall all but preclude sampling for consumer surveys, making participant feedback expensive to obtain.

Data on total number of clients served, whether public and private pay, cannot be reliably obtained from existing DHS databases. This information is the crucial denominator from some measures. In order to report out of these measures, DHS will need cooperation from the providers in determining their caseloads.

Most extant HCBS measures identified in the measure scan are tied to a particular data collection tool or population (or both) and cannot be easily adapted to MN's needs.

In many ways, Minnesota is at the forefront in this effort to capture and publish comparative data on provider performance. There are few, if any, provider performance measures that have been developed and tested that are appropriate for the range of provider types under consideration by DHS. Most measures we identified were specific to a particular sub-population, such as individuals with developmental disabilities, or derived from a particular tool, often a consumer survey or automated assessment process. Furthermore, most were not initially designed to measure the performance of individual providers. Most measures on the candidate list, therefore, will require original development and testing by the state.

IV. Recommendations

The previous section clearly delineates the many feasibility challenges DHS faces in collecting and reporting valid, cross-cutting measures for the five proof-of-concept providers. However, DHS is in a unique position to implement changes that will facilitate collecting and collating the data needed to support the candidate measures. Any effort to make changes should be guided by the three goals articulated for the provider performance measures:

- Facilitate consumer decision-making by providing data consumers find accessible and useful
- Create incentives for provider quality improvement
- Allow public purchasers to meaningfully compare providers.

Specific recommendations enhancing the feasibility of the candidate list are included below.

Licensing:

1) Because of the differences in their standards for conditional licensure and the investigatory process and data maintained for substantiated complaints, at this point it does not seem valid to compare providers licensed by DHS and MDH on a single metric.
2) Both DHS and MDH have some searchable licensing information already available on-line. A future HCBS report card might include links to this information for further consumer research, in addition to any summary metrics. For example, the results of all the MDH reviews of assisted living providers are available to the public on-line, athttp://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurveyresults.htm. Users can choose a provider by name and review pdf copies of recent surveys. Complaint information from MDH is also already available on-line.
3) It may be valuable to include data from multiple reviews to give a more accurate provider profile. However, the long lag between reviews make may this approach less meaningful.
4) The licensing reviews conducted by both MDH and DHS (including county-level reviews) captures at lot of rich information that is not current available in a searchable electronic format, including detailed findings around service quality and fines. Investment of additional resources would allow for keypunching and analysis of the rich data set currently collected through DHS' licensing function, and may also permit

abstraction of key data elements from the findings letters to providers that MDH posts. DHS may wish to consider collaboration with both licensing entities in this area, as well as determining what internal priorities and initiatives might align with this effort.

5) A key requirement for the measures on the candidate list was that they differentiate meaningfully between providers. DHS should conduct a "dry run" of existing licensing data to gather baseline data for the first two measures, conditional licensure and substantiated allegations against provider staff, to see if any meaningful patterns emerge.

COMPASS:

1) The planned implementation of the COMPASS assessment tool, which will be administered at least annually to all waiver program participants, offers a unique opportunity to collect participant experience data at minimal cost.
2) In order to use COMPASS to support the candidate measures derived from participant feedback, modification of the assessment form is required. Suggested language that directly aligns with the current candidate measures is included in Appendix IV.
3) If COMPASS is to be used to gather data for provider performance measures, DHS needs to develop policies around who will administer COMPASS, how data will be collected from those whose cognitive impairments make it difficult for them to provide valid responses, and the policy, if any, regarding proxy respondents for the person-centered interview and similar modules.
4) Because the number of individuals that will have a COMPASS assessment completed is small for many providers, raw data should be report, rather than percentages.

Provider Enrollment:

1) As DHS works to revamp its provider enrollment process, it has an opportunity to specify data requirements for enrollment that would support the performance measurement initiative. There is also an opportunity and obligation to involve providers in the discussion around measures, to facilitate their cooperation and endorsement of the effort.
2) DHS will need a count of the discrete number of individuals served during the previous year for each of the proof-of-concept providers. This becomes the denominator for the measure of substantiated allegations of abuse and neglect by provider staff. Depending on the scope of complaints tracked in SSIS and the comparable MDH system, this count may need to be limited to Medicaid recipients only. Supplying this data annually may be a condition of enrollment
3) The proposed employee retention measure relies entirely on data obtained from providers, which could also be a condition of enrollment. Providers could be asked to provide two statistics annually: 1) the number of direct care staff employed for at least six months as of January 1 (or other specified date) that were still employed one year later; 2) The total number of direct care staff care staff employed at least six months as of January 1. The state would need to articulate a clear definition of "direct care staff" and may wish to consider periodic audits to prevent "gaming" the numbers. In addition, the measure definition should address part-time workers, as well as those who are promoted or transferred to another location operated by the provider.
4) Since one of the candidate measures proposes to assess the accuracy of the information providers post on MNHelp.info, DHS will need to articulate clear expectations for what

providers must post and how often it should be updated. This measure does not yet specify what should be measured: date of last update, accuracy of contact info, etc. The work group for modifying the provider enrollment process should decide what it wants to require providers to do with respect to MNHelp.info, and how DHS will monitor compliance with these requirements. A related issue is how/if the new enrollment process will impact providers licensed by MDH.

Ombudsman:

1) DHS should initiate dialog with both the DHS and MDH Ombudsman's Offices to explore the options for defining violations of participant rights and for capturing this information in existing tracking systems. Any changes in definitions and procedures must be cognizant of the neutral function of the Ombudsman.
2) Currently, the DHS Ombudsman database does not support searches on individual providers. Any modification of either the MDH or DHS system should support this functionality.

Other Recommendations:

1) Any provider performance measure that is ultimately implemented must be evaluated with regards to the need for risk adjustment. As currently configured, none of the candidate measures suggest a need for risk adjustment, but provider feedback and recommendations on this issue should be sought.
2) DHS, in collaboration with the provider community, should "test" the measures with different possible scenarios and populations to see how they perform.
3) As noted previously, the importance of clear and comparable cost data is paramount in supporting consumers in their decision-making about long-term care. Obtaining, analyzing and publishing this information will require both development of meaningful specifications for what cost data should be reported and how these costs and units of measurement are defined, as well as original data collection efforts. This is an important role for DHS to explore.

V. Expert Panel Feedback

Members of the Expert Panel were given the opportunity to provide written comments on the final list of candidate measures. These comments are included verbatim below, for DHS reference.

