LTSS Medicaid Pathway: Outcome and Performance Measures Environmental Scan July 2016

Preface:

LTSS and HCBS performance, quality and outcome measures are set in the legal, political, and financial context of these services. This context currently includes:

1. Medicaid services are governed by different rules and requirements than Medicare or commercial insurance, including required coverage of DLTSS for individuals who meet eligibility requirements established by the state. (Medicaid is required to provide DLTSS services to eligible individuals)
2. Federal law and regulation including Medicaid law, the Olmstead decision, CMS HCBS rules, and MLTSS rules.
3. State law, regulation, and policy including the DD Act, DDSD regulations, the State System of Care Plan, Choices for Care regulations, nursing home ratesetting regulations, provider tax regulations, DDSD policies and procedures, and Choices for Care policies and procedures.
4. Agreements between the federal government and Vermont government including the Global Commitment Special Terms and Conditions, the Comprehensive Quality Strategy, and the Operational Protocol. (note: negotiations for the All Payer Model are currently ongoing).
5. The Vermont budget process including specific legislative appropriations for Developmental Disability Services (in the DAIL budget) and Choices for Care (in the DVHA budget)
6. Provider licensing, Certificates of Need, designation, and certification procedures for designated agencies, specialized service agencies, home health agencies, nursing homes, area agencies on aging, adult day programs, residential care homes, assisted living residences, therapeutic community residences, and intermediate care facilities.
7. Preferences/advocacy from consumers, family members, providers, and other stakeholders.
8. Costs: in the aggregate, HCBS are less costly than the institutional services that a state is obligated to provide.

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DAIL Mission Statement

The mission of the Department of Disabilities, Aging and Independent Living (DAIL) is to make Vermont the best state in which to grow old or to live with a disability; with dignity, respect and independence.

Core Values and Principles of DAIL

1. **Person-centered**: We help people to make choices and to direct their own lives; pursuing their own choices, goals, aspirations and preferences.
2. **Natural Supports**: We recognize the importance of family and friends in people's lives. We respect the unique needs, strengths and cultural values of each person and each family.
3. **Community participation**: We support consumers' involvement in their communities, and recognize the importance of their contributions to their communities.
4. **Effectiveness**: We pursue positive outcomes through effective practices, including evidence-based practices. We seek to develop and maintain a trained and competent workforce, and to use staff knowledge, skills and abilities effectively.
5. **Efficiency**: We use public resources efficiently; avoiding unnecessary activities, costs, and negative impact on our environment.
6. **Creativity**: We encourage progress through innovation, new ideas, and new solutions. We accept that creativity involves risk, and we learn from mistakes.
7. **Communication**: We communicate effectively. We listen actively to the people we serve and to our partners. We are responsive.
8. **Respect**: We promote respect, honesty, collaboration and integrity in all our relations. We empower consumers, staff and partners to achieve outcomes and goals. We provide opportunities for people to grow, both personally and professionally.
9. **Leadership**: We strive to reach our vision and to demonstrate our values in all our work. We collaborate with consumers and other partners to achieve outcomes, goals and priorities. We are accountable.

HCBS/LTSS Quality and Outcome Measures: Leading National Frameworks and DA/SSA measures

	National Quality Forum: HCBS Performance Measures June 15 2016 report	National Core Indicators: Aging/Disabilities	National Core Indicators Intellectual/Developmental Disabilities	Council on Quality and Leadership: Personal Outcome Measures		Designated Agencies and SSAs: DAIL performance measures for DD HCBS
Stated Purpose	To develop a conceptual framework to address performance measure gaps in home and community-based services to enhance the quality of community living. Intent is to help build a high-quality HCBS system that supports older adults and people with disabilities in achieving independence, good health, and quality of life	Designed to support states' interest in assessing the performance of their programs and delivery systems in order to improve services for older adults and individuals with physical disabilities. The project will help to address long-recognized gaps in assessing outcomes in long term services and supports (LTSS) service systems that go beyond measures of health and safety to address important social, community, and person-centered goals as well as quality of life.	National Core Indicators (NCI)™ is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families.	21 indicators are used to understand the presence, importance and achievement of outcomes involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment and more. The 21 indicators are those that people and their families have said are most important to them. The insight gained during an interview can be used to inform a person-centered plan, and at an aggregate level to influence an organization's strategic plan. An effective data set for valid and reliable measurement of individual quality of life.		The Grantee will report performance measures to the State in order to measure achievement of stated program purpose(s). Performance measures measure quantity ("how much are you doing?"), quality ("how well are you doing it?), and impact of services delivered (is anyone better off?") in accordance with grant requirements and expectations. Developmental Disabilities HCBS are designed to support individuals with developmental disabilities to work and participate in the community rather than in institutional setting. A variety of program options and designs that are supported by HCBS funding provide opportunities for people who are eligible for Medicaid to receive services in their own home or community. These programs serve people with a variety of needs with personalized services designed to advance full participation as active citizens in their community.
Target populations	Older adults and people with disabilities	Historical grounding: people with intellectual and developmental disabilities. Currently expanding to older adults and people with disabilities.	People with intellectual and developmental disabilities	Historical grounding: people with intellectual and developmental disabilities, and people with mental illness. Currently expanding to other populations.		People with intellectual and developmental disabilities
National use	NA- proposed framework for development (through HHS contract)	Piloted in three states, now expanding; Vermont may participate	45 states including Vermont	7800 people (multiple states, specific states unclear from website)		NA; Some measures are from NCI
Target settings	HCBS settings.	HCBS, facilities, and nursing homes	HCBS and facilities	HCBS?		HCBS
Domains and measures	**Service Delivery and Effectiveness:**	**Community Participation:** People are able to participate in preferred activities outside of home when and with whom they want. Proportion of people who are able to do things they enjoy outside of their home when and with whom they want Reasons why people are unable to do things they enjoy outside of their home when and with whom they want	**Individual Outcomes:**	**My Self:**		
	Delivery	**Choice and Decision-making:** People are involved in making decisions about	**Choice:** People make choices about their lives and are actively	People are connected to natural support networks		Preventative Health Services – Percentage of adults age 22 and over served by Developmental Disabilities Home and Community Based Services

	National Quality Forum: HCBS Performance Measures June 15 2016 report	National Core Indicators: Aging/Disabilities	National Core Indicators Intellectual/Developmental Disabilities	Council on Quality and Leadership: Personal Outcome Measures		Designated Agencies and SSAs: DAIL performance measures for DD HCBS
		their everyday lives and with whom they spend their time. Proportion of people who are able to choose their roommate (if in group setting) Proportion of people who get up and go to bed at the time they want Proportion of people who can eat their meals when they want Proportion of people who are able to decide how to furnish and decorate their room (if in group setting)	engaged in planning their services and supports. CHOSE HOME CHOSE ROOMMATES CHOSE PAID COMMUNITY JOB CHOSE DAY PROGRAM OR REGULAR ACTIVITY CHOSE STAFF DECIDES DAILY SCHEDULE DECIDES HOW TO SPEND FREE TIME CHOOSES HOW TO SPEND MONEY CHOSE CASE MANAGER/SERVICE COORDINATOR			who have access to one or more annual preventive health services during the calendar year.
	Person's Needs Met	**Relationships:** People have friends and relationships and do not feel lonely. Proportion of people who can always or almost always see or talk to friends and family when they want (if there are friends and family who do not live with person) Reasons why people are unable to see or talk to friends and family Proportion of people who sometimes or often feel lonely, sad or depressed	**Community Inclusion:** People have support to participate in everyday community activities. WENT OUT SHOPPING IN THE PAST MONTH AVERAGE TIMES WENT OUT SHOPPING IN THE PAST MONTH WENT OUT ON ERRANDS IN THE PAST MONTH AVERAGE TIMES WENT OUT ON ERRANDS IN THE PAST MONTH WENT OUT FOR ENTERTAINMENT IN THE PAST MONTH AVERAGE TIMES WENT OUT FOR ENTERTAINMENT IN THE PAST MONTH WENT OUT TO EAT IN THE PAST MONTH AVERAGE TIMES WENT OUT TO EAT IN THE PAST MONTH WENT OUT TO A RELIGIOUS OR SPIRITUAL SERVICE IN THE PAST MONTH	People have intimate relationships		Percentage of adults age 18 and over and out of high school, who report they like (the home) where they live

	National Quality Forum: HCBS Performance Measures June 15 2016 report	National Core Indicators: Aging/Disabilities	National Core Indicators Intellectual/Developmental Disabilities	Council on Quality and Leadership: Personal Outcome Measures		Designated Agencies and SSAs: DAIL performance measures for DD HCBS
			AVERAGE TIMES WENT OUT TO RELIGIOUS OR SPIRTUAL SERVICE IN THE PAST MONTH WENT OUT FOR EXERCISE IN THE PAST MONTH AVERAGE TIMES WENT OUT FOR EXERCISE IN THE PAST MONTH WENT ON VACATION IN THE PAST YEAR AVERAGE TIMES WENT ON VACATION IN THE PAST YEAR			
	Person's identified goals realized	**Satisfaction:** People are satisfied with their everyday lives – where they live, the staff who work with them, and what they do during the day. Proportion of people who like where they are living Reasons why people do not like where they are living Proportion of people who would prefer to live somewhere else Where people would prefer to live (among those who would prefer to live somewhere else) Proportion of people who like how they usually spend their time during the day Proportion of people whose paid support staff change too often Proportion of people whose paid support staff do things the way they want them done	**Work:** People have support to find and maintain community integrated employment. HAS A PAID JOB IN THE COMMUNITY TYPE OF PAID EMPLOYMENT IN THE COMMUNITY AVERAGE BIWEEKLY HOURS BY TYPE OF EMPLOYMENT AVERAGE BIWEEKLY GROSS WAGES BY TYPE OF EMPLOYMENT AVERAGE BIWEEKLY HOURLY WAGE BY TYPE OF EMPLOYMENT WORKED 10 OF THE LAST 12 MONTHS IN PAID COMMUNITY EMPLOYMENT AVERAGE MONTHS OF EMPLOYMENT AT CURRENT PAID COMMUNITY JOB RECIEVES PAID VACATION AND/OR SICK TIME AT PAID COMMUNITY JOB FOUR MOST COMMON FIELDS OF PAID COMMUNITY EMPLOYMENT	People are safe		Percentage of adults age 18 and over and out of high school, who report they choose (helped pick) the place where they live.

