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Reporting: Managing and Using Home and Community-based Services Data for Quality Improvement

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Community Living Exchange

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NATIONAL ACADEMY *for* STATE HEALTH POLICY

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Managing and Using Data for Quality Improvement

The Data Management and Use Series represents the third in a group of papers synthesizing the ideas and practices of states as they improve the quality of home and community based services (HCBS) and supports for older persons and persons with disabilities.

In 2003, the Centers for Medicare & Medicaid Services (CMS) awarded grants to 19 states to enhance their quality management (QM) programs for HCBS programs.[1] CMS contracted with the Community Living Exchange Collaborative[2] to assist states in their grant activities by promoting information exchange and facilitating discussions on topics of common interest. As part of its work with the Community Living Exchange Collaborative, the Muskie School of Public Service, together with grantee states, identified three initial priority topics for working papers:

1. Quality Management (QM) Roles and Responsibilities
2. Discovery Methods for Remediation and Quality Improvement
3. **Managing and Using Data for Quality Improvement**

The Data Management and Use Series builds upon the concepts and techniques discussed in the two previous papers and provides additional resources for states as they seek to organize, analyze and report data in a way that informs decision making and supports quality management and improvement.

Focus and Purpose of Data Use and Management Series

As 2003 Quality Grantees move into the third year of their projects, their methods for collecting and automating HCBS waiver data are continuously improving, and program and outcome data are becoming more readily available. One challenge that is frequently articulated by grantees is how to organize, analyze and report this data in a way that is timely, accurate and cost-effective. States are challenged to integrate information from of a variety of separate systems and present data in a format that is meaningful, purpose-driven and often dependent on the audience or stakeholder. CMS's requirement that states report data in a way that directly addresses HCBS waiver assurances gives each of these challenges additional weight.

A number of specific issues and questions were identified through monthly conference calls and one-on-one discussions with grantees. These include the following:

- ***Performance Measurement***: How do states construct and use performance measures to evaluate HCBS programs?
- ***Data Quality and Analysis***: How do states validate, clean and analyze waiver data in a way that supports project management and informs decision-making?
- ***Data Presentation***: What types of tables, charts and graphics are used to present data, and how does the effectiveness of these formats vary depending on the type of information and/or pattern being conveyed?
- ***Reporting***: What types of reports are generated from HCBS waiver data and how do these reports vary depending on the audience and purpose?

[1] QA/QI grantee states include: California, Colorado, Connecticut, Delaware, Georgia, Indiana, Maine, Minnesota, Missouri, North Carolina, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Wisconsin, and West Virginia.
[2]The Community Living Exchange Collaborative is a partnership of the Rutgers Center for Health Policy, the National Academy for State Health Policy and Independent Living Research Utilization. Under contract with the Technical Exchange Collaborative, the Muskie School of Public Service is the lead for providing technical assistance in the area of quality assurance/quality improvement.

- ***Data Integration***: How is data from different sources blended and linked to create a larger and more comprehensive data environment?

This paper is an attempt to address the challenges of reporting from a program manager's perspective. It is not meant to be an exhaustive research document, nor is it intended to single out any one correct approach. The paper is meant to facilitate communication between program units and analytic staff and serve as one reference for states as they continue to improve upon data collection techniques and use this information for ongoing quality management and improvement.

Reporting

Final reports are typically the end product of an involved process of data gathering, cleaning, integration and analysis. Effective reports present information in a structured way that highlights key messages, such as areas of poor or strong performance, and enables readers to make informed decisions about how to act on information provided. While the construction of reports is not necessarily the first chronological step in designing and thinking through data analyses, it is helpful to understand the final output that is desired when identifying data sources, selecting performance measures and developing the structure and scope of data analysis plans.

This paper walks through different types of HCBS waiver reports and includes steps for thinking through the purpose, content and format of each, while tailoring report presentation to meet the needs of specific audiences. Wherever possible, state examples are provided at the end of each section and are supplemented by sample reports that combine promising features of these and other examples.

Seven types of reports are highlighted that guide program management, inform policy development, measure program outcomes and identify areas for quality improvement. Each of these reports targets a specific set of questions (*e.g.,* Are states meeting CMS waiver assurances? Are participants satisfied with their quality of life and services?) and may vary in content and format depending on the audience. Sample reports include:

- Annual Report
- HCBS Evidence Report
- Management Report
- Claims-Based Report
- Provider Specific Reports
- Critical Incident Reports
- Consumer Survey Reports

Please note that the reports presented in this paper are illustrative only and should not replace the process of soliciting input from stakeholders on what kind of information should be included in a report. These examples can provide a starting point for those discussions but should be adapted to a state's own needs and priorities to become useful and meaningful. In some cases, examples from other settings of care are included if the format has application to HCBS.