Substantiated Allegations of Abuse/Maltreatment. Agree this is a valid measure with the following revisions:

- Revise definition to *"As determined by the investigative authority, number of substantiated allegations of abuse or maltreatment by provider staff during the previous calendar year"*. This will anchor the determination to the proper party and allow for any future revisions to the definitions of abuse or maltreatment.
- For simplicity, the denominator should be the *"Number of discrete individuals served by the provider on the last program day of the calendar year"*. Trying to include all

participants enrolled and discharged throughout the calendar year gets complex and is statistically insignificant.
- This measure should be reported on a "rolling" three-year period so the audience can see trends and the provider is not hammered for one bad year.
- Provider enrollment may only happen once and not be a good source of participant count. Can we get a participant count from the paid claims database?

Conditional Licensure. Not a valid measure for the following reasons:
- It is still a license.
- Time lag and infrequency of licensing reviews is problematic.

Retention of Staff Employed at least Six Months. Agree this is a valid measure with the following revisions:
- Better to report average tenure of direct care staff employed by the provider on the last business day of their fiscal year (add total months employed of each direct care staff together, divide by number of direct care staff, and divide by 12).
- Need to define direct care staff as those who worked at least 80% of their time providing program support to participants (accommodates for part-time and employees that work in multiple facilities for the same provider).
- This measure should be reported on a "rolling" three-year period so the audience can see trends.
- Data source would need to be the provider which is a weakness because it presumes accuracy.

Participant Satisfaction. Agree this is a valid measure with the following revisions:
- Numerator description revised to – *"Number of participants who say they would recommend the provider to someone seeking similar services"*.
- COMPASS does not seem like a good source of information for two reasons. First, it seems like a one-time eligibility assessment. Second, even if used annually, the COMPASS is a planning not an evaluation tool.
- Aren't most providers required to survey all their participants on this question making this our best source of data? If yes, then the denominator is number of participants that answered this question. Another option is to require the case manager to ask this question at the annual IDT meeting and report the response to a DHS website using a discreet participant and provider PIN.

Respectful Treatment. Agree this is a valid measure with the following revisions:
- Numerator description revised to – *"Number of participants who say provider staff treat them with respect"*.
- COMPASS does not seem like a good source of information for two reasons. First, it seems like a one-time eligibility assessment. Second, even if used annually, the COMPASS is a planning not an evaluation tool.
- Aren't most providers required to survey all their participants on this question making this our best source of data? If yes, then the denominator is number of participants that answered this question. Another option is to require the case manager to ask this

question at the annual IDT meeting and report the response to a DHS website using a discreet participant and provider PIN.

Safety with Provider. Agree this is a valid measure with the following revisions:

- Numerator description revised to – "*Number of participants who say I receive services at a place that is clean and safe"*.
- COMPASS does not seem like a good source of information for two reasons. First, it seems like a one-time eligibility assessment. Second, even if used annually, the COMPASS is a planning not an evaluation tool.
- Aren't most providers required to survey all their participants on this question making this our best source of data? If yes, then the denominator is number of participants that answered this question. Another option is to require the case manager to ask this question at the annual IDT meeting and report the response to a DHS website using a discreet participant and provider PIN.

Substantiated Complaints Related to Violation of Participant's Rights. Not a valid measure for the following reasons:

- Don't have a good data source.
- If true for a participant, they would answer no to satisfaction and respectful treatment questions.

Accuracy of MNHelp.info profile. No comment on this measure.

Activities Meet Preferences in Day Programs. Agree this is a valid measure with the following revisions:

- Numerator description revised to "*Number of participants who say they receive their preferred day services"*.
- Neither the COMPASS or PES seem to be good sources of data.
- Aren't most providers required to survey all their participants on this question making this our best source of data? If yes, then the denominator is number of participants that answered this question. Another option is to require the case manager to ask this question at the annual IDT meeting and report the response to a DHS website using a discreet participant and provider PIN.

Adequate Employment Support for Current Job. Agree this is a valid measure with the following revisions:

- Numerator description revised to "*I receive the support I need to maintain my current job"*.
- Neither the COMPASS or PES seem to be good sources of data.
- Aren't most providers required to survey all their participants on this question making this our best source of data? If yes, then the denominator is number of participants with a job that answered this question. Another option is to require the case manager to ask this question at the annual IDT meeting and report the response to a DHS website using a discreet participant and provider PIN.

Ability to Make Choices at Home. Agree this is a valid measure with the following revisions:

- Numerator description revised to *"Number of participants who say they are able to make choices that are important to them".*
- Neither the COMPASS or PES seem to be good sources of data.
- Aren't most providers required to survey all their participants on this question making this our best source of data? If yes, then the denominator is number of participants that answered this question. Another option is to require the case manager to ask this question at the annual IDT meeting and report the response to a DHS website using a discreet participant and provider PIN.

We have reviewed the Candidate Provider Performance Measures and have some feedback for you.

1. Substantiated Allegations. The proposed metric seems to favor large providers like ourselves. The outcome of the metric would yield a very small percentage. We think a better metric is either:
    a. a raw count; or.
    b. number of substantiated allegations of abuse or maltreatment by provider staff during the previous calendar year / Number of reports of suspected maltreatment. However this metric can be biased based on the higher number of reports. Increasing "safe reports" will decrease the percentage of substantiated reports
    c. Seems a better system might be to just compliment the MDH system currently in existence.
2. Conditional Licensure. Our comments are that the metric needs to compare apples to apples in its application.
3. Retention of Staff. The ICI 4 HR metrics are being universally adopted in our field. We should adopt those instead of recreating the wheel. These are Retention, Stability, Separation and Turnover
4. Participant Satisfaction. This seems to be a county issue, just let us know what they decide to measure us on.
5. Respectful Treatment. This seems to be a county issue, just let us know what they decide to measure us on.
6. Safety with Provider. This seems to be a county issue, just let us know what they decide to measure us on.
7. Substantiated Complaints. No real feedback, seems to be a state issue.
8. Activities meet Preferences in Day Programs. We think this requires a lot more information. There are multiple issues affecting employment, everything from realistic job expectation to shrinking economy.
9. Adequate Employment Support. This needs to be better spelled out; more accurately describing employment services.
10. Ability to make choices. If they are going to open the door on choice they need to be sure they are measuring real choices that lie within providers' power. That is the choices need to fall within the framework of service provisions.