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			WANTS A PAID JOB IN THE COMMUNITY HAS COMMUNITY EMPLOYMENT AS A GOAL IN SERVICE PLAN ATTENDS A DAY PROGRAM OR REGULAR ACTIVITY VOLUNTEERS			
	Person-Centered Planning and Coordination:	**Service and Care Coordination:** Individuals are provided appropriate coordination of care. Service coordinators are accessible, responsive, and support the person's participation in service planning and the person receives needed services**.** Proportion of people who know whom to call if they have a complaint about their services Proportion of people who know whom to call to get information if their needs change and they need new or different types of services and supports Proportion of people who can reach their case manager/care coordinator when they need to (if know they have case manager/care coordinator) Proportion of people whose paid support staff show up and leave when they are supposed to Proportion of people who have an emergency plan in place Proportion of people who want help planning for their future need for services Proportion of people whose services meet all their needs and goals Additional services that may help if not all needs and goals are met Proportion of people whose case manager/care coordinator talked to them about services that might help with unmet needs and goals (if have case manager and have unmet needs and goals)	**Self-Determination**: People have authority and are supported to direct and manage their own services. USES SELF-DIRECTED SUPPORTS SOMEONE TALKS TO PERSON ABOUT THE BUDGET/SERVICES AVAILABLE SOMEONE HELPS PERSON DECIDE HOW TO USE BUDGET/SERVICES RECEIVES INFORMATION ABOUT HOW MUCH MONEY IS LEFT IN BUDGET/SERVICES	People have the best possible health		Percentage of adults age 18 and over and out of high school, who report their staff (support workers) treat them with respect.

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		How people first find out about the services available to them Who helps people most often Proportion of people whose family member (unpaid or paid) is the person who helps them most often Proportion of people whose family member (unpaid or paid) provides additional assistance Proportion of people who stayed overnight in a hospital or rehabilitation facility (and were discharged to go home) in past year Proportion of people who reported feeling comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility (if occurred in the past year) Proportion of people who reported someone followed-up with them after discharge from a hospital or rehabilitation facility (if occurred in the past year) Proportion of people who reported having one or more chronic conditions Proportion of people who reported they know how to manage their chronic condition(s)				
	Assessment	**Access:** Publicly funded services are readily available to individuals who need and qualify for them. Proportion of people who have transportation when they want to do things outside of their home Proportion of people who have transportation to get to medical appointments when they need to Proportion of people who receive information about their services in the language they prefer (if non-English) Proportion of people who need grab bars to be installed in the bathroom or elsewhere in home	**Relationships:** People have friends and relationships. HAS FRIENDS HAS A BEST FRIEND CAN SEE FRIENDS CAN SEE FAMILY FEELS LONELY CAN GO ON A DATE CAN HELP OTHER PEOPLE	People exercise rights		Percentage of adults age 18 and over and out of high school, who report they can see their friends when they want.

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		Proportion of people who need an upgrade to grab bars in the bathroom or elsewhere in home Proportion of people who need bathroom modifications to be installed (other than grab bars) Proportion of people who need an upgrade to bathroom modifications (other than grab bars) Proportion of people who need a specialized bed to be installed Proportion of people who need an upgrade to a specialized bed Proportion of people who need a ramp or stair lift to be installed in or outside the home Proportion of people who need an upgrade to a ramp or stair lift in or outside the home Proportion of people who need a remote monitoring system to be installed Proportion of people who need an upgrade to a remote monitoring system Proportion of people who need an emergency response system to be installed Proportion of people who need an upgrade to an emergency response system Proportion of people who need other home modifications to be installed Proportion of people who need an upgrade to other home modifications Proportion of people who need a new walker Proportion of people who need an upgrade to a walker Proportion of people who need a new scooter Proportion of people who need an upgrade to a scooter Proportion of people who need a new cane				

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		Proportion of people who need an upgrade to a cane Proportion of people who need a new wheelchair Proportion of people who need an upgrade to a wheelchair Table 81. Proportion of people who need new hearing aids Proportion of people who need an upgrade to hearing aids Proportion of people who need new glasses Proportion of people who need an upgrade to glasses Proportion of people who need a new communication device Proportion of people who need an upgrade to a communication device Proportion of people who need a new portable oxygen Proportion of people who need an upgrade to a portable oxygen Proportion of people who need a new other device Proportion of people who need an upgrade to another device				
	Person-Centered planning	**Safety:** People feel safe from abuse, neglect, and injury. Proportion of people who feel safe at home Proportion of people who feel safe around their paid support staff Proportion of people who are ever worried for the security of their personal belongings Proportion of people whose money was taken or used without their permission Proportion of people who have concerns about falling or being unstable (or about whom there are concerns) Proportion of people with whom somebody talked to or worked with to	**Satisfaction:** People are satisfied with the services and supports they receive. LIKES HOME WANTS TO LIVE SOMEWHERE ELSE TALKS WITH NEIGHBORS LIKES PAID COMMUNITY JOB WANTS TO WORK SOMEWHERE ELSE LIKES DAY PROGRAM OR REGULAR ACTIVITY WANTS TO GO SOMEWHERE ELSE OR DO SOMETHING ELSE DURING THE DAY	People are treated fairly		Percentage of adults age 18 and over and out of high school, who report they feel lonely (don't have anyone to talk to)

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		reduce risk of falling or being unstable (if there are such concerns) Proportion of people who are able to get to safety quickly in case of an emergency like a fire or a natural disaster				
	Coordination	**Health Care:** People secure needed health services. Proportion of people who have gone to the emergency room for tooth or mouth pain in the past year Proportion of people who have gone to the emergency room for falling or losing balance in the past year Proportion of people who have gone to the emergency room in the past year (for reasons other than tooth/mouth pain or falling/losing balance) Proportion of people who have a primary care doctor Proportion of people who can get an appointment to see their primary care doctor when they need to Proportion of people who have talked to someone about feeling sad and depressed during the past 12 months (if feeling sad and depressed) Proportion of people who have had a physical exam or wellness visit in the past year Proportion of people who have had a hearing exam in the past year Proportion of people who have had a vision exam in the past year Proportion of people who have had a flu shot in the past year Proportion of people who have had a routine dental visit in the past year Proportion of people who have had a cholesterol screening done by a doctor or nurse in the past five years	**Service Coordination:** Service coordinators are accessible, responsive, and support the person's participation in service planning. MET CASE MANAGER/SERVICE COORDINATOR CASE MANAGER/SERVICE COORDINATOR ASKS WHAT PERSON WANTS CASE MANAGER/SERVICE COORDINATOR HELPS GET WHAT PERSON NEEDS CASE MANAGER/SERVICE COORDINATOR CALLS PERSON BACK RIGHT AWAY STAFF COME WHEN THEY ARE SUPPOSED TO HAS HELP NEEDED TO FIX PROBLEMS WITH STAFF PERSON HELPED MAKE SERVICE PLAN	People are free from abuse and neglect		Percentage of working age adults who are employed.
	Choice and Control:	**Wellness:** People are supported to maintain health.	**Access**: Publicly-funded services are readily available to	People experience continuity and security		

	National Quality Forum: HCBS Performance Measures June 15 2016 report	National Core Indicators: Aging/Disabilities	National Core Indicators Intellectual/Developmental Disabilities	Council on Quality and Leadership: Personal Outcome Measures		Designated Agencies and SSAs: DAIL performance measures for DD HCBS
		Proportion of people who describe their overall health as poor Proportion of people who reported their health is much better or somewhat better compared to 12 months ago Proportion of people who reported they forget things more often in the past 12 months Proportion of people who have discussed (or somebody else discussed) their forgetting things with a doctor or a nurse (if they forget things more often in the past 12 months)	individuals who need and qualify for them. GETS NEEDED SERVICES STAFF HAVE RIGHT TRAINING TO MEET PERSON'S NEEDS ALWAYS HAS A WAY TO GET PLACES ADDITIONAL SERVICES NEEDED (1 OF 3) ADDITIONAL SERVICES NEEDED (2 OF 3) ADDITIONAL SERVICES NEEDED (3 OF 3)			
	Personal choices and goals	**Medications:** Medications are managed effectively and appropriately. Proportion of people who take medications that help them feel less sad or depressed Proportion of people who take or are supposed to take any prescription medications Proportion of people who understand why they take their prescription medications and what they are for (if take or are supposed to take prescription medications)	**Health:** People secure needed health services. HAS A PRIMARY CARE DOCTOR IN POOR HEALTH HAD AN ANNUAL PHYSICAL EXAM (IN THE PAST YEAR) HAD A DENTAL EXAM (IN THE PAST YEAR) HAD AN EYE EXAM OR VISION SCREENING (IN THE PAST YEAR) HAD A HEARING TEST (IN THE PAST FIVE YEARS) HAD A PAP TEST (IN THE PAST THREE YEARS, WOMEN) HAD A MAMMOGRAM (IN THE PAST TWO YEARS, WOMEN 40 AND OVER) HAD A COLORECTAL CANCER SCREENING (IN THE PAST YEAR, AGE 50 AND OVER) HAD A FLU VACCINE (IN THE PAST YEAR) HAS EVER BEEN VACCINATED FOR PNEUMONIA	People decide when to share personal information		