The reports highlighted in this document are intended primarily for HCBS program managers, legislators, and care providers. Reports specifically designed for consumers are beyond the scope of this paper and warrant additional considerations. The reader is advised to review the bibliography at the end of this paper for resources that may be helpful in developing consumer reports.

I. Annual Report

An annual report is designed specifically to provide a diverse group of stakeholders with a formal statement of the previous year's activities. It may include contextual information, client demographic data and a statement of future goals and activities. It may also include detailed financial data, reports on select performance measures and other important facts about program operations. Typically, annual reports are written with the intention of providing an accessible snapshot of a program and its recent accomplishments. The report tends to be broad in scope, but may reference other products, reports and websites where additional information can be obtained.

Annual Reports at a Glance	
Purpose:	• To provide stakeholders with an overview of the previous year's activities, expenditures and program performance.
Audience:	• Legislators • Committee, council and board members • Service agencies/provider organizations • Consumer advocacy groups
Sample content:	• Enrollment trends • Expenditures, cost per member • Program performance against goals, objectives • Comparison of program performance to benchmarks
Level of specificity:	• Simple, clear presentation • Short paragraphs, use of bullets
Literacy:	• Fifth grade literacy • No jargon
Frequency:	• Annual

State Examples:

Maine's report, *Quality Indicators for Home and Community-Based Services: Older Adults and Adults with Disabilities,* provides summary information on the program design and performance of Maine's home and community-based waiver for older adults and adults with disabilities. The report is organized around the CMS Quality Framework and its seven focal areas. For each area of quality, the report includes the state's results on one to three core performance indicators. For more information, visit:
http://www.hcbs.org/moreInfo.php/state/159/sby/Date/doc/1467/HCBS_Quality_Indicators_for_Home_and_Community-Bas

Massachusetts Department of Mental Retardation Quality Assurance Report presents the results of a series of outcome measures in the following ten areas: health, protection from harm, safe environments, human and civil rights, decision-making and choice, community integration, relationships, achievement of goals and work and qualified providers. The data that forms the basis of this report is drawn from a wide variety of quality assurance processes in which the department is routinely engaged. For more information, visit:
http://www.hcbs.org/files/56/2788/Assurance_Report.pdf

2004 New York State Managed Care Plan Performance Report is designed to help inform and educate health care consumers, providers and insurers as they make important decisions about health plans. Information is divided into the following sections: plan profiles, provider network, child and adolescent care, women's health, adults living with illness, behavioral health and access and services. Each section of the report contains groups of quality care performance measures with results for each plan and the statewide average. The last page of each section includes a graph showing New York's performance over time and comparable national benchmarks for the performance measures published in that section. While the report does not deal specifically with HCBS waiver programs, it is a good example of how complex information can be analyzed at different levels (state, plan, etc.) and presented to the public using clear, easy to read graphs and tables. For more information, visit: http://www.health.state.ny.us/health_care/managed_care/qarrfull/qarr_2004/qarintro.htm

II. HCBS Evidence Report

At the time of waiver renewal, states must document the performance of their waiver programs with respect to the six CMS waiver assurances. CMS uses this data to make a decision regarding continuation of the waiver program. The evidence report is intended primarily for CMS staff, but could be used on a more regular basis by state program managers in their assessment of waiver performance. In producing evidence, states are generally asked to (a) briefly describe the indicators and discovery methods they use to monitor performance against each waiver assurance, (b) report findings of this assessment and (c) explain how this data is used to make continuous quality improvements. In a case where a state has not implemented indicators and discovery methods to fully assess all aspects of each waiver assurance, the report identifies how the state plans to do so in the future.

HCBS Evidence Report at a Glance	
Purpose:	• To provide an overview of discovery methods, program outcomes and quality improvement activities and demonstrate to CMS that required waiver assurances are being met.
Audience:	• CMS central and regional offices • Medicaid agency • Department heads • Committee, council and board members • State-level managers • Service agencies/provider organizations • Consumer advocacy groups
Sample content:	• Quality indicators for each waiver assurance • Discovery methods for collecting data to generate quality indicators • Findings and interpretation of quality indicators • Actions taken/proposed to address weaknesses
Level of specificity:	• Concise descriptions with sufficient detail to understand methods for assessing performance, data interpretation, conclusions and actions taken
Literacy:	• No inside jargon or abbreviations
Frequency:	• One year prior to waiver renewal, usually every five years

Example:

There are no required formats for producing evidence and states vary in the level of detail they provide. To help guide states with a possible format, the following report structure was prepared for a single sub-domain within an assurance area. Please note that this is not intended as an all-inclusive list of evidence that demonstrates compliance with CMS 1915(c) waiver assurances, nor do these examples assure waiver compliance as assessed by CMS. For a complete list of the six CMS assurances and their sub domains, states should refer to the CMS *Interim Procedural Guidance* and the probing questions: http://hcbs.org/files/36/1783/CMS_Interim_Guidance_B.pdf

II. HCBS EVIDENCE REPORT SAMPLE

Report Audience: CMS and state-level managers
Purpose: To document how the state waiver program monitors its performance with respect to the six CMS waiver assurances

Waiver:	**HCBS Elderly**
Assurance:	**Plan of Care (POC)**
Sub-Assurance:	2.1 Individual plans address needs and personal goals including health and welfare risk factors through waiver or other means
Indicator:	POC 2.1.1 Percent of participants with risk factors whose plan of care addresses risk factors.
Discovery Method:	Program Audit staff annually review a 10 percent sample of all plans of care to determine whether participants have one or more risk factors and how the following risk factors are addressed: depression; 9+ medications; unintended weight loss; behavior-related factors; lives alone; and unsafe environment.

Findings

Percent of at-risk population with a plan of care (POC) that addressed risk factor in 2005
(The Program Audit staff sampled 359 plans of care out of a total of 3,590)

Risk Factor	Number of participants with risk factor	Number of POCs addressing risk factor	% of at-risk participants with a POC that addressed risk factor
Lives alone	62	47	75.8%
Unsafe environment	14	11	78.6%
Depression	227	145	63.9%
Behavior-related factors	182	87	47.8%
Unintended weight loss	217	184	84.8%
9+ Medications	280	127	45.4%

Source: Record review of ten percent sample of Plans of Care

Actions Taken

- POC instrument revised to more specifically identify risk factors of interest.
- Training conducted with care coordinators to enhance knowledge and understanding about assessment of risk and services appropriate to address known risks.

Barriers to Improvement

- Turnover of care coordinators continues to impact the collection of risk factors and identification of services to address those factors.
- More guidance is needed to help care coordinators determine how best to address risk factors in plans of care.
- The waiver program does not currently include services that address problems with medication management and incompatibilities.
- There are no benchmarks for evaluating the percent of participants that are expected to have risk factors.

Status and Rationale

- This is considered a high priority for improvement since it is believed that risk factors play a critical role in the health and welfare of participants and the ability of the waiver to adequately address their needs.

Recommendations for FY 2006

- Conduct further analysis through sample chart reviews of the dominant risk factors of our waiver participants.
- Bring in experts to assist program staff and care coordinators to better understand how to address and monitor priority risk factors.
- Continue to improve through training and meetings with care coordinators the reporting of risk factors in the plan of care.

III. Management Report

This report provides an aggregate overview of how well the waiver program is meeting its targets with respect to eligibility determination, enrollment, service planning and cost. It can be used to identify trends, potential problems and areas that may require further investigation to understand underlying causes.

Management Reports at a Glance	
Purpose:	• To provide an overview of program operations and assess the extent to which HCBS programs are meeting their statutory and fiduciary responsibilities.
Audience:	• State-level program managers • Medicaid agency • Department heads
Sample content:	• Level of care determination (number, turnaround time, denials) • Enrollment change • Service plans (number, turnaround time) • Cost per member per month • Notations on unusual developments that may influence trends • Complaints
Level of specificity:	• This report is fairly detailed and can speak in "shorthand" so as to provide maximum information within limited space. How measures are calculated should be documented to assure consistency over time.
Literacy:	• Given the limited audience, jargon is permissible.
Frequency:	• Produced routinely, perhaps quarterly

Example:

The following example is a composite of ideas from several states about the types of information program managers could review on a regular basis to anticipate or detect potential problems. Some of the data elements may come from other reports (such as Evidence Reports) but are included here to encourage more regular monitoring of the relationship among indicators, over time and across geographic or agency designations.

III. MANAGEMENT REPORT SAMPLE (Report 1 of 1)
Report Audience: State managers
Purpose: Track changes in key indicators and identify areas where improvements are needed.

ALL REGIONS: HCBS Waiver Management Report by Region

Description: Tracks key management issues, including enrollment rates, recertification of waiver participants, program costs, appeals and complaints.