- Page 3 - 1st measure – the operational definition might be easier if it is simply stated as employed for at least one year.

    - Also, under notes – maybe you could measure number of hours or define what is part-time.
- Page 3 – 2nd measure – should the question be asked of the client or of the family?
- Page 3 – 3rd measure – Should the scale be a 1 to 5 rating or a yes/no?
- Page 4 – 1st measure – Again, should a rating of 1 – 5 be used instead of yes/no.
- Page 4 – 3rd measure – It would be simpler for providers to just have their link there instead of updating the MNHelp website.
- Page 5 – 2nd measure – Will this include clients in DTH as well as SES?
    - Is there a question somewhere about whether the person is employed?

And finally, there was a concern expressed about the timeliness of investigation and reports of maltreatment. It can take almost a year at times to receive a report back from licensing. The information as presented in SSIS therefore may not be a current picture.

Executive Summary

In order to realize its goal of improving the performance data it collects for home and community-based services (HCBS), Minnesota's Department of Human Services (DHS) contracted with the Healthcare and Science business of Thomson Reuters (TR) to recommend provider performance measures to help facilitate government and consumer purchasing. Specifically, the contractor was asked to propose a candidate list of measures for assessing and comparing individual providers, as well as an assessment of the feasibility of implementing these measures for an initial subset of HCBS provider types. We found that Minnesota has an opportunity to capitalize on extant performance measures and its current and potential data sources to publish information on individual HCBS provider performance and characteristics. This information could serve the dual purpose of informing and facilitating consumer comparison of select HCBS providers and encouraging these providers to engage in internal continuous quality improvement initiatives.

Given the disparate nature of the services available from HCBS providers and the populations they serve, relatively few cross-cutting measures are appropriate across the spectrum of HCBS providers. In order to demonstrate proof of concept, DHS selected two provider settings and five services as pilots for this initiative. The state may best be served by adopting a tiered approach to performance reporting for this set of providers, which includes some generic measures that apply to all five proof of concept provider types, and that may also ultimately apply to the full range of non-institutional HCBS providers in the state, whether officially licensed or merely enrolled. These would be complemented by more targeted measures related to service in a specific setting, e.g. residential or day services, where the provider controls the direct service and physical environment, along with measures specific to a particular provider type or service, such as Supported Employment Services.

This preliminary report presents a candidate list of performance measures and includes an initial evaluation of the feasibility and implementation issues related to each measure. There are multiple challenges to calculating and reporting these measures, including the small number of individuals (five or fewer) who may be served by an individual provider, as well as the fact that individual consumers may receive services from more than one provider. The selection and evaluation of the candidate measures in this report reflects considerable input from the Expert Panel of project stakeholders convened by DHS. A more comprehensive report fully exploring data needs and implementation and reporting issues will be released later in 2009.

Early analysis indicates that the success of this effort will hinge in part on several factors. First, the planned implementation of the COMPASS assessment tool will provide comprehensive and comparable information on consumer experience with providers as part of the overall data set. This information could be more valuable with slight modifications to the existing COMPASS modules. In addition, DHS has an opportunity to leverage its planned revision of the HCBS provider enrollment process to request and collate comparable data on provider characteristics and practices. Similarly, investment of additional resources would allow for keypunching and analysis of the rich data set currently collected through DHS' licensing function. Without such as investment, relatively limited information about providers' compliance with state requirements can be compiled and compared across the state. Finally, earlier work in Minnesota by Wilder Research has illustrated the importance of clear and comparable cost data to support consumers

in their decision-making about long-term care. Obtaining, analyzing and publishing this information will require both development of meaningful specifications for what cost data should be reported and how these costs and units of measurement are defined, as well as original data collection efforts.

Regardless of which measures are adopted, DHS will need to be sensitive to any additional reporting burdens placed on providers, and the need to secure provider buy-in with regards to any published data. Furthermore, there was general recognition amongst the Expert Panel that such provider performance data are only one factor in consumer decision-making, and that the manner in which these data are presented may be as influential as the data themselves. Full and complete use of "report card" information may require a more comprehensive strategy for providing information and supporting consumers in accessing and using provider data, including (a) written materials such as consumer guides and provider directories, (b) web-based access to provider comparisons, and (c) occasional personal assistance in accessing and interpreting the comparative information. At the same time, the data needs of consumers vary depending on their experience with the service delivery system; those new to the system may require information packaged quite differently than those who have received services for years, or than families facing long-term care crises. Finally, some measures included in public reporting may not ultimately be of much value to consumers, but their perceived importance could play a role in promoting internal provider quality improvement efforts.

I. Introduction and Scope of Work

Throughout the health care delivery system, increasing attention is being paid to assessing and reporting provider performance and consumer outcomes. Two key drivers of this phenomenon are an effort to improve service quality and the goal of empowering consumers to make decisions and take control of their own care. The myriad of measures developed to date by states, providers, professional associations, government entities, and accrediting bodies support efforts to define healthcare quality and to give providers, consumers, and payers a mechanism for assessing and comparing quality. Relatively few measures and measurement development efforts, however, have focused on non-acute care, and even fewer have been specific to the primarily non-medical support services provided to people with disabilities and those 65 and over in community-based settings.

Recognizing this gap, the Minnesota Department of Human Services' (DHS) priorities include establishing and using provider performance measures and standards in managing the home and community-based services (HCBS) it funds and provides. Specifically the department has articulated the following goal:

> *The Department will improve the provider performance data collected for home and community-based services so that consumers and government can make more informed purchasing decisions. As a result, services will be more efficient, effective and appropriate in meeting the needs of consumers.*
>
> *DHS Vision Statement, July 21, 2008*

The value of collecting such data is three-fold: for public reporting to current and potential consumers to facilitate decision-making; to influence provider behavior and quality improvement; and to inform government purchasing decisions. In choosing measures, the state

wanted to capitalize on any extant HCBS provider performance measures, along with the data it currently collects, to identify valid, reliable and feasible means for assessing individual provider performance.