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	Choice of services and supports	**Rights and Respect:** People receive the same respect and protections as others in the community. Proportion of people who feel that their paid support staff treat them with respect Proportion of people who report that others ask permission before entering their home/room Proportion of people who are able to lock the doors to their room if they want (if in group setting) Proportion of people who have enough privacy in their home (if in group setting) Proportion of people who are able to have visitors come at any time (if in group setting) Proportion of people who have privacy with visitors at home if they want it (if in group setting) Proportion of people who can use the phone privately whenever they want (if in group setting) Proportion of people who have access to food at all times of the day (if in group setting) . 148 Proportion of people whose mail or email is read without asking them first (if in group setting)	**Medication:** Medications are managed effectively and appropriately. TAKES AT LEAST ONE MEDICATION FOR MOOD DISORDERS, ANXIETY, AND/OR PSYCHOTIC DISORDERS BOOKMARK NOT DEFINED. HOW MANY MEDICATIONS TO TREAT FOR MOOD DISORDERS, ANXIETY AND/OR PSYCHOTIC DISORDERS DOES THIS PERSON TAKE? TAKES AT LEAST ONE MEDICATION FOR BEHAVIOR CHALLENGES HOW MANY MEDICATIONS TO TREAT FOR BEHAVIORAL CHALLENGES DOES THIS PERSON TAKE?	**My World:**		
	Personal freedoms and dignity of risk	**Self-Direction of Care:** People have authority and are supported to direct and manage their own services. Proportion of people who are participating in a self-directed supports option (as defined by their State—data for this indicator come directly from State administrative records) Proportion of people who can choose or change the kind of services they get and determine how often and when they get them	**Wellness**: People are supported to maintain healthy habits. ENGAGES IN REGULAR, MODERATE PHYSICAL ACTIVITY BMI (BODY MASS INDEX) CHEWS OR SMOKES TOBACCO	People choose where and with whom they live		

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		Proportion of people who can choose or change who provides their services if they want				
	Self-direction	**Work:** People have support to find and maintain community integrated employment if they want it. Proportion of people who have a paying job in the community, either full-time or part-time Proportion of people who would like a job (if not currently employed) Proportion of people who reported that someone has talked to them about job options (if wanted a job) Proportion of people who do volunteer work	Respect and Rights: People receive the same respect and protections as others in the community. PEOPLE LET THIS PERSON KNOW BEFORE ENTERING THEIR HOME PEOPLE LET THIS PERSON KNOW BEFORE ENTERING THEIR BEDROOM CAN BE ALONE AT HOME WITH VISITORS OR FRIENDS HAS ENOUGH PRIVACY AT HOME MAIL OR EMAIL IS NOT READ BY OTHERS WITHOUT PERMISSION CAN USE PHONE AND INTERNET WITHOUT RESTRICTIONS STAFF TREAT THEM WITH RESPECT PARTICIPATED IN A SELF-ADVOCACY MEETING, CONFERENCE, OR EVENT	People choose where they work		
	Community Inclusion:	**Everyday Living:** People have enough supports for everyday living. Proportion of people who generally need a lot or some assistance with everyday activities (things like preparing meals, housework, shopping or taking their medications) Proportion of people who always get enough assistance with everyday activities when they need it (if need any assistance) (things like preparing meals, housework, shopping or taking their medications) Proportion of people who generally need a lot or some assistance for self-care (things like bathing, dressing,		People use their environments		

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		going to the bathroom, eating, or moving around their home) Proportion of people who always get enough assistance with self-care when they need it (if need any assistance) (things like bathing, dressing, going to the bathroom, eating, or moving around their home) Proportion of people who have access to healthy foods like fruits and vegetables when they want them				
	Social connectedness and relationships	**Affordability:** People have enough available resources. Proportion of people who ever have to skip a meal due to financial worries	**Safety:** People are safe from abuse, neglect, and injury. NEVER OR RARELY FEEL AFRAID OR SCARED AT HOME NEVER OR RARELY FEEL AFRAID OR SCARED IN NEIGHBORHOOD NEVER OR RARELY FEEL AFRAID OR SCARED AT WORK, DAY PROGRAM OR REGULAR ACTIVITY SOMEONE TO GO TO FOR HELP IF AFRAID	People live in integrated environments		
	Meaningful activity	**Planning for future:** People have support to plan and make decisions about the future. Proportion of people who want help planning for their future need for services Proportion of people who have any of the following forms of decision-making assistance		People interact with other members of the community		
	Resources and settings to facilitate inclusion	**Control:** People feel in control of their lives Proportion of people who feel in control of their life Ranking of how important people reported health was to them right now (out of health, safety, being independent, being engaged with community and friends)		People perform different social roles		

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		Ranking of how important people reported safety was to them right now (out of health, safety, being independent, being engaged with community and friends) Ranking of how important people reported being independent was to them right now (out of health, safety, being independent, being engaged with community and friends) Ranking of how important people reported being engaged with community and friends was to them right now (out of health, safety, being independent, being engaged with community and friends)				
	Caregiver support:			People choose services		
	Family caregiver/natural support well-being			**My Dreams:**		
	Training and skill-building			People choose personal goals		
	Family caregiver/natural support involvement			People realize personal goals		
	Access to resources			People participate in the life of the community		
	Workforce:			People have friends		
	Person-centered approach to services			People are respected		
	Demonstrated competencies, when appropriate					
	Safety of and respect for the worker					
	Sufficient workforce numbers, dispersion, and availability					
	Adequately compensated, with benefits					
	Culturally competent					
	Workforce engagement and participation					
	Human and legal rights:					
	Freedom from abuse and neglect					
	Optimizing the preservation of legal and human rights					
	Informed decision making					

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	Privacy					
	Supporting individuals in exercising their human and legal rights					
	Equity:					
	Equitable access and resource allocation					
	Transparency and consistency					
	Availability					
	Reduction in health disparities and service disparities					
	Holistic health and functioning:					
	Individual health and functioning					
	Population health and prevention					
	System performance and accountability:					
	Financing and service delivery reforms					
	Evidence-based practice					
	Data management and use					
Links	http://www.qualityforum.org/Measuring_HCBS_Quality.aspx	http://nci-ad.org/upload/reports/NCI-AD_2015-2016_Six_State_Mid-Year_Report_FINAL.pdf	http://www.nationalcoreindicators.org/upload/state-reports/2014-15_ACS_Vermont_Report.pdf	http://www.c-q-l.org/the-cql-difference/personal-outcome-measures		

RESULTS BASED ACCOUNTABILITY (RBA) SCORECARDS

Choices for Care

Outcome: All Vermonters have access to high quality health care

Measure:

Percentage of Choices for Care clinical eligibility determinations remaining incomplete after 30 days

Outcome: Vermont's elders and people with disabilities and people with mental conditions live with dignity and independence in settings they prefer

Measures:

Percentage of CFC HCBS participants who report that personal care services always or usually meet their needs

Percentage of CFC HCBS participants who report that choice and control when planning services was excellent or good

Percentage of CFC HCBS participants who are satisfied with how they spend their free time

Percentage of CFC HCBS participants who are satisfied with their contact with family and friends

Developmental Services (DS) Home and Community Based Services (HCBS)

Outcome: Vermont's elders and people with disabilities and people with mental conditions live with dignity and independence in the settings they prefer

Measure:

Employment rate among people age 21 to 64 who are served by Developmental Disabilities Services HCBS

Outcome: All Vermonters have access to high quality health care

Measure:

Percentage of adults age 22 and over served by Developmental Disabilities Services HCBS who have access to preventive health services (by CY)

Choices for Care Program Objectives (2010)

http://ddas.vt.gov/ddas-publications/publications-cfc/publications-cfc-documents/vt-cfc-renewal-application-06-16-10.pdf

The goal of Choices for Care is to provide Vermonters with individual choice and equal access to long-term care options in the community and nursing facilities. This is intended to prevent unnecessary use of nursing facility care by elders and adults with disabilities who have functional impairments. Choices for Care's main objectives are as follows:

1. Increase access to home and community-based services;
2. Expand the range of community-based service options; and
3. Provide elders and adults with physical disabilities who are at potential risk of future nursing facility placement with early intervention services.