Data Source: Administrative data collected by the regional offices and system management database

Reporting Period: 2004 and percent change from the previous year

Data Category	*[Note: "Percent change" is the change from previous year]*	Data/Information by State Region								Notes and Recommendations
		Region I		Region II		Region III		Total		
		Number	% Chng.	Number	% Chng.	Number	% Chng.	Number	% Chng.	
1. Enrollment										
Total number of participants		1,247	11.3%	898	8.3%	1,445	17.6%	3,590	13.1%	An unanticipated 1-1/2 month staff vacancy at the Region II office delayed the processing of waiver applications and home assessments for members of the waiting list. Having filled the vacant position in mid-December, the Region II manager expects to reduce the application backlog to normal before the start of the next year.
Number of new participants		316	3.7%	137	-5.6%	408	2.4%	861	1.6%	
Number of disenrollments		189	2.9%	68	6.7%	192	-1.3%	449	1.7%	
Due to death		48		12		31		91		
Nursing home entry		35		21		53		109		
Loss of eligibility		63		24		56		143		
Other reasons		43		11		52		106		
Number of applicants on waitlist		31	4.2%	47	14.6%	54	3.2%	132	7.5%	
Waitlist as percent of current enrollment		2.5%		5.2%		3.7%		3.7%		
2. Level of Care										
Number of new applications		529	2.8%	268	-3.4%	564	3.5%	1,361	1.9%	See note above on how Region II's backlog has been addressed. Region I has been showing great improvement for two consecutive years in reducing the number of days between initial application and the completion of a level of care authorization following their July 7th site visit to the Region I office to learn from their methods of organization and procedure.
Number of new applications denied		208	-5.7%	88	-7.2%	176	3.7%	472	-2.5%	
Initial Level of Care (LOC) authorizations		315	5.4%	135	-4.7%	392	4.2%	842	3.2%	
Average time from date of application to final LOC authorization (in days)		3	-1.2%	14	12.4%	4	-2.3%	5	7.7%	
Number of LOC authorizations due for annual re-evaluation during the year		952	1.8%	647	2.1%	822	3.7%	2,421	2.5%	
Percent of LOC annual re-evaluations completed on-time		98.5%		96.2%		99.2%		98.1%		

ALL REGIONS: HCBS Waiver Management Report by Region

Description: Tracks key management issues, including enrollment rates, recertification of waiver participants, program costs, appeals and complaints.

Data Source: Administrative data collected by the regional offices and system management database

Reporting Period: 2004 and percent change from the previous year

Data Category *[Note: "Percent change" is the change from previous year]*	Data/Information by State Region								Notes and Recommendations
	Region I		Region II		Region III		Total		
	Number	% Chng.	Number	% Chng.	Number	% Chng.	Number	% Chng.	
3. Plans of Care									
Number of initial Plan of Care (POC) approvals	320	4.7%	108	-3.6%	420	2.3%	848	2.5%	
Average time from date of initial LOC authorization to approved POC (in days)	22	-2.1%	19	-4.3%	14	-5.6%	18	-3.8%	
Number of POCs due for annual re-evaluation during the quarter	950	1.8%	653	2.1%	818	3.7%	2,421	2.5%	
Percent of POC annual re-evaluations completed on-time	96.6%		92.0%		99.4%		96.3%		
4. Cost per Member per Month									
Waiver cap per member per month†	$2,800		$2,800		$2,800		$2,800		The lower cost per member per month in Region II resulted primarily from a worker shortage and fewer hours of service available to members.
Average cost per member per month†	$2,183	-0.3%	$2,087	-0.1%	$2,291	0.7%	$2,202	0.2%	
Average cost as percent of cap	78.0%		74.5%		81.8%		78.7%		
5. Administrative Hearings									
Number of new LOC appeals filed	52	-7.1%	32	14.3%	32	-20.0%	116	-4.8%	Appeals are being upheld at a much higher rate in Region II than in the other two. The state office is performing a record review to determine if the successful appeals indicate a need for better training for the LOC assessment staff or for provider agency care managers.
Number of LOC appeals denied	36	28.6%	16	0.0%	24	-20.0%	76	7.2%	
Number of LOC appeals awaiting resolution at the end of the year	4	100.0%	1	-50.0%	2	0.0%	7	50.0%	
Number of new service denial appeals filed	44	-15.4%	16	-20.0%	28	0.0%	88	-11.3%	
Number of service appeals denied	32	-11.1%	12	0.0%	24	-20.0%	68	-12.3%	
Number of service denial appeals awaiting resolution at the end of the year	4	0.0%	1	-66.7%	2	0.0%	7	-9.5%	

† This hypothetical example assumes that the State of Franklin has opted to assign every elderly waiver participant the same individual monthly cap of $2,800 and that many participants do not come close to reaching it.

ALL REGIONS: HCBS Waiver Management Report by Region

Description: Tracks key management issues, including enrollment rates, recertification of waiver participants, program costs, appeals and complaints.