Scope of Work

The Provider Performance Measures task is one component of Minnesota's State Profile Grant from CMS. As part of its overall contract with Thomson Reuters to complete a profile of the state's long-term care system, DHS also requested assistance in developing a candidate list of performance measures for a subset of the state's HCBS providers. Specifically, Thomson Reuters was asked to recommend a limited number of cross-cutting provider performance measures for five provider types offering HCBS services in Minnesota. The initial criteria for these measures were that they:

- Be applicable to all five providers types
- Be relevant across target adult LTC populations
- Be meaningful to participants and purchasers
- Facilitate valid comparison and differentiation among providers
- Potentially apply to other HCBS provider types as well

In order to demonstrate ***proof of concept***, DHS selected two provider settings and five provider types: two categories of residential service providers - Adult Foster Care and Assisted Living - and three day services and employment providers: Supported Employment Services, Day Training & Habilitation programs, and Adult Day Care. All of these providers are subject to state rules and/or statutes and are licensed by the state (either directly or through counties), although only Assisted Living services, not facilities, require licensure. All licensed providers in these categories are eligible for Medicaid reimbursement through at least one or more Medicaid HCBS waiver programs operated by the state. In addition, all of these services are available to state residents through private pay. Although there are many unlicensed entities that help make up the HCBS provider network in the state, these unlicensed providers are not included in this initial task.

Work Plan

To fulfill this scope of work, the project team identified six key tasks for developing and analyzing the candidate measures. These are summarized below. This work was and is still being conducted in collaboration with an Expert Panel convened for the purpose of advising this task and the overall Long-Term Care Profile effort. The Expert Panel comprises stakeholders from across the state, representing consumers, providers, the public sector, and associations knowledgeable and active in HCBS issues. Contractor staff participated in all the bi-monthly meetings of the Expert Panel, to update members on project activities and to obtain feedback on project findings and deliverables.

Task 1. Identify Key Measure Constructs

In order to identify measurement constructs that were important and meaningful to project stakeholders, project staff used data from an on-line survey and held subsequent discussions with

the Expert Panel and DHS staff. These constructs were ultimately grouped into domains defining a framework for assessing provider performance. These were:

- "Red Flags": Critical incidents or other serious adverse outcomes that affect participant health and welfare
- Participant Satisfaction: Participant's self-reported satisfaction with services and supports
- Meeting State or Professional Standards: Measures of compliance with either state requirements, or industry standards and best practices
- Quality Outcomes: Positive participant outcomes (or the lack thereof) as a direct result of provider services
- Provider Characteristics: Descriptive provider features or attributes that are meaningful to service recipients

Task 2. Environmental Scan of Extant Provider Measures

The contractor conducted an environmental scan of existing provider measures, as well as measures that could potentially be adapted for assessing providers, which aligned with the domains identified in Task1. The resulting report documented current use, relevant providers and populations, endorsement by the National Quality Forum, and any caveats and limitations for approximately 170 measures and measure sources, grouped by the domains identified above. This report, without attachments, is included as Appendix I.

Task 3. Initial Candidate List of Potential Provider Measures

An initial list of 31 potential candidate measures was compiled from the measure scan and feedback from the Expert Panel and DHS. This list was presented to DHS in April and then shared with the Expert Panel on May 1, and is included as Appendix II. Comments on relevance, feasibility and missing measures were obtained. Following this meeting, more formal feedback was obtained via an on-line survey. All of this information was used to create the revised candidate measure list presented in this report.

Task 4. Gap Analysis against Tested and Reliable Extant Measure Definitions

Measures on the candidate list were compared to those identified in the scan, to determine if existing specifications could be used, or if new measure development was required. This analysis is reflected in the measure summaries which follow.

Task 5. Gap Analysis against Available Data Sources

The project team reviewed current and potential DHS data sources to determine which measures on the candidate list could be calculated from these sources, and which would require additional data collection. Preliminary information on data availability and feasibility is included in this memo; additional feasibility issues will be explored over the summer and reflected in the final report.

Task 6. Outline Pros and Cons (feasibility) for Final Candidate List

This preliminary feasibility report will be followed by a final feasibility report in the fall. These reports will evaluate the efforts, financial and other, required to develop and publish measures on the candidate list, issues around how data should be packaged and reported, caveats associated with individual measures, and criteria for prioritizing choices.

II. Preliminary Findings and Approach

Preliminary research and analysis revealed key considerations regarding the scope of provider services and data availability, and suggested a hybrid reporting approach to provider assessment that incorporates both general and specific measures. This approach was presented to DHS and the Expert Panel on May 1, and was subsequently endorsed. The factors that led to this decision, and a further explanation of the proposed approach to developing and reporting measures, is presented below.

Considerations

The measure scan identified several potential metrics of provider performance that could be adapted for HCBS programs. However, many of these measures were not originally developed for the purpose of allowing consumers to compare individual providers, nor were they specifically tied to the provider types and services under consideration. In addition, many would require original data collection using a tool developed by another organization. Therefore, there is not much that could be easily imported for Minnesota's intended purposes without modification or additional investment. As a result, feasibility is low for the bulk of extant measures.

The five provider types under consideration do not provide a common bundle of services, which hampers developing and reporting cross-cutting provider measures that apply to all five. Furthermore, the populations they serve can differ as well. The lack of common services across providers means there are few, if any, common outcomes that can be tied to service delivery beyond general satisfaction. Many of the consumer outcome measures identified in the measure scan were developed for a specific population – frequently individuals with developmental disabilities or severe mental illness – and would require further testing before application to other HCBS recipients.

One common measure of provider performance is adherence to licensing or other state requirements. The MN Nursing Facility report card, for example, uses an algorithm to compare providers based on their most recent reviews by the state. However, the standards for licensing and reviewing the provider types under consideration in this study vary; while they share broad expectations regarding training, staffing, etc., specific statutory requirements are not the same. In addition, not all five fall directly under the aegis of state DHS licensing staff. Even for those who do, there is no central repository of electronic data on the detailed findings of reviews, only summary indicators of compliance in the form of fines and conditional licensure.

DHS has the potential to obtain participant feedback on experience with publicly-funded HCBS services in Minnesota, including provider-level data, from two state-specific surveys. These are the Consumer Experience Survey for participants on the Elderly Waiver and the Participant Experience Survey, MN Version for participants in waivers operated by the Disability Services Division. The former has been in use for a few years, the latter will be finalized this summer. While these surveys contain many similar items, they are not identical, and would require some additional work to combine data across population groups. Furthermore, the current and proposed sampling strategies for these surveys do not support profiling of individual providers. The number of responses required to develop meaningful estimates per individual provider would likely be in the thousands.