By offering a range of innovative service options and earlier intervention, Vermont has intended to:

1. Ensure enrollee satisfaction with the long-term care services received;
2. Reduce utilization of institutional care; and
3. Control overall costs of long-term care.

Figure 1.1 – Desired Outcomes (2010) **Short-term Desired Outcomes** (to be achieved within 1-5 years)	
1. Information Dissemination	Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need
2. Access	Participants have timely access to long-term supports in the setting of their choice
3. Effectiveness	Participants receive effective home and community-based services to enable them to live longer in the community
4. Experience of Care	Participants have positive experiences with the types, scope, and amount of Choices for Care services
5. Quality of Life	Participants report that their quality of life improves
6. Applicants List (Waiting List) Impact	Choices for Care applicants who meet the high needs special circumstances criteria have equal access to service regardless of the setting of their choice
7. Budget Neutrality	Medicaid's cost of serving Choices for Care participants is equal to or less than would have been spent under the previous Medicaid and HCBS waiver system
Long-term Desired Outcomes **(to be achieved after the initial five years of the project)**	
8. Public Awareness	Vermont's general public is aware of the full range of long-term care settings for persons in need of long-term care and have enough information to make decisions regarding long-term care
9. Health Outcomes	Participant's medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed

1. Information Dissemination: CFC participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with participant's expressed preferences and needs.
Question 1.1: To what extent did participants receive information to make choices and express preferences regarding services and setting?
1.1 Process measures
1. Percentage of HCBS CFC participants rating "good" or above to the survey question "*how well people listen to [their] needs and preferences*" 1a. Percentage of NF and ERC participants rating facility "good" or above to "*meeting [your] needs and preferences"* 2. Percentages of HCBS CFC participants responding to the different awareness mechanisms for "*how did you first learn about the long-term care services you receive*" 2a. Percentage of NF and ERC participants responding "doctor's or hospital's recommendation" or "relative's or friend's recommendation" or "good reputation" to "*what was the most important reason [you (or your family)] chose this facility"*
1.1 Outcome measures
3. Percentage of HCBS CFC participants rating "good" or above to survey question that they *"had choice and control when planning for their services*"
4. Percentage of HCBS CFC participants responding affirmatively to whether participant's "*current setting is setting of choice"*
2. Access: CFC participants have timely access to long-term care supports in the setting of their choice.
Question 2.1: Are people able to receive CFC services in a timely manner?
2.1 Outcome measures
5. Percentage of HCBS CFC participants rating "good" or above to survey question "*timeliness of your services*" 5a. Percentage of NF and ERC participants rating facility "good" or above to "*providing an adequate number of nursing staff to meet care needs*"
6. Percentage of HCBS CFC participants rating "good" or above to survey question "*when you receive your services or care*"
7. Measure about the number of days from application to financial and/or clinical eligibility determination
Question 2.2: To what extent are CFC participants receiving the types and amount of supports consistent with their needs and preferences?
2.2 Outcome measures
8. Number and percentage of Long-term Care Ombudsman complaints from CFC participants regarding CFC service scope or amount
9. Percentage of HCBS CFC participants rating "almost always" or better to survey question that "*services meet [their] needs*" 9a. Percentage of NF and ERC participants rating facility "good" or above to "*meeting your need for grooming*"

9b. Percentage of NF and ERC participants rating facility "good" or above on "*the competency of staff*"
3. Effectiveness: Participants receive effective HCBS to enable participants to live longer in the community.
Question 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need in the community?
3.1 Process measure
10. Number of individuals on waiting list for high needs
3.1 Outcome measures
11. Percentage of CFC participants residing in nursing facilities out of total CFC participants in the highest and high levels of need
12. Number of licensed Medicaid nursing home beds
13. For CFC participants in the highest, high, and moderate levels living in the community, percentage of participants rating "good" or better on survey item whether their "*service meets [their] needs*"
Question 3.2: To what extent are participants' long-term care supports coordinated with all services?
3.2 Process measure
14. Percentage of HCBS CFC participants who attended or whose family member attended a care planning meeting
3.2 Outcome measure
15. Measure around HCBS CFC participant perception of coordination of services
Question 3.3: To what extent does Medicaid nursing facility residents' acuity change over time?
3.3 Outcome measure
16. Case mix acuity
4. Experience with Care: Participants have positive experiences with the types, scope, and amount of CFC services.
Question 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?
4.1 Outcome measures
17. Percentage of HCBS CFC participants reporting that the "*quality of [their CFC] services*" is "good" or better 17a. Percentage of NF and ERC participants rating facility "good" or above on "*the quality of care provided by nurses and nursing assistants"*
18. Percentage of HCBS CFC participants rating "good" or above on "*courtesy of those who help [them]"* 18a. Percentage of NF and ERC participants rating facility "good" or above on "*the staff's care and concern for [you]"*

19. Percentage of HCBS CFC participants reporting that they are "*getting services in the places they prefer"* (add to Market Decisions survey)
20. Percentage of HCBS CFC participants reporting problems and reporting that staff worked to resolve problems 20a. Percentage of NF and ERC participants rating facility "good" or above on "*management's responsiveness to your suggestions and concerns*"
21. Percentage of HCBS CFC participants reporting that they were very or somewhat satisfied with services 21a. Percentage of NF and ERC participants rating facility "good" or above on "*overall satisfaction"*
5. Quality of Life: Participants' reported that their quality of life improves.
Question 5.1: To what extent does CFC participants' reported quality of life improve?
5.1 Outcome measures
22. Percentage of HCBS CFC participants who report "*the help you received made your life*" somewhat or much better
23. Composite Quality of life score 23a. Percentage of NF and ERC participants rating facility "good" or above on "*offering [you] meaningful activities*" 23b. Percentage of NF and ERC participants rating facility "good" or above on "*meeting [your] religious and spiritual needs*" 23c. Percentage of NF and ERC participants rating facility "good" or above on "*offering [you] opportunities for friendships with other residents*" 23d. Percentage of NF and ERC participants rating facility "good" or above on "*offering [you] opportunities for friendships with staff*" 23e. Percentage of NF and ERC participants rating facility "good" or above on "*how enjoyable the dining experience is"* 23f. Percentage of NF and ERC participants rating facility "good" or above on "*how safe it is for you"*
24. Measure about personal goals (add to Market Decisions survey)
6. Waiting List: CFC applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing home, enhanced residential care, home care).
Question 6.1: In the presence of an active waiting list, to what extent does the implementation of a waiting list for the high needs group in CFC have different impact on applicants waiting to access HCBS vs. nursing facility services?
6.1 Process measure
25. Percentage of CFC applicants on the high needs waiting list who waiting for HCBS, compared with applicants waiting for ERCs, and nursing facilities
7. Budget Neutrality Medicaid cost of serving CFC participants is equal to or less than Medicaid and HCBS funding.
Question 7.1: Were the total costs of serving CFC participants less than or equal to the projected maximum costs for serving this population in the absence of the waiver?

7.1 Process measure
26. Total annual CFC expenditures by setting
7.1 Outcome measures
27. Ratio of annual Medicaid expenditures to DAIL projected long-term care budget
28. Percentage of Medicaid expenditures for nursing facilities in comparison with Medicaid community services for highest and high needs participants
29. Total appropriations versus actual expenditures
30. Measure around how savings are used
8. Health Outcomes: CFC participants' medical needs are addressed to improve self-reported health.
Question 8.1: To what extent are CFC participants' medical needs addressed to improve self-reported health?
8.1 Outcome measures
31. Percentage of CFC participants whose rating of their general health is "good" or better
32. Measure about the degree to which CFC services help HCBS CFC participants to maintain or improve health
33. Measure about the HCBS CFC participants' perception of how well case management understands health needs
9. Service Array and Amounts: Array and amounts of services available in the community to people who are eligible for CFC increase.
9.1 Did CFC further growth and development of home and community based services and resources throughout the state?
9.1 Outcome measures
34. Number of CFC participants by Nursing facilities, ERCs, PACE, PCA, Flexible Choices, Homemaker, Adult Day Health, 24 hour care, paid spouses
35. Number of providers of Nursing facility services, ERCs, PCA, Homemaker and Adult Day Health

United Health Foundation: 2016 Vermont Senior Health Ranking
http://www.americashealthrankings.org/Senior/VT
http://cdnfiles.americashealthrankings.org/SiteFiles/StateSummaries/Vermont-Senior-Health-Summary-2016.pdf