Data Source: Administrative data collected by the regional offices and system management database

Reporting Period: 2004 and percent change from the previous year

Data Category	*[Note: "Percent change" is the change from previous year]*	Data/Information by State Region								Notes and Recommendations
		Region I		Region II		Region III		Total		
		Number	% Chng.	Number	% Chng.	Number	% Chng.	Number	% Chng.	
6. Complaints										
Number of complaints received		261	4.0%	254	-6.5%	222	2.1%	737	-0.2%	
Most frequent complaints for the year										
Missing hours		72		55		63		190		
No help on weekends		29		15		22		66		
Agency changes my workers too often		35		34		27		96		
Family not notified of assessment date		15		13		21		49		
Agency won't let worker drive me		11		5		9		25		
Inconvenient hours - late meals		21		33		17		71		
No replacement for worker no-show		16		21		19		56		
Suspected theft / missing valuables		6		9		5		20		
Durable equipment not delivered		4		5		2		11		
Other complaints		52		64		37		153		

IV. Claims-Based Report

This report uses claims data to review health service use and outcomes of waiver participants. To conduct this analysis, states must have access to Medicaid claims data and, to the extent that waiver participants are dually eligible, Medicare claims data as well. This combined data set allows a state to capture diagnoses, emergency room visits, avoidable hospitalizations and other service use indicators. Findings can be used to think through how the waiver program may link with participants' health care providers to assure that they are receiving appropriate preventive and primary care.

Note that if your waiver is administered by an agency other than the state Medicaid agency, you may need to execute a formal data use agreement with the state Medicaid agency before you can obtain access to the Medicaid claims data. A typical data use agreement describes the data to be used, the approved purpose and uses for the data, and sets conditions for its use and for the protection of the confidentiality of individually identifiable medical information. If your waiver population includes persons who are dually eligible for Medicaid and Medicare, you will need to request a data use agreement from CMS to allow the use of Medicare claims records. The CMS website provides more information on Medicare data use agreements:
http://www.cms.hhs.gov/PrivProtectedData/TOR/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS040634

Claims-Based Reports at a Glance	
Purpose:	• To measure and trend health related outcomes of participants.
Audience:	• State program managers who can use the data to assess whether and how the waiver program can address health-related conditions • Provider agencies who may be unaware of the health-related conditions of participants
Sample content:	• Identification of standardized measures and findings • Explanatory text when numbers are too small to be significant • Interpretation of findings and what they mean for the waiver program
Level of specificity:	• For small waiver programs, statewide aggregate numbers • Larger waiver programs may have sufficient caseload to breakdown indicators by region.
Literacy:	• Intended for a professional audience
Frequency:	• Annual

Example:

The attached report contains quality indicators in common use within other health care settings, such as hospitals and managed care organizations, but have application to HCBS. Some of the most nationally recognized health measurement data sets include:

- AHRQ (Agency for Health Research and Quality): http://www.qualityindicators.ahrq.gov/
  The AHRQ quality indicators consist of three modules measuring various aspects of quality:
  - **Prevention QIs** identify hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care.
  - **Inpatient QIs** reflect quality of care inside hospitals including inpatient mortality for medical conditions and surgical procedures.

- **Patient Safety Indicators** also reflect quality of care inside hospitals, but focus on potentially avoidable complications and iatrogenic events.

- HEDIS (Health Plan Employer Data Information Set):
  http://www.health.state.mn.us/divs/hpsc/mcs/hedishome.htm
  Measures focus on quality of care, access to care and member satisfaction with the health plan and doctors.

IV. CLAIMS-BASED REPORT SAMPLE (Report 1 of 1)
Report Audience: State managers
Purpose: Use key measures to monitor quality of health care for waiver participants.

ALL REGIONS: HCBS Waiver Claims-Based Quality Indicators

Description: Tracks key claims-based indicators to ensure that participants are provided with appropriate health care services.
Data Source: Medicare and Medicaid claims data
Reporting Period: 2004

Data Category	Region I			Region II			Region III			Total		
	Den.	Num.	Percent‡	Den.	Number	Percent	Den.	Number	Percent	Den.	Number	Percent
Claims-Based Indicators												
Hospital Use												
Participants with at least one emergency room (ER) visit not resulting in a hospital stay	1,247	629	50%	898	502	56%	1,445	696	48%	3,590	1,827	51%
Average number of ER visits not resulting in a hospital stay among participants with at least one ER visit	401	2.4		299	2.5		497	2.2		1,197	2.3	
Avoidable hospitalizations (Including: asthma, pneumonia, kidney and urinary tract infections, severe nose and throat infections, gastroenteritis, congestive heart failure)†	1,247	200	16%	898	158	18%	1,445	195	13%	3,590	553	15%
Prevention and Screening												
Cervical cancer screening in last 2 years (percent of women ages 21-64)**	59	9	16%	42	5	12%	68	10	14%	169	24	14%
Breast cancer screening in the last year (percent of women age 52+)**	749	210	28%	539	129	24%	867	278	32%	2,155	617	29%
Diabetes - hemoglobin test in last year (percent of participants with diabetes)**	436	300	69%	314	189	60%	506	351	69%	1,257	840	67%
Use of Medications												
Use of medications that are potentially inappropriate for persons age 65+*	774	325	42%	557	212	38%	896	412	46%	2,227	949	43%
Use of psychotropic medications	1,247	734	59%	898	522	58%	1,445	799	55%	3,590	2,055	57%
Use of nine or more different medications	1,247	444	36%	898	343	38%	1,445	594	41%	3,590	1,381	38%
Use of fifteen or more different medications	1,247	95	8%	898	82	9%	1,445	114	8%	3,590	291	8%
Use of five or more prescribing physicians	1,247	87	7%	898	41	5%	1,445	98	7%	3,590	226	6%