Many of the providers in the proof of concept group serve only a handful of individuals (e.g. no more than five residents in adult foster care settings). These small caseloads render it difficult to make valid and statistically significant comparisons between the participants served by individual providers. Any reported rates may be misleading for very small providers: one unhappy resident out of five total residents translates to 20 percent dissatisfaction, while one out of 100 day services participants equals only one percent. As noted above, the small numbers of clients per individual provider and the large number of provides overall also preclude sampling for consumer surveys, making participant feedback expensive to obtain.

Recent approval of the COMPASS assessment tool will result in common assessment data for individuals from different populations and waiver programs. COMPASS will provide a single, comparable source of information that can be used for risk adjustment or assessing functional, health or social outcomes. However, it is important to bear in mind that COMPASS was not designed to assess experience with individual providers, but rather to determine service planning needs. There are challenges in adapting the COMPASS tool to tasks for which it was not designed.

Approach

During the May 1, 2009 Expert Panel meeting, the project team and DHS project officer proposed a "pyramid" approach to developing and reporting provider performance measures, in light of the considerations listed above. The top of the pyramid (Tier I) would include only those measures that are truly cross-cutting and relevant to all five provider types. By necessity, these measures would be relatively generic in scope. The middle level of the pyramid (Tier II) would be a smaller set of measures that apply to one or the other of two provider groups: residential services providers (Adult Foster Care and Assisted Living) and day services providers (Supported Employment, Day Training/Habilitation, and Adult Day Care). Because each group provides similar services and providers control the physical environment where services are delivered, some outcome type measures are more feasible at this level. Finally, measures that are specific to only one of the five provider types or one particular service compose the "bottom" of the pyramid (Tier III). These would be measures that only apply, for example, to supported employment services. At this point in the project, the candidate list contained in this report does not include a proposed measure for every type of provider, nor even group of providers.

Within each Tier, measures can be categorized according the broad domains identified by the Expert Panel. These are (from above):

- Red Flags
- Participant Satisfaction
- Meeting State or Professional Standards
- Quality Outcomes
- Provider Characteristics

These five domains were intended to specify a framework of important provider quality attributes and performance information that would be valuable to current and potential service recipients. In the list below, each tier does not necessarily include candidate measures for each of the five domains. Sometimes a suitable, feasible and applicable measure could not be found; other times measures included in the larger universe of candidates did not meet additional criteria for evaluation.

III. Candidate Measure Summaries

Included in this section are summaries for 13 candidate provider measures for the five HCBS provider types: five in Tier I, three in Tier II and five in Tier III. Each summary includes preliminary measure specifications and information about data source, domain, applicable providers, and any current usage. The domains listed are from the framework developed in early conversations with the Expert Panel (Task 1 above). In addition, each summary includes a "notes" section which explores the feasibility, caveats and pros and cons of each measure. This analysis will be significantly expanded in the final report for this task. It also includes a summary of Expert Panel feedback on the proposed measures obtained at the May 1, 2009 meeting.

For the candidate list, the contractor was asked to recommend no more than 15 total measures. The selection of measures for this list was influenced considerably by input over the last several months from members of the Expert Panel and DHS officials. In addition, the following criteria were considered:

- Was the construct measurable, e.g. could it be quantified?
- Was the measure directly tied to services offered by the provider?
- Would the measure be meaningful to consumers and other stakeholders?
- Would the measure generate incentives for internal provider quality improvement efforts?
- Would the measure actually distinguish between individual providers (or would all show essentially the same results)?
- Could the measure be fairly applied to both large and small providers?
- Is there a feasible source for obtaining the data necessary to support the measure?

Many other constructs were suggested and evaluated in addition to those included here. In particular, we identified some measures that would be useful to DHS as systems or internal measures, but not necessarily appropriate for public reporting or provider evaluation. The final report for this contract will include some measures identified by DHS for its larger quality agenda. Other constructs were left out because they were difficult to translate into quantitative metrics, or would require significant original data collection. It is important to bear in mind that the planned feasibility analysis in the coming months may result in changes to the scope and specifications of some measures. In addition, more measures may be dropped from this list, or additional candidates proposed.

Measure Name: *Substantiated Allegations of Abuse/Maltreatment (rate)*

Numerator: Number of substantiated allegations of abuse or maltreatment by provider staff during the previous calendar year:

Denominator: Number of discrete individuals served by the provider during the previous calendar year.

Data Source: The Social Services Information System, an electronic database maintained by DHS that includes adult and child protection data, should be able to support provider-specific searches within the next year. This system covers all investigations, including those in facilities not licensed by DHS (i.e., Assisted Living providers), and has information on the alleged perpetrator, so that findings of abuse by persons other than facility staff can be excluded. Data on provider caseload will need to come from another source, most likely providers themselves.

Domain: Red Flags

Applies to: All providers (Tier I)

Other Current Use: Many states (e.g. Ohio, Delaware) use data on substantiated abuse or from their incident reporting systems to review and profile their waiver providers; however, these data may not be reported publicly.

Notes: This measure is restricted to substantiated incidents of abuse, neglect or maltreatment (e.g. reportable incidents) *by provider staff,* and does not include complaints. Any reporting format needs to acknowledge that some providers serve only a very few participants (e.g. five residents in an Adult Foster Care setting), meaning that abuse "rates" may be misleading. Two alternatives are to report the raw numbers (e.g. one substantiated event and eight residents) so that the reader is aware of the small client base or to create a bi-variate measure (e.g. provider had one or more substantiated allegation last CY/provider had no substantiated allegations). Risk adjustment is not required.

Expert Panel Feedback: Additional concerns raised by panel members include the implications of self-reporting and unintended consequences. In order to be included in the numerator, a report must be substantiated. For providers that are better about self-reporting, substantiated claims may be higher. One potential unintended consequence may be an increase in appeals; providers may be more likely to appeal if they know a substantiated finding will be openly publicized. This can increase financial burden, because appeals are costly. Finally, involvement of law enforcement was suggested as a potential tie-in to this measure. County attorneys make their determination based on findings of law enforcement; this data may not be available on a routine basis. One option may be to gather statistics on the number of calls to local law enforcement for a particular residence or address, but this could be burdensome.

Measure Name: *Fines and/or Conditional Licensure*

Numerator: Did the provider receive a conditional license for any reason as a result of the most recent DHS review: Yes or No.

or

Did the provider receive a fine for any reason other than failure to comport with background screening requirements as a result of the most recent DHS review: Yes or No.

Denominator: N/A

Data Source: This information is available from DHS Licensing for all relevant providers except assisted living facilities, which are regulated by the Department of Health.