#	Item	Value	**Rank**	Comments
1	Hospice Care (% of decedents aged 65+) *(related: 22.9% of VT decedents age 65+ die in hospital, versus US rate of 15.3%; VT ranks **#37**)*	34.4	**47**	Vermonters can receive Medicare hospice and active treatment at the same time. Vermonters can receive hospice and Choices for Care at the same time. 2015 VT hospice report from USM included recommendation to address and improve physician referrals to hospice: https://www.vnacares.org/wp-content/uploads/2015/11/FINAL-VHS-REPORT-pdf-version.pdf 2015 VDH legislative report: "It is difficult to draw any conclusions at this time from the existing data on whether Vermont is experiencing any significant changes or trends regarding deaths at home or in hospice settings." http://legislature.vermont.gov/assets/Legislative-Reports/Annual-Report-on-Deaths-and-Hospice-Care-2015-.pdf
2	Excessive Drinking (% of adults aged 65+)	8.5	**42**	Expand/improve screening and age-appropriate treatment. Substance use was a priority in 2014 health reform document from Gov Commission on Successful Aging: I:\ALLDAIL\Gov. Commission on Successful Aging\Health Reform Subcommittee\Final Report Submitted to the Governor 3.12.15.pdf
3	Falls (% of adults aged 65+)	31.7	**41**	Falls prevention was a priority in 2015 health reform document from Gov Commission on Successful Aging: I:\ALLDAIL\Gov. Commission on Successful Aging\Health Reform Subcommittee\Final Report Submitted to the Governor 3.12.15.pdf VDH has evidence-based FallScape grant using EMTs. AAAs support evidence-based falls prevention among health promotion activities. Falls Prevention Coalition met in June and will meet again in July.
4	Suicide (deaths per 100,000 adults aged 65+)	19.9	**41**	Suicide prevention was a priority in 2015 health reform document from Gov Commission on Successful Aging: I:\ALLDAIL\Gov. Commission on Successful Aging\Health Reform Subcommittee\Final Report Submitted to the Governor 3.12.15.pdf Plan in place: J Batra discussed the active Vermont zero suicide prevention initiative with DAIL Advisory Board on 6/9/2016. Initiative is ongoing and includes the aging network.
5	Prescription Drug Coverage (% of adults aged 65+)	84.0	**31**	
6	Nursing Home Quality (% of 4 and 5 star beds)	44.1	**29**	Medicare 'next gen' ACO allows waiver of the three-day qualifying hospital stay, limited to nursing homes with a rating of three stars or more. 'Companion Aide' project is under way, intended to improve care for people w dementia in nursing homes. *Does an action plan exist?
7	Food Insecurity (% of adults aged 60+)	15.3	**28**	DCF manages 3Squares; AAAs receive some outreach funding from DCF. Vermont State Plan on Aging includes AAA goal of improving 3Squares outreach and enrollment among people aged 60+: http://www.ddas.vermont.gov/ddas-publications/publications-older-americans-act/publications-older-americans-act-documents/vt-state-plan-on-aging

Vermont Dual Eligibles Demonstration (funding application)

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VermontProposal.pdf

Vermont will develop a comprehensive performance measurement strategy that fosters smooth access, improved quality and health status, positive beneficiary experience, more effective utilization of services, and reduced overall spending. The strategy will include (1) analyses of how desired outcomes are achieved, (2) regular feedback of findings to State staff, providers, and other stakeholders in order to improve policies and service systems, and (3) more comprehensive analyses of broader, long term transformations of care and outcomes for dual eligible beneficiaries.

Vermont anticipates that the Demonstration will improve a range of outcomes, such as avoidable hospitalizations and readmissions, as well as quality, access and satisfaction in both the home and community-based and medical care sectors. Due to delays in accessing integrated data, Vermont has yet to develop specific baseline measures and performance improvement targets. Based on experience with other groups and other services, Vermont anticipates significant variations among different providers and geography. This makes the task of establishing baselines and performance targets more complex but also more focused and effective.

Improved outcomes will be achieved through maturation and spread of Vermont's APCP medical home initiative (Blueprint for Health and Community Health Teams), expansion of the Vermont Chronic Care Initiative model to include people who are dually eligible, and improved integration of medical care and home and community-based services through care coordinators with interdisciplinary and interagency collaboration. The service system sectors addressed in the logic models below, as well as related performance targets and measures, will be monitored during implementation and operation. Ongoing performance feedback will be given to State staff, care coordinators, provider staff and other stakeholders to support real-time assessment of performance and performance improvements.

Quality and outcomes from Vermont Model of Care (SS)
Encounter Data (e.g., service type, location, provider, duration, date), Grievance and Appeal Trends, Consumer Experience of Care

- ✓ Involvement in plan of care development and decision-making
- ✓ Satisfaction regarding care coordination and access
- ✓ Support during care transitions
- ✓ Increased overall satisfaction with services and supports

Access, Structure and Process

- ✓ Efficiency and timely access
- ✓ Primary Care involvement in comprehensive treatment planning
- ✓ Communication & level of integration between the medical and specialized systems of care
- ✓ Adherence to State standards and best practice (based on model of care)

Person and Service Related Outcomes

- ✓ Decreased emergency room utilization
- ✓ Decreased avoidable hospital admissions / re-admissions
- ✓ Decreased nursing home utilization
- ✓ Health assessment and/or condition specific scores (asthma, diabetes, overall assessment of functioning)
- ✓ Decreased use of residential care for children, youth and adults
- ✓ Stable community living situation
- ✓ Stable employment (and school attendance for children)
- ✓ Attainment of person-centered goals and objectives
- ✓ Increased access to PCP, dental, preventative health care services
- ✓ Cost Containment

DLTSS/CFC (JW): Desired outcomes for people can drive system design:

1. Reduction in nursing home utilization
2. Reduction in avoidable hospital admissions / re-admissions
3. Reduction in avoidable hospital days
4. Reduction in emergency room visits
5. Reduction in falls
6. Reduction of poly-pharmacy / improved medication management
7. Reduction in homelessness / improved stability in living situation
8. Reduction in unemployment
9. Improved community involvement
10. Improved utilization of PCP
11. Reduction in acute hospital days for mental health crises
12. Reduction in ER visits for mental health crises

AHS 2015-2016 Health Care Related Quality & Outcome Measures: DRAFT July 13, 2016
(Measures that align with three or more Medicaid programs are highlighted)

Measure Sources

- Medicare, Commercial and Medicaid ACO
- Medicaid Shared Savings
- GC Comprehensive Quality Strategy
- DA/SSA Performance and Quality Measures
- IFS Outcome Measures
- Certified Community Behavioral Health Center (CCBHC) Demonstration

Key:

HMIS=Homeless Mgt Information System
SSMIS=Social Services Mgt Information System (DCF)
C=Claims
D=Documentation Review
DOL= Department of Labor
MR=Medical Record
MSR=Monthly Service Report
O=Oversight
P=Payment
PR=Provider Report
R=Reporting
S=Survey
SATIS=Substance Abuse Treatment Information System
Y=Yes; N=No;
YRBS= Youth Risk Behavior Survey (VDH)

Measure Description	Data Type	Medicare	Commercial	Medicaid	GC Quality Strategy	DA/SSA	CCBHC	IFS
1. Risk-Standardized All Condition Readmission	C	P					P	
2. Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	C	P	R	R				
3. Ambulatory Sensitive Conditions Admissions: Heart Failure	C	P						
4. 30-Day All-Cause Skilled Nursing Facility Readmission	C	R						
5. All-Cause Unplanned Readmissions for People w/ Diabetes	C	R						
6. All-Cause Unplanned Readmissions for People w/ Heart Failure	C	R						
7. All-Cause Unplanned Readmissions for People w/ Multiple Chronic Conditions	C	R						
8. Depression Remission at 12 Months	MR	R						
9. % of PCPs who Successfully Qualify for an EHR Program Incentive Payment	Other	P						
10. Documentation of Current Medications in the Medical Record	MR	R						
11. Falls: Screening for Future Fall Risk	MR	P						
12. Influenza Immunization	MR	P						
13. Pneumococcal Vaccination for Patients 65 and Older	MR	P						
14. Adult BMI Screening and Follow-Up	MR	P	R	R	R			
15. Tobacco Use: Screening and Cessation Intervention	MR	P	R	R				
16. Screening for Clinical Depression and Follow-Up Plan	MR	P	R	R				
17. Colorectal Cancer Screening	MR	P	R	R				
18. Breast Cancer Screening	C	P			R			
19. Diabetes Eye Exam (Composite)	MR	R	R	R				
20. Diabetes HbA1c poor control (Stand-Alone/Composite)	MR	R	P/R	P/R				
21. HbA1c Testing	C				R			
22. LDL Screening	C				R			
23. Hypertension: Controlling High Blood Pressure	MR	P	P	P	R			
24. Proportion of Adults who had Blood Pressure Screened	MR	P						
25. IVD: Use of Aspirin or Another Antithrombotic	MR	P						
26. Heart Failure: Beta Blocker Therapy for LVSD	MR	P						
27. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	MR	R						
28. All-Cause Readmission	C		P	P	R			
29. Adolescent Well-Care Visit	C		P	P	R	R(JOBS)		R
30. Follow-Up After Hospitalization for Mental Illness (7 day)	C		P	P	R		P	
31. Follow-Up After Hospitalization for Mental Illness (30 day)	C				R		P	
32. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	C		P	P	R		P	
33. Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	C		P	P				