† *AHRQ indicators: http://www.qualityindicators.ahrq.gov/downloads/pqi_guide_v30.doc*

‡ *Percent of total number of participants in region unless specified otherwise*

* *Fick, Donna M, et.al.,"Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults,". Archives of Internal Medicine, 12/8/2003*

** *HEDIS measures*

V. Provider-Specific Reports

This is a series of four reports showing how one data source can be used to satisfy multiple monitoring needs. A preliminary report presents an overview of the caseload and characteristics of each provider agency participating in a waiver program. Data presented in remaining reports are presumed to come from participant assessment records. Aggregate reports allow state managers to compare the performance of provider agencies or other sub-state entities against each other and against state averages to identify high and poor performing entities. Data on individual provider agencies (or sub-state entities) can be used by state managers and providers to identify specific areas where performance varies from statewide averages. At the person-level, reports can focus on specific participants where need for more intensive care management or support may be needed.

Provider Specific Reports at a Glance	
Purpose(s):	• To assess performance of service agencies against program goals and objectives. • To identify providers, participants and/or target areas (such as falls and depression) where closer monitoring and attention may be needed.
Audience:	• State-level program managers • State quality reviewers • Service agency managers • Care coordinators; frontline staff
Sample content:	• Performance scores on select quality indicators by service agencies. • Graphics comparing one service agency's performance to state and/or regional benchmarks. • Identification of service agencies with good and poor performance scores. • Identification of target areas, such as falls or depression, where further improvement and remediation are needed. • Identification of participants within an agency who are flagging on key indicators and displaying the most cause for concern.
Level of specificity:	• ***State-level managers*** require performance information on all service agencies on a small set of key indicators that reflect the most critical aspects of home and community-based services and allow for comparisons across agencies. • ***State quality reviewers*** require an additional layer of detail to target reviews to particular problem areas within an agency (*e.g.,* prevalence of inadequate meals) and/or consumers who are displaying a cause for concern (*e.g.,* prevalence of social isolation). • ***Service agency managers*** are interested in a comprehensive breakdown of agency performance on a number of quality indicators representing the full scope of home and community-based services. Comparisons to a peer group or statewide average are helpful in identifying specific issues for improvement and remediation.

Provider Specific Reports at a Glance (cont'd)	
Level of specificity (cont'd):	• ***Care coordinators*** need information on client characteristics and risk factors, as well as guidance in developing a plan of care that addresses these issues.
Literacy:	• Limited jargon acceptable for sake of brevity
Frequency:	• Produced routinely. • Exact frequency will depend on data source; *e.g.,* survey-based quality measures are generally reported annually, while measures based on operations data, such as claims, assessments, incidents, etc., are likely to be available on a more regular basis.

Examples:

The following reports are a composite of forms and formats used by different states in HCBS and other settings of care. They are meant to be read sequentially with each subsequent report "drilling down" on the details of the former report. The data used in these reports are less significant than is the method of taking a single source of information and viewing it from multiple perspectives or units of analysis. Reports included in this package are:

1. ***HCBS Waiver Participant Demographics and Characteristics***: displays basic demographic data and other characteristics of the provider agency's waiver participants.
2. ***HCBS Waiver Participant Assessment-Based Indicators – All Agencies***: compares agency-specific quality indicators across all provider agencies and to the state average.
3. ***HCBS Waiver Participant Assessment-Based Indicators – Single Agency***: compares a provider agency's quality indicators to the statewide average for all assessment-based measures.
4. ***HCBS Waiver Participant Assessment-Based Indicators – Individual Participant***: lists out all participants within a provider agency and identifies which participants are triggering certain quality flags.

V. PROVIDER-SPECIFIC REPORTS SAMPLE (Report 1 of 4)
Report Audience: Program managers and provider agencies
Purpose: Summarize an agency's waiver participants and provide a context for evaluating other measures.