Domain: Meets State and/or Professional Standards

Applies to: All providers (Tier I)

Other Current Use: States that license HCBS providers track concerns with and penalties for provider non-compliance, although this information may not be publicly available.

Notes: Use of this measure may require defining the scope of fines and penalties to be considered. Concerns were raised that not all fines are meaningful or equal. As a result, this measure may need to be limited to "conditional" licensing. More review is needed to define the meaning and implications of conditional licensure, as well as how best to present and explain this information to consumers. In general, this measure may be of little interest to consumers, but may well prompt improvement on the part of providers in their compliance with state requirements. More detailed data on the results of provider reviews for most of the providers of interest are collected by DHS Licensing and county reviewers, but not captured electronically, due to resource issues. If this data were computerized, there is a potential to create a far more sophisticated algorithm of provider compliance, similar to that used for the Nursing Home Report Card project. Risk adjustment is not required.

Expert Panel Feedback: Some stakeholders raised concerns about a perceived lack of clearly articulated standards and fine procedures within Licensing and about how well this measure captures "quality." Some findings during the provider review process don't necessarily result in a fine if they are corrected. And, there is an important difference between fines for service violations and for physical plant violations. There is no licensing per se for assisted living facilities, which are registered as housing with services and licensed as home care. This is a measure that may well require a dry run to assess if the differences between providers are meaningful. Further investigation of the data actually captured by and available from DHS Licensing may determine whether this measure stays on the list, and if a more nuanced measure could be developed.

Measure Name: *Fines for Failure to Comply with Criminal Background Check Requirements*

Numerator: Did the provider receive a fine during their most recent review for failure to comply with state requirements for worker screening?: Yes or No

Denominator: N/A

Data Source: This information is available from DHS Licensing for all relevant provider types except assisted living facilities, which are regulated by the Department of Health.

Domain: Meets State and/or Professional Standards

Applies to: All providers (Tier I)

Other Current Use: Not clear if any other states publicly report this information for their HCBS providers. There are no federal laws regarding criminal background screening for HCBS direct care and other workers, and state laws vary considerably. Furthermore, responsibility for conducting background screens (or even if such screening is required at all), as well as interpretation of the findings, ranges from state-to-state. This measure does align with the CMS waiver assurance regarding participant health and welfare.

Notes: While the scholarship linking previous criminal activity to abuse of vulnerable adults is limited, there is strong public support for screening of direct care workers. Minnesota has well-defined legislative requirements for screening, which is conducted by DHS Licensing on behalf of a wide range of providers, including assisted living. However, because DHS does not license this latter group, they have no data on which assisted living providers failed to comply with state requirements. This measure was rated both as important and of interest to consumers during the Expert Panel survey. Risk adjustment is not required.

Expert Panel Feedback: This information is only available for licensed providers. While the five initial proof of concept provider types are subject to state licensure, other HCBS providers (such as Personal Care Provider Organizations) are not. The eventual goal is to include these non-licensed providers as well, so it is good to be thinking about what could work across broader HCBS provider types. Because there is not good evidence that background checks relate to quality of care, some questioned the true value of reporting this, other than salving fears of the public. Others noted that this measure will be part of a bigger picture assessing quality and that it speaks to whether providers are doing what they should be doing (e.g. complying with state requirements.) Still others questioned the value of a measure with which they anticipated everyone was already complying.

Measure Name: *Retention of Staff Employed at least Six Months (rate)*

Numerator: Number of direct care staff employed for at least six months as of a defined date that were still employed one year layer

Denominator: All direct care staff employed for at least six months as of a defined date.

Data Source: From providers

Domain: Provider Characteristics

Applies to: All providers (Tier I)

Other Current Use: Staff retention measures are commonly tracked by providers, and a similar measure is used in the MN Nursing Home Report Card.

Notes: The specifications for this measure will require additional refinement. Traditional turnover measures have been criticized because of concerns that they penalize providers who quickly unload "bad" staff. At the same time, the longer retention measures used by some provider organizations (e.g. five years) may be unrealistic. This measure is intended to be a compromise: one year retention for staff members who have likely surpassed a probationary period with the provider. Because these data will need to come from the providers themselves, the data specifications will need to be clear and precise to insure comparability. Such information could be become one of the conditions of the revised provider enrollment process.

Risk adjustment not required.

Expert Panel Feedback: This is an important measure in all types of business. One stakeholder noted that staff retention is critical to quality outcomes, especially for those participants whose disabilities and behavior problems benefit from consistent staffing. Some providers only have six direct care staff; if they are being compared to a place with 27 direct care staff, turnover can look quite disproportionate. It may be more accurate to list the raw data, rather than the rate. Other methodological concerns raised were how to address employees who moved from one facility to another within the same organization, part-time employees and those who are promoted out of direct care positions.

Measure Name: *Participant Satisfaction (rate)*

Numerator: Number of service recipients who say they would recommend the provider to someone else.

Denominator: All individuals served by the provider and administered the COMPASS assessment during a specified time frame. Does not include those individuals who did not provide a valid response to this item

Data Source: COMPASS (proposed)

Domain: Participant Satisfaction

Applies to: All providers (Tier I)

Other Current Use: Satisfaction items are very common metrics of provider performance.

Notes: This measure would require adding a new item or series of items to the COMPASS person-centered interview that queried whether the participant would recommend their provider (by type, e.g. assisted living, SES) to someone else requiring the same type of service. Because COMPASS should be administered to all HCBS waiver recipients annually, data should be available for all service recipients funded by DHS (but not private pay). This "new" measure would require specification of who to exclude from the numerator and denominator, including initial assessments for those not yet receiving services and those who did not provide a valid answer to the question, as well as the relevant time frame for measurement. This measure received strong endorsement from the respondents to the Expert Panel survey as being both meaningful and relevant to consumers. The small caseload of many providers, particularly adult foster care, raises concerns about validity, and suggests that reporting raw data may be more meaningful than rates. Risk adjustment not required.

Expert Panel Feedback: Several members stated this was the most important question. Satisfaction may be high initially, until people become aware of other options. One panel member noted that participants who are trying to gain greater independence may not be totally happy with the services they receive, regardless of how good they are. COMPASS won't be administered by providers, which is important in ensuring anonymity to respondents about their feedback. It will also be important for this measure, and COMPASS in general, to determine how to accommodate dementia and other cognitive impairments when administering the person-centered interview.