Measure Description	Data Type	Medicare	Commercial	Medicaid	GC Quality Strategy	DA/SSA	CCBHC	IFS
34. Chlamydia Screening in Women	C		P	P	R			
35. Developmental Screening in First 3 Years of Life	C		R	P				R (& are referred)
36. Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	C		P	P				
37. Appropriate Testing for Children With Pharyngitis	C		R	R				
38. Childhood Immunization Status	MR		R	R				
39. Pediatric Weight Assessment and Counseling	MR		R	R				
40. Cervical Cancer Screening	MR		R	R				
41. Appropriate Asthma Medication	C				R			
42. Pregnant Women Receiving Prenatal and Postpartum Care	C/VDH				R			R (1st trimester)
43. Access to Dental Care	C				R	R		
44. Adult Access to Preventive/Ambulatory Health	C				R	R		
45. Child and Adolescent Access to Primary Care	C				R	R		R (Medical Home)
46. Well-child Visits (first 15 months and 3-6 years) 6 or more	C				R			R
47. Antidepressant Medication Management (Acute and Continuation Phase)	C				R		P	
48. Children ready for kindergarten	S							R
49. Rate of Child Abuse and Neglect	SSMIS							R
50. Families (with one or more children) experiencing homelessness	HMIS							R
51. Youth who have a plan following high school	YRBS							R
52. Adolescents in grades 9-12 who drank alcohol before age 13	YRBS							R
53. Children living below 200% FPL	DCF							R
54. Adherence to Antipsychotics for Individuals with Schizophrenia	C						P	
55. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment							P	
56. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment							P	
57. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	C						P	
58. Screening for Clinical Depression and Follow-Up Plan							P	
59. Depression Remission at Twelve Months-Adults	C						P	
Patient Experience Surveys								
1. Patient Experience: Satisfaction with Health Plan	S				R			
2. Patient Experience: Getting Timely Care, Appointments, Information	S	P			R			
3. Patient Experience: How Well Providers Communicate	S	P						
4. Patient Experience: Patients' Rating of Provider	S	P			R			
5. Patient Experience: Access to Specialists	S	P						

Measure Description	Data Type	Medicare	Commercial	Medicaid	GC Quality Strategy	DA/SSA	CCBHC	IFS
6. Patient Experience: Health Promotion and Education	S	P						
7. Patient Experience: Shared Decision Making	S	P						
8. Patient Experience: Health Status/Functional Status	S	R						
9. Patient Experience: Stewardship of Patient Resources	S	R						
10. PCMH Patient Experience: Access to Care	S*		R	R	R			
11. PCMH Patient Experience: Communication	S*		R	R				
12. PCMH Patient Experience: Shared Decision-Making	S*		R	R				
13. PCMH Patient Experience: Self-Management Support	S*		R	R				
14. PCMH Patient Experience: Comprehensiveness	S*		R	R				
15. PCMH Patient Experience: Office Staff	S*		R	R				
16. PCMH Patient Experience: Information	S*		R	R				
17. PCMH Patient Experience: Coordination of Care	S*		R	R				
18. PCMH Patient Experience: Specialist Care	S*		R	R				
19. PCMH Patient Experience: DLTSS Services	S*		R	R				
AHS Performance and Quality (Master Grant)								
1. Percentage of people who receive Flexible Family Funding for the purpose of addressing specific anticipated areas of need.	PR					R		
2. A) Percentage of people who receive One Time Funding who demonstrated achieving one or more of the eight possible outcomes. B) Percentage for each outcome area that was demonstrated as being achieved.	PR					R		
3. Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they like (the home) where they live.	S					R		
4. Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they choose (helped pick) the place where they live.	S					R		
5. Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report their staff (support workers) treat them with respect.	S					R		
6. Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they can see their friends when they want.	S					R		

Measure Description	Data Type	Medicare	Commercial	Medicaid	GC Quality Strategy	DA/SSA	CCBHC	IFS
7. Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they feel lonely (don't have anyone to talk to).	S					R		
8. HCBS Setting Standards	S					R		
9. HCBS Person Centered Planning Standards	S					R		
10. Employment Rate	DOL					R		
11. Number of Project SEARCH students who receive job development	PR					R		
12. % of people served of total people referred	PR					R		
13. % of people improved upon discharge from AOP	PR					R		
14. % occupancy of crisis bed programs	PR					R		
15. % of working age clients who are employed	PR/DOL					R		
16. # of CRT enrollees that are living independently in community settings (and not living in institutional settings including residential facilities)	PR					R		
17. % of CRT enrollees that are living independently in community settings (and not living in institutional settings including residential facilities)	PR					R		
18. % of CRT clients reporting positive outcomes	PR					R		
19. % of crisis services occurring within the community	PR					R		
20. % of face to face crisis services that result in involuntary hospitalization	PR					R		
21. % of clients receiving non-emergency services within 7 days of emergency services	MSR?					R		
22. # clinicians co-located in primary care	PR					R		
23. % of clients with improvement on standardized assessment	PR					R		
24. % of clients successfully completing a treatment plan goal	PR					R		
25. % of children living at home or close to home in a family-like setting	PR					R		
26. % of youth/ parents or guardians satisfied with services	PR					R		
27. Percent of people (children under age 21) with health insurance for all or part of the year.	PR					R		
28. Percent of children with mental health problems who receive treatment.	PR					R		
29. Social Supports	SATIS					R		
30. Treatment Engagement	SATIS					R		
31. Percent of Public Inebriate services available 24 hours per day, 7 days per week	PR					R		
32. Percent of identified, potential public inebriates are screened for appropriateness of placement in diversion beds	PR					R		

Measure Description	Data Type	Medicare	Commercial	Medicaid	GC Quality Strategy	DA/SSA	CCBHC	IFS
33. Percent of group leaders receive and complete curriculum training from Rocking Horse Program Developer	**PR**					**R**		
34. Percent of group leaders attend Annual Rocking Horse Training	**PR**					**R**		
35. Rocking Horse Curriculum implemented with fidelity to the model	**PR**					**R**		

***The same survey is used in Vermont to provide practice-level results and ACO-level results. Implementation of the survey by a certified vendor is coordinated and financed by the State, using SIM and DVHA funds; Global Commitment CQS uses Health Plan version of survey, ACO use Primary Care Medical Home version of survey.**

VII. LONG TERM SERVICES AND SUPPORTS PROTECTIONS FOR CHOICES FOR CARE

29. **Person Centered Planning.** The state agrees to use person centered planning processes to identify participants' and applicants' long term service and support needs, the resources available to meet those needs, and to provide access to additional service and support options, such as the choice to use spouse caregivers, and access a prospective monthly cash payment. The state assures that person centered planning will be in compliance with the characteristics set out in 42 CFR 431.301(c)(1)-(3).

30. **Self- Directed Supports.** The state agrees to provide resources to support participants or their proxies (e.g., a surrogate, parent or legal guardian/representative) in directing their own care. This support assures, but is not limited to, participants' compliance with laws pertaining to employer responsibilities and provision for back-up attendants as needs arise. The state agrees to assure that background checks on employees and their results are available to participants. State policies and guidelines will include, but not be limited to: criteria for who is eligible to self-direct, a fiscal agent/intermediary, and consultants to assist participants with learning their roles and responsibilities as an 'employer' and to ensure that services are consistent with care plan needs and allocations.

Choices for Care program enrollees will have full informed choice on the requirements and options to: self-direct Choices for Care services; have a qualified designated representative direct Choices for Care services on their behalf, or select traditional agency-based service delivery. State and provider staff will receive training on these options.

31. **Participant/Applicant Waiting List Monitoring.** The state agrees to report on the status of the waiting lists for Choices for Care services during regular progress calls between CMS and the state and in reports submitted to CMS by the state.

The state assures that it has a system as well as policies and procedures in place through which the providers must identify report and investigate critical incidents that occur within the delivery of Choices for Care Long Term Services and Supports (LTSS). The state also has a system as well as policies and procedures in place through which to prevent, detect report, investigate, and remediate abuse, neglect, and exploitation. Providers and participants are educated about this system. Provider obligations include specific action steps that providers must take in the event of known or suspected abuse, neglect or exploitation. The

Vermont policies and procedures are specified in Vermont Statute, 33 V.S.A. Chapter 69, available at: http://www.leg.state.vt.us/statutes/sections.cfm?Title=33&Chapter=069.

32. The state will assure compliance with the characteristics of home and community based settings in accordance with 42 CFR 441.301(c)(4), for those Choices for Care services (e.g., those not found in the Vermont State Plan) that could be authorized under 1915(c) and 1915(i). The Choices for Care services are described in Attachment D.

33. In its role as single state agency, the AHS will ensure a managed LTSS plan for a comprehensive care model is developed that promotes the integration of home and community based services, institutional, acute, primary and behavioral health care.

34. To support the beneficiary's experience receiving medical assistance and long term services and supports, the state shall assure that all Choices for Care program enrollees have access to independent support services that assist them in understanding their coverage options and in the resolution of problems regarding services, coverage, access and rights. Independent support services will:

a. Operate independently from any provider and to the extent possible, services will be provided independently of the state and support transparent and collaborative resolution of issues between beneficiaries and state government.

b. Be easily accessible and available to all Choices for Care enrollees. Activities will be directed towards enrollees in all settings (institutional, residential and community based) accessible through multiple entryways (e.g., phone, internet, office) and reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

c. Assist with access to services and supports and help individuals understand their choices, resolve problems and address concerns that may arise between the individual and a provider or payer. The state will assure:

i. beneficiaries have support in the pre-enrollment stage, such as unbiased options counseling and general program-related information.

ii. beneficiaries have an access point for complaints and concerns about Choices for Care enrollment, access to services, and other related matters.

iii. enrollees understand the fair hearing, grievance, and appeal rights and processes within the Choices for Care program and assist them through the process if needed/requested.

iv. trainings are conducted with providers on community-based resources and covered services and supports.

d. Ensure staff and volunteers are knowledgeable. Training will include information about the state's Medicaid programs; beneficiary protections and rights under Medicaid

managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the state will ensure services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency.
e. Collect and report information on the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support quarterly reporting requirements to CMS.