SINGLE AGENCY: HCBS Waiver Participant Demographics and Characteristics

Description: Displays basic demographic data and other characteristics of the provider agency's waiver participants.
Data Source: Each member's most recently completed assessment as of the closing date of the year
Reporting Period: Calendar Year 2004

Agency: **Acme Home Care Services, Inc.** **County:** Farmingdale **Town:** New Bryher

	Agency		State Average	
	Number	Percent	Number	Percent
Number of participants	**125**	**100%**	**1,348**	**100%**
Gender				
Male	43	34%	431	32%
Female	82	66%	917	68%
Average Age (in years)	81		79	
Top Diagnoses†				
Hypertension	81	65%	849	63%
Arthritis	79	63%	741	55%
Depression	55	44%	580	43%
Diabetes	53	42%	472	35%
Cerebrovascular accident	40	32%	445	33%
Any dementia	45	36%	404	30%
Congestive heart failure	35	28%	337	25%
Anxiety disorder	34	27%	283	21%
Behavior Symptoms† (exhibited in last 7 days before assessment)				
Wandering	11	9%	94	7%
Verbally Abusive	8	6%	81	6%
Physically Abusive	4	3%	27	2%
Socially Inappropriate Behavior	4	3%	54	4%
Resists Care	14	11%	121	9%
Intimidating Behavior	5	4%	67	5%
Mean Number of Medications	11.5		10.0	
Activities of Daily Living† **(ADL)** (Number of persons requiring hands-on assistance with the ADL)				
Bed Mobility	98	78%	1,119	83%
Transfer	116	93%	1,308	97%
Locomotion	105	84%	1,186	88%
Dressing	119	95%	1,321	98%
Eating	26	21%	297	22%
Toileting	116	93%	1,281	95%
Bathing	119	95%	1,321	98%

† Participants who have more than one diagnosis, behavioral symptom or ADL appear multiple times in the same table.

V. PROVIDER-SPECIFIC REPORTS SAMPLE (Report 2 of 4)
Report Audience: State-level program managers
Purpose: Compare participant risk factors across all agencies.

ALL AGENCIES: HCBS Waiver Participant Assessment-Based Indicators

Description: Agency-specific QI scores compared to the state average.
Data Source: Most recent participant assessments performed during the reporting period (and the prior assessment for some measures)
Reporting Period: Fourth quarter 2004 (9/1 to 12/31)

Prevalence of inadequate meals

Description: Measures the number and percentage of persons who ate one or less meals per day over the last three days

Lower percentages indicate better outcomes ←

Home Care Agency		Den.	Nom.	Pct.	Percent
State Average		**3,510**	**401**	**11%**	
Acme Home Care Services, Inc.	⚑	352	60	17%	
Apple Valley Home Care	☆	179	11	6%	
Columbia HomeServ		566	50	9%	
Community Home Care, Inc.	⚑	484	86	18%	
ELDOR, Inc.	☆	56	4	7%	
Excel Elder Services	☆	489	13	3%	
Happy Family Home-Aid		225	24	10%	
Helping Hands at Home		148	18	12%	
Home Care Agency of Jackson		562	64	11%	
In-Your-Home, Inc.	⚑	116	32	28%	
UniTrust Help-at-Home		183	15	8%	
Visiting Home Aides of Durham		150	25	16%	

Prevalence of weight loss

Description: Measures the number and percentage of persons who have had an unintended weight loss of 5%-or-more in the last 30 days, or 10%-or-more in the last 180 days.

Lower percentages indicate better outcomes ←

Home Care Agency		Den.	Nom.	Pct.	Percent
State Average		**2,994**	**563**	**19%**	
Acme Home Care Services, Inc.	⚑	301	87	29%	
Apple Valley Home Care	⚑	151	34	22%	
Columbia HomeServ		483	82	17%	
Community Home Care, Inc.	☆	417	42	10%	
ELDOR, Inc.		48	9	18%	
Excel Elder Services		423	93	22%	
Happy Family Home-Aid	⚑	190	65	34%	
Helping Hands at Home		125	22	18%	
Home Care Agency of Jackson	☆	469	71	15%	
In-Your-Home, Inc.	☆	98	7	7%	
UniTrust Help-at-Home		158	25	16%	
Visiting Home Aides of Durham		130	28	22%	

Legend

☆	Indicates provider agency scores that were in the **best** quintile (lowest 1/5th) of all agencies.
⚑	Indicates provider agency scores that were in the **worst** quintile (highest 1/5th) of all agencies.

V. PROVIDER-SPECIFIC REPORTS SAMPLE (Report 3 of 4)
Report Audience: Provider agency managers and state quality reviewers
Purpose: Compare participant risk factors for one agency to the statewide average.