Measure Name: *Satisfaction with Current Living Situation (rate)*

Numerator: Number of residents responding yes to "Do you like where you live?"

Denominator: All residents who provide a valid response to this item, during a defined time period.

Data Source: COMPASS person-centered interview

Domain: Participant satisfaction

Applies to: Residential providers (Tier II)

Other Current Use: This measure is included on the Participant Experience Survey (used by multiple states) and other national surveys of HCBS participant experience.

Notes: Because COMPASS should be administered to all HCBS waiver recipients annually, data should be available for all service recipients funded by DHS (but not private pay). Certain exclusions, for invalid responses or new applicants, would apply and would need to be defined. Many factors influence satisfaction with current residence, not all of which are under provider control. In addition, cultural differences and preferences can also impact satisfaction (or lack thereof), and will not be captured. Nonetheless, this straightforward satisfaction item would likely be of interest to consumers comparing residential providers. The small facility size of many residential providers, particularly adult foster care, raises concerns about validity and suggests that reporting raw data may be more meaningful than rates. Risk adjustment is not required.

Expert Panel Feedback: According to some members, as written, this is as much a systems indicator as an individual provider performance measure, because it does not specify a specific physical residence. Some modification to the wording of the COMPASS item may be necessary. As currently written, this item was thrown out of the nursing facility report card project. For those who respond "no" there isn't a "then what" option. Also, it is unclear what "where you live" is referring to - the city? The room in my house? This street? There are portions of COMPASS that could capture this type of narrative data, but it may be difficult to extract and analyze this information.

Measure Name: *Respectful Treatment by Residential Staff (rate)*

Numerator: Number of residents who report that the people who help/assist them where they live treat them with respect.

Denominator: Number of discrete individuals served by the provider during a defined time period.

Data Source: Participant Experience Survey, Minnesota version and the Elderly Waiver's Consumer Experience Survey. COMPASS (potentially)

Domain: Quality Outcomes

Applies to: Residential providers (Tier II)

Other Current Use: Similar items are included in the Home Care Satisfaction Measure and other comparable participant surveys.

Notes: This measure would require compiling data from comparable (but not identical) items on two separate surveys: the Consumer Experience Survey currently administered to a sample of participants on the Elderly Waiver and the Participant Experience Survey for MN, proposed for use with a sample of respondents from the four waivers operated by the Disability Services Division. Currently, the sampling plans for both surveys do not support profiling individual providers. Given the small caseload of most residential providers, a 100 percent sample would be required for accuracy, which would significantly increase overall sample size and cost. Although the construct is the same, differences in item wording also raise concerns about comparability, and the validity of combining responses. An alternative would be to require providers to include a prescribed item regarding respectful treatment by staff into an internal resident survey, or to fold the existing survey items into the COMPASS person-centered interview. This measure is perceived as meaningful to consumers, and aligns with the Department's Guiding Principles. It would not require risk adjustment.

Expert Panel Feedback: A question was raised about adding a similarly worded item to COMPASS, to avoid the issues with sampling. DHS staff stated that if the Panel wants it added there, this will be explored. Panel members noted that feeling respected by staff is a key issue for consumers. Many issues could be resolved if people felt respected; when they don't they may get combative or non-cooperative. While disrespect is subjective, an experience question allows program participants to report whether they feel respected.

Measure Name: *Safety at Home (rate)*

Numerator: Number of residents responding yes to "Do you feel safe in your home?"

Denominator: All residents who provide a valid response to this item, during a defined time period.

Data Source: COMPASS person-centered interview

Domain: Quality Outcomes

Applies to: Residential providers (Tier II)

Other Current Use: Safety, as a component of health and welfare, is one of the assurances all states must make to CMS regarding the HCBS waiver programs they operate.

Notes: Because COMPASS should be administered to all HCBS waiver recipients annually, data should be available for all service recipients funded by DHS (but not private pay). Certain exclusions would apply and would need to be defined. In addition, perception of safety in the home could be influenced by perceived safety of neighborhood, which is not necessarily under provider control. The small facility size of many residential providers, particularly adult foster care, raises concerns about validity and suggests that reporting raw data may be more meaningful than rates. Risk adjustment is not required.

Expert Panel Feedback: According to panel members, safety is a significant issue, particularly the level of risk people should be able to assume in their lives. Sometimes older adults and their adult children want different things – participants may be "safer" than they want to be. There was also discussion about making this a Tier 1 item (applicable to all provider types), which would involve changing the COMPASS item to ask about feeling safe when with a particular provider (at home or at a day program).

Measure Name: *Activities Meet Preferences (rate)*

Numerator: To be determined

Denominator: To be determined

Data Source: Information on experience with day training and habilitation (DT&H) services is available from the Participant Experience Survey (PES), MN version. There is no comparable data source for experience with Adult Care Programs

Domain: Quality Outcomes/Participant Satisfaction

Applies to: Day Training & Habilitation and Adult Day Care Providers (Tier III)

Other Current Use: Similar items are present on various national participant surveys.

Notes: The Minnesota version of the PES includes two items related to DT&H providers which could be used to construct a satisfaction/preferences measure:
1) Do you have a chance to try new things at your day program?
2) Overall, are you generally happy with your day program?
There are no comparable questions about experience with Adult Day Care on the current Consumer Experience Survey for participants on the Elderly Waiver, so this measure would require original data collection. If the data were to be combined with the PES data, wording would need to be identical. Regardless of data source, this measure would be based on consumer reported data with the same sampling implications for the measures discussed above. Risk adjustment is not required.

Expert Panel Feedback: This construct seems tightly related to satisfaction. Feasibility will depend on the ability to address the data collection and sampling issues.

Measure Name: *Adequate Employment Support (rate)*

Numerator: All Supported Employment Services (SES) participants who respond yes to "Do the people paid to help you at work provide the supports you need?

Denominator: All SES participants who provide a valid response to this item.

Data Source: Participant Experience Survey, MN Version

Domain: Quality Outcomes

Applies to: Supported Employment Services providers (Tier III)

Other Current Use: The Commonwealth of Virginia employs a range of employment measures, including quality of on the job supports.

Notes: The sampling strategy necessary to support profiling of individual SES providers would require significant resources. The average Medicaid caseload for SES providers in Minnesota is about 22 clients, which essentially precludes sampling within individual providers. Using this survey item, data would be captured only for those SES clients who are funded by Medicaid (i.e., no private pay). This question refers only to personal assistance while on the job, namely job coaches, and not the full range of services offered by SES providers.