XIV. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE

69. **Comprehensive State Quality Strategy (CQS).** The state shall adopt and implement a comprehensive, dynamic, and holistic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program. This CQS must address quality improvement for all components of the state's Medicaid state plan and its section 1115 demonstration. The CQS must meet all the requirements of 42 CFR 438 and must include LTSS and HCBS quality components.
a. *CQS Elements*. The CQS must also address the following elements:
i. Goals. The state's goals for improvement, identified through claims and encounter data, quality metrics, and expenditure data. The goals should align with the three part aim but should be more specific in identifying pathways for the state to achieve these goals.
ii. Responsibilities. The CQS must identify Single State Agency and public managed care responsibilities. The Single State Agency retains ultimate authority and accountability for public managed care responsibilities and adherence to the CQS, including monitoring and evaluation of the public managed care model's compliance with requirements specific to the MLTSS assurances identified in STC 1(a)(vii)(2) below as well as the health and welfare of enrollees.
iii. Performance Improvement Projects (PIPs). The associated interventions for improvement in the goals. All PIP topics, tied to specific goals, must be included in the CQS.
iv. Performance Measures. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where

possible and appropriate. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care.
1. Levels of Aggregation. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, specific health care program (such as Choices for Care), if applicable, and potentially at each direct health services provider. The state will work with CMS to further define metrics, as appropriate, for collection.
2. Benchmarks and Targets. The specific methodology for determining benchmark and target performance on these metrics.
v. Populations. Specific metrics related to each population covered by the Medicaid program, including children, pregnant women, non-disabled adults (including parents), individuals receiving HCBS services, and individuals receiving LTSS.
1. HCBS performance measures in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, outcomes, quality of life, effectives process, community integration, and assuring there are qualified providers and appropriate HCBS settings.
2. The CQS must include a special focus on MLTSS populations and address the following:
a. A self-assessment of MLTSS adherence to state and federal standards of care to include:
i. Assessment of existing initiatives designed to improve the delivery of MLTSS, including performance measures or PIPs directed to this population.
ii. Examination of processes to identify any potential corrective action steps toward improving the MLTSS system.
b. Person-Centered Planning and Integrated Care Settings
c. Comprehensive and Integrated Service packages
d. Qualifications of Providers
e. Participant Protections
http://dvha.vermont.gov/administration/vt-1115-consolidation-amendment-approval-01302015.pdf

Table 3: Global Commitment to Health Specialized Program Assessment and Quality Phases

	GC Specialized Program Self-Assessment and Quality Phases				
	Choices for Care	Developmental Services	Traumatic Brain Injury	Community Rehabilitation and Treatment	Children's Mental Health (Mental Illness under 22)
Quality Strategy Timeline					
Phase 1: Due 12/31/15	✓				
Phase 2: Due 12/31/16	✓	✓	✓		
Phase 3: Due 12/31/17	✓	✓	✓	✓	✓
Phase 4: Due 12/31/18	✓	✓	✓	✓	✓

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The state's goal in implementing the demonstration is to improve the health status of all Vermonters by:

• Increasing access to affordable and high quality health care;
• Improving access to primary care;
• Improving the health care delivery for individuals with chronic care needs;
• Containing health care costs; and
• Allowing beneficiaries a choice in long-term services and supports and providing an array of home and community-based alternatives recognized to be more cost-effective than institutional based supports.

The goals align with Institute for Healthcare Improvement's Triple Aim but are more specific in identifying pathways for the state to achieve its goals.

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Table 4: Quality Strategy Objectives:

Focus Area	Objective	Time Frame	Targets
Diabetes	AHS will demonstrate a 5% improvement in the HgA1c testing and LDL screening of Medicaid managed care beneficiaries with diabetes over the next two years.	1/2015-12/2017	68.3% & 48.5%

Asthma	AHS will demonstrate a 5% improvement in the use of appropriate medications for people with asthma over the next two years.	1/2015-12/2017	86.5%
Prenatal care	AHS will demonstrate a 5% improvement in the rate of pregnant women receiving prenatal care over the next two years.	1/2015-12/2017	TBD*
Annual dental visits	AHS will demonstrate a 5% improvement in enrollee access to dental visits over the next two years.	1/2015-12/2017	71.1%
Prevention	AHS will demonstrate a 5% improvement in enrollee breast cancer screening over the next two years.	1/2015-12/2017	40.0%
Prevention	AHS will demonstrate a 5% improvement in enrollee chlamydia screening in women over the next two years.	1/2015-12/2017	53.1%
Prevention	AHS will demonstrate a 5% improvement in controlling enrollee high blood pressure over the next two years.	1/2015-12/2017	TBD*
Behavioral Health	AHS will demonstrate a 5% improvement in antidepressant medication management (acute and continuation phase) over the next two years.	1/2015-12/2017	66.5% & 46.3%
Behavioral Health	AHS will demonstrate a 5% improvement in follow-up after hospitalization for mental illness (7 day and 30 day) over the next two years.	1/2015-12/2017	43.7% & 64.9%
Behavioral Health	AHS will demonstrate a 5% improvement in Initiation and engagement of alcohol and other drug dependence treatment over the next two years.	1/2015-12/2017	36.0% & 14.3%
Access to Care	AHS will demonstrate a 5% improvement in adult enrollee access to preventive/ambulatory health services over the next two years.	1/2015-12/2017	91.7%
Access to Care	AHS will demonstrate a 5% improvement in children and adolescents' access to primary care practitioners over the next two years.	1/2015-12/2017	TBD*
Access to Care	AHS will demonstrate a 5% improvement in the rate of children (First 15 months and 3rd-6th years) receiving 6 or more well child visits over the next two years.	1/2015-12/2017	79.8% & 75.1%
Access to Care	AHS will demonstrate a 5% improvement in the rate of adolescents receiving well care visits over the next two years.	1/2015-12/2017	49.3%

Consumer Satisfaction	AHS will demonstrate a 5% improvement in consumers rating of satisfaction with health plan over the next two years.	1/2015-12/2017	TBD*

***** Targets to be identified by the waiver measures work group by December 31, 2015.

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Definition of special health care needs.

The MCE is required to establish and maintain policies and procedures to identify and coordinate health care services for members with special health care needs. Participants in the following programs are identified by the state as having special health care needs:

☐Developmental Services, Traumatic Brain Injury, Choices for Care MLTSS program (DAIL)

☐Community Rehabilitation and Treatment (CRT) and Children with a Severe Emotional Disturbance (DMH)

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Measures include, but are not limited to:

1. HCBS performance measures in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, outcomes, quality of life, effectives process, community integration, and assuring there are qualified providers and appropriate HCBS settings.

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For each enrollee that the managed care entity confirms as having special health care needs, the individual is assigned a care coordinator. In addition to facilitating the development of a multidisciplinary service plan, the care coordinator is also responsible for coordinating service among providers, monitoring the treatment plan, and providing periodic reassessments. The MCE defines individuals with special health care needs and is able to identify such enrollees through information contained in Health Risk Assessments; special application for service (e.g., DS, CMH, TBI, etc.), claims data review, or any other available data source.

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Home and Community Based Service (HCBS)

Special focus is placed on long term care services and supports (CFC) populations and addresses the following:

1. A self-assessment of CFC adherence to state and federal standards of care to include:

i. Assessment of existing initiatives designed to improve the delivery of CFC, including performance measures or Performance Improvement Projects (PIPs) directed to this population.

ii. Examination of processes to identify any potential corrective action steps toward improving the CFC system.

2. Person-Centered Planning and Integrated Care Settings

3. Comprehensive and Integrated Service packages

4. Qualifications of Providers

5. Participant Protections

The MCE must determine whether services in these settings meet the community standards set forth in the rules. Initial and ongoing compliance with standards will include, but not be limited, to the following methods: licensing reviews, provider qualification reviews, site visits, survey of individuals in receipt of HCBS, provider self-assessment, or a sample of settings. If necessary, CMS will allow Vermont up to four years to phase in these changes. All such services will be in compliance with CMS requirements before March 2019.

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The MCE shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the requirements established by AHS for the Medicaid program. At a minimum, the MCE shall ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section

1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

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The MCE is required to report Performance Measures including results from Consumer Satisfaction Feedback Activities to AHS to assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs. Performance Measures will be required in the following focus areas:

☐Childhood and Adolescent Immunization

☐Chronic Conditions – Asthma and Diabetes

☐Prenatal Care

☐Children's Health – Well-Child Visits

☐Oral Health – Annual Dental Visits

☐Behavioral Health

☐Consumer Satisfaction

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Table 9: HCBS Regulations – Examples of Acceptable Practice.

REGULATORY REQUIREMENT	EXAMPLES OF ACCEPTABLE PRACTICE
Opportunities to seek employment and work in competitive integrated settings	Individual works in an integrated setting or, if the individual would like to work, there is activity that ensures the option is pursued.
Engage in community life	Individual regularly accesses community as chooses (shops, attends religious services, schedules appointments, lunch with family and friends) Individual has access to public transportation, accessible transportation for appointments and shopping; training to use public transportation. Where public transportation is limited, other resources are provided. Individual participates regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual
Control personal resources	Individual has checking or savings account or other means to control own funds; access to own funds.
Receive services in the community	Individual can choose from whom they receive services and supports.
Privacy	Individual can make private telephone calls/text/email at the individual's preference and convenience. Health information is kept private. Assistance provided in private, as appropriate, when needed.
Dignity and respect	Individual is assisted with grooming as desired; assisted with dressing in their own clothes appropriate to the time of day, weather and preferences. Staff communicates with individuals in dignified manner. Informal (written and oral) communication conducted in a language that the individual understands.
Freedom from coercion	Individuals are free from coercion: e.g., able to file complaints, discuss concerns; able to make personal decisions such as hairstyle and hair color
Freedom from restraint	Individual has unrestricted access in the setting: no barriers to exit and entrance; physical accessibility.
Initiative, autonomy and independence	Individual is free to come and go at will (no curfew or other requirement for a scheduled return to the setting). The setting is an environment that supports individual comfort, independence and preferences (*e.g.*, kitchen with cooking facilities, dining area, laundry, and comfortable seating in shared areas).
Daily activities	Individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan. Participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services. The individual chooses when and what to eat. The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.
Physical environment	The individual has his/her own bedroom or shares a room with a roommate of choice.
With whom to interact	The individual chooses with whom to eat or to eat alone. Visitors are not restricted.
Choice of services	Staff ask individual about needs and preferences. Individuals are aware of how to make a service request. Requests for services and supports are accommodated as opposed to ignored or denied. Choice is facilitated in a manner that leaves the individual feeling empowered to make decisions.
Choice of providers	The individual chooses from whom they receive services and supports. Individual knows of other providers who render the services s/he receives. Individual knows how and to whom to make a request for a new provider.

http://dvha.vermont.gov/global-commitment-to-health/1vt-gc-cqs-september-15-2015-cms-submission.pdf

Principles of Developmental Disabilities Services

The Developmental Disabilities Act of 1996 states that services provided to people with developmental disabilities and their families shall foster and adhere to the following principles:

1. **Children's Services**: Children, regardless of the severity of their disability, need families and enduring relationships with adults in a nurturing home environment. The quality of life of children with developmental disabilities, their families and communities is enhanced when the children are cared for within their own homes. Children with disabilities benefit by growing up in their own families; families benefit by staying together; and communities benefit from the diversity provided when people of varying abilities are included.
2. **Adult Services**: Adults, regardless of the severity of their disability, can make decisions for themselves, can live in typical homes, and can contribute as citizens to the communities where they live.
3. **Full Information**: In order to make good decisions, people with developmental disabilities and their families need complete information about the availability and choice of services, the cost, how the decision making process works, and how to participate in that process.
4. **Individualized Support**: People with disabilities have differing abilities, needs, and goals. Thus, to be effective and efficient, services must be individualized to the capacities, needs, and values of each individual.
5. **Family Support**: Effective family support services are designed and provided with respect and responsiveness to the unique needs, strengths, and cultural values of each family and the family's expertise regarding its own needs.
6. **Meaningful Choices**: People with developmental disabilities and their families cannot make good decisions unless they have meaningful choices about how they live and the kinds of services they receive. Effective services are flexible so they can be individualized to support and accommodate personalized choices, values and needs and assure that each recipient is directly involved in decisions that affect that person's life.
7. **Community Participation**: When people with disabilities are segregated from community life, all Vermonters are diminished. Effective services and supports foster full community participation and personal relationships with other members of the community. Community participation is increased when people with disabilities meet their everyday needs through resources available to all members of the community.
8. **Employment**: The goal of job support is to obtain and maintain paid employment in regular employment settings.
9. **Accessibility**: Services must be geographically available so that people with developmental disabilities and their families are not required to move to gain access to needed services, thereby forfeiting natural community support systems.
10. **Health and Safety**: The health and safety of people with developmental disabilities is of paramount concern.
11. **Trained Staff**: In order to assure that the purposes and principles of this chapter are realized, all individuals who provide services to people with developmental disabilities must have training as required by section 8731 of the Developmental Disabilities Act.
12. **Fiscal Integrity**: The fiscal stability of the service system is dependent upon skillful and frugal management and sufficient resources to meet the needs of Vermonters with developmental disabilities.

Developmental Services Consumer Survey

The Consumer Survey Project conducted 603 interviews of adults who receive developmental disabilities services over the course of the past three years (2011, 2012 and 2013). Overall, individuals expressed general satisfaction with where they lived, worked, what they did during the day, and with the individuals who provide them support. A high percentage of individuals who responded to the survey said they:

- Are happy with where they live.
- Are happy with how they spend their free time at home.
- Feel safe at home and in their neighborhoods.
- Have a say in how they spend their money.
- Like their jobs and are treated with respect by their coworkers.
- Like their community activities and the people with whom they spend time.
- Have opportunities to meet new people.
- Are happy with their guardian and get to see their guardian when they want.
- Are happy with their case manager and service agency.
- Get to learn new things/skills.

Survey results also indicated individual's satisfaction was lower in regard to their autonomy. For example, a high percentage of individuals who responded to the survey said they:

- Do not have a choice in where they live or who they live with.
- Do not decide when friends or family can come over to visit.
- Do not have privacy when friends and family visit.
- Cannot stay home alone when others go out.
- Do not have a key to their home.
- Do not work enough hours at their job.
- Do not have a job but want to work.
- Do not have enough community activities.
- Have not voted in an election.
- Feel lonely and wish they had more friends.

CAHPS
stands for "Consumer Assessment of Healthcare Providers and Systems." The name represents a standardized approach to gathering, analyzing, and reporting information on consumers' and patients' experiences with health care services. The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. Since its launch in 1997, this survey has become the national standard for measuring and reporting on the experiences of consumers with their health plans. A version of this survey is conducted in almost every State in the U.S.

Surveys Available from AHRQ
•Health Plan
•Clinician & Group
•Surgical Care
•Child Hospital
•Dental Plan
•Experience of Care and Health Outcomes (ECHO)
•American Indian
•Nursing Home

Supplemental Items
•Item Set for Children with Chronic Conditions
•Item Set for People with Mobility Impairments
•Cultural Competence Item Set
•Health Information Technology Item Set
•Item Set for Addressing Health Literacy
•Patient-Centered Medical Home (PCMH) Item Set

Table 1. 5.0 Adult Medicaid composite items 5.0 Adult Medicaid Composite Items

		Response Grouping for Presentation
Getting Needed Care		
Q25	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	Never + Sometimes, Usually, Always
Q14	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	Never + Sometimes, Usually, Always
Getting Care Quickly		

Q4	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	Never + Sometimes, Usually, Always
Q6	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	Never + Sometimes, Usually, Always
How Well Doctors Communicate		
Q17	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	Never + Sometimes, Usually, Always
Q18	In the last 6 months, how often did your personal doctor listen carefully to you?	Never + Sometimes, Usually, Always
Q19	In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never + Sometimes, Usually, Always
Q20	In the last 6 months, how often did your personal doctor spend enough time with you?	Never + Sometimes, Usually, Always
Health Plan Information & Customer Service		
Q31	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	Never + Sometimes, Usually, Always
Q32	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	Never + Sometimes, Usually, Always

Table 2. 5.0 Child Medicaid composite items 5.0 Child Medicaid Composite Items	**Response Grouping for Presentation**	
Getting Needed Care		
Q46	In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?	Never + Sometimes, Usually, Always
Q15	In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?	Never + Sometimes, Usually, Always
Getting Care Quickly		

Q4	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	Never + Sometimes, Usually, Always
Q6	In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?	Never + Sometimes, Usually, Always
How Well Doctors Communicate		
Q32	In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?	Never + Sometimes, Usually, Always
Q33	In the last 6 months, how often did your child's personal doctor listen carefully to you?	Never + Sometimes, Usually, Always
Q34	In the last 6 months, how often did your child's personal doctor show respect for what you had to say?	Never + Sometimes, Usually, Always
Q36	In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?	Never + Sometimes, Usually, Always
Q37	In the last 6 months, how often did your child's personal doctor spend enough time with your child?	Never, Sometimes, Usually, Always
Health Plan Information & Customer Service		
Q50	In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?	Never + Sometimes, Usually, Always
Q51	In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?	Never + Sometimes, Usually, Always

Table 5. CAHPS 5.0 chronic conditions questions by category 5.0 Chronic Conditions Questions by Category	**Response Grouping for Presentation**
Parents' Experiences With Prescription Medicine	

Q56	In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?	Never + Sometimes, Usually, Always
Parents' Experiences Getting Specialized Services for Their Children		
Q20	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?	Never + Sometimes, Usually, Always
Q23	In the last 6 months, how often was it easy to get this therapy for your child?	Never + Sometimes, Usually, Always
Q26	In the last 6 months, how often was it easy to get this treatment or counseling for your child?	Never + Sometimes, Usually, Always
Family Centered Care: Parents' experiences with the child's personal doctor or nurse		
Q38	In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?	Yes, No
Q43	Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	Yes, No
Q44	Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?	Yes, No
Family Centered Care: Parents' experiences with getting needed information about their child's care		
Q9	In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?	Never + Sometimes, Usually, Always
Parents' experiences with coordination of their child's care		
Q18	In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	Yes, No
Q29	In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	Yes, No

https://www.cahpsdatabase.ahrq.gov/cahpsidb/Public/Files/Doc4_CAHPSHP_Methodology_2015.pdf