Expert Panel Feedback: Concern was raised about the fact that this measure only reflects experience with paid staff that provide support at the work site. The definition of supported employment is evolving to encompass a broader range of supports, including assistance finding employment, training and communication with employers, which would not be captured here. Use of alternative wording for this survey could capture experience with more than just on-site staff, namely job coaches.

Measure Name: *Compliance with Adult Day Care Standards*

Numerator: Did the provider meet all relevant standards for licensure during the most recent review: Yes or No

or

An algorithm that represents overall compliance with standards, using some type of scale.

Denominator: N/A

Data Source: DHS Licensing

Domain: Meets States and/or Professional Standards

Applies to: Adult Day Care providers (Tier III)

Other Current Use: This would be a new measure.

Notes: This measure, suggested by representatives from the Adult Day Care field, is similar to Tier I item regarding conditional licensure. Further review is required to determine what level of electronic detail from licensing reviews is available for reporting, including whether an assessment could be made that the provider had exceeded minimum state standards. While this measure may not be of significant interest to potential and current consumers, it may motivate providers to improve their performance. Risk adjustment is not required.

Expert Panel Feedback: This information is already publicly available, but not always easy for consumers to find. Furthermore, there are very different degrees of meeting compliance, for example compliance with requirements for the physical plant as opposed to meeting individual needs. More review is needed to determine how much detailed data is needed and the value-added of including this information as part of a report card.

Measure Name: *Satisfaction with Current Employment (rate)*

Numerator: SES recipients who answer "yes" to "Are you satisfied with your current job or volunteer/educational activities?"

Denominator: All recipients served by the provider who provide a valid response to this item within a defined time period.

Data Source: COMPASS vocational module

Domain: Quality Outcomes

Applies to: SES providers (Tier III)

Other Current Use: Satisfaction items like this one are common metrics for provider profiling.

Notes: Because COMPASS should be administered to all HCBS waiver recipients annually, data should be available for all SES service recipients funded by DHS (but not private pay). Certain exclusions would apply and would need to be defined, such as individuals who have not yet started receiving services. The COMPASS item does not distinguish between working, volunteering and employment. In addition, this module is only administered to those under the age of 65. Risk adjustment is not required.

Expert Panel Feedback: The main concern voiced by the Expert Panel regarding this measure is that working, studying and volunteering should not be considered comparable substitutes. Competitive employment is the primary goal of supported employment services; volunteer work and education should be means to this end. It was strongly suggested that the COMPASS vocational module be revisited to address this concerns, so that more direct satisfaction with employment can be measured.

Measure Name: *Respectful Treatment by Employment Staff (rate)*

Numerator: All supported employment service (SES) recipients who respond yes to "Do the people paid to help you at work treat you respectfully?"

Denominator: All SES recipients who provide a valid response to this item.

Data Source: Participant Experience Survey, Minnesota Version

Domain: Quality Outcomes

Applies to: Supported Employment Services providers (Tier III)

Other Current Use: Similar to staff respect items on other comparable experience surveys

Notes: The sampling strategy necessary to support profiling of individual SES providers would require significant resources. The average Medicaid caseload for SES providers in MN is about 22 clients, which essentially precludes sampling. Using this survey item, data would be captured only for those SES clients who are funded by Medicaid (i.e. no private pay). This question refers only to personal assistance while on the job, namely job coaches, and not the full range of services offered by SES providers.

Expert Panel Feedback: The same concerns were voiced about this measure as about the one assessing adequacy of job supports. Namely, the restriction to treatment by on-the-job personal assistance (job coaches) does not reflect the full range of SES. A more appropriate question, according to one stakeholder, might be one that asks how people are treated where they work (by everyone); it was recommended that DHS consider amending the PES, MN version to include this or adding such an item to COMPASS.

IV. Implications and Recommendations

The feasibility of implementing the items on this candidate list will depend on several factors, primarily related to potential data sources. In addition, there are other issues for DHS to consider in its effort to develop and publish provider performance data for public use. The next phase of this project will review some of these issues, which are summarized below, in greater depth.

COMPASS Assessment Tool

The proposed COMPASS automated assessment tool could be a significant data source of data on consumers' experience with individual providers. Funding for implementing COMPASS was recently approved by the State. Because this tool will be administered to all waiver program participants, there are no issues with sampling, and the resulting electronic data will be relatively easy to access and manipulate. Some candidate measures could be derived from variables already included in the COMPASS modules. Others could be supported through addition of new items or modifications of existing ones.

There remain, however, some caveats regarding use of COMPASS data for assessing individual provider performance. First and foremost, COMPASS was not designed for this purpose, but rather for assessing individual need and guiding appropriate service planning. In order to use it for evaluating provider performance, there may be a need to revisit the modules. At the same time, it will be important not to burden COMPASS with too many additional mandates. Another question to be addressed is how data will be collected from those whose cognitive impairments make it difficult for them to provide valid responses, and the policy, if any, regarding proxy respondents for the person-centered interview and similar modules. Implementation of the planned system should include a strategy to address these caveats.

Provider Enrollment Process

Concurrent to this effort, the Department is undertaking a project to develop a new system for HCBS provider enrollment in Minnesota. This parallel endeavor offers a tremendous opportunity to more consistently and uniformly collect critical provider information that could support profiling of individual providers. Close collaboration within DHS will be necessary to leverage this opportunity. Some of the candidate measures proposed in this report will require data that can only be obtained directly from providers. Revising the data requirements for provider enrollment could entail adding new specifications tied to the candidate measures, as well as an opportunity for providers to supply additional information to include in their profile. In order for this effort to be successful, providers will need an opportunity to offer their input on any new data requirements, although DHS retains the right to require additional data as a condition of provider enrollment.

Licensing

Data captured during state and country reviews of providers represents an untapped potential source for provider profiling. Currently four out of the five "proof of concept providers" are reviewed by DHS Licensing or its county delegates (assisted living facilities are licensed by the Department of Health for the home health services they provide.) However, current resource constraints prevent all but the most basic information from these reviews from being captured electronically. Additional investment would allow some of the rich detail from these reviews to be keypunched for further reporting and analyses, including findings with respect to specific standards and narrative information regarding best practices.

Cost Data

A recent report by Wilder Research, examining factors that influenced decision-making around long-term care for older adults, found that the mos