SINGLE AGENCY: HCBS Waiver Participant Assessment-Based Indicators†

Description: An individual home care agency's indicators compared to the state average for all participant assessment-based measures.
Data Source: Most recent consumer assessments performed during the reporting period (and the prior assessment for some measures)
Reporting Period: Fourth quarter 2004 (9/1 to 12/31)

Agency: **Acme Home Care Services, Inc.** **County:** Farmingdale **Town:** New Bryher

Quality Indicator		Den.	Num	Pct.
Lower percentages indicate better outcomes ←				
Prevalence of inadequate meals	Agency	352	60	17%
	St. Avg.	3,510	389	11%
Prevalence of weight loss	Agency	301	87	29%
	St. Avg.	2,994	574	19%
Prevalence of dehydration	Agency	351	5	1%
	St. Avg.	3,409	122	4%
Prevalence of not receiving a medication review by a physician	Agency	355	3	1%
	St. Avg.	3,412	224	7%
Failure to improve/ Incidence of bladder continence	Agency	136	43	32%
	St. Avg.	3,413	538	16%
Failure to improve/ Incidence of skin ulcers	Agency	65	7	11%
	St. Avg.	3,420	192	6%
Prevalence of no assistive devices among clients with difficulties in locomotion	Agency	122	47	39%
	St. Avg.	945	129	14%
Prevalence of ADL rehab potential and no therapies	Agency	122	34	28%
	St. Avg.	2,987	1,002	34%
Failure to improve/ Incidence of decline on ADL long form	Agency	129	39	30%
	St. Avg.	3,411	1,920	56%
Failure to improve/Incidence of impaired locomotion in the home	Agency	98	35	36%
	St. Avg.	957	389	41%
Prevalence of falls	Agency	351	12	3%
	St. Avg.	3,419	254	7%

Quality Indicator		Den.	Num	Pct.
Lower percentages indicate better outcomes ←				
Prevalence of social isolation	Agency	351	147	42%
	St. Avg.	3,416	982	29%
Incidence of cognitive decline	Agency	354	45	13%
	St. Avg.	3,411	647	19%
Prevalence of delirium	Agency	351	17	5%
	St. Avg.	3,409	124	4%
Prevalence of negative mood	Agency	354	83	23%
	St. Avg.	3,417	1,587	46%
Failure to improve/Incidence of difficulty in communication	Agency	37	22	59%
	St. Avg.	457	294	64%
Prevalence of disruptive or intense daily pain	Agency	352	9	3%
	St. Avg.	3,416	142	4%
Prevalence of inadequate pain control among those with pain	Agency	142	87	61%
	St. Avg.	3,408	1,007	30%
Prevalence of neglect/abuse	Agency	355	4	1%
	St. Avg.	3,411	99	3%
Prevalence of any injuries	Agency	354	13	4%
	St. Avg.	3,420	45	1%
Prevalence of not receiving influenza vaccination	Agency	351	95	27%
	St. Avg.	3,414	1,149	34%
Prevalence of hospitalization	Agency	353	4	1%
	St. Avg.	3,420	129	4%

Legend

- ☆ Indicates agency scores that were in the **best** quintile (lowest 1/5th) of all agencies.
- ⚑ Indicates agency scores that were in the **worst** quintile (highest 1/5th) of all agencies.
- Single agency percentage.
- Average percentage for all home care agencies across the state.

† All indicators are from the InterRAI Home Care Quality Indicators for MDS-HC Version 2.0 See: http://www.interrai.org/section/view/?fnode=15

V. PROVIDER-SPECIFIC REPORTS SAMPLE (Report 4 of 4)
Report Audience: Care coordinators and state quality reviewers
Purpose for Agencies: Identify which participants are triggering certain quality flags so that they may be more closely monitored for improved care.
Purpose for State Quality Reviewers: Improve home care reviews and inspections by being able to focus on those participants who are displaying the most cause for concern.

SINGLE AGENCY: HCBS Waiver Participant Assessment-Based Indicators by Individual Participant

Description: A single agency's participants are listed by name, and checkmarks indicate areas of potential concern for each participant.
Data Source: Most recent participant assessments performed during the reporting period (and the prior assessment for some measures)
Reporting Period: Fourth quarter 2004 (9/1 to 12/31)

Facility: **Acme Home Care Services, Inc.** **County:** Farmingdale **Town:** New Bryher

				Assessment Variable																					
Participant's Name	**Enrollment Date**	**Level of Care**	**Age**	Weight loss	Dehydration	No medication review by a physician	Failure to improve/ Incidence of bladder incontinence	Failure to improve/ Incidence of skin ulcers	No assistive device among clients with difficulty in locomotion	ADL/ rehab potential and no therapies	Failure to improve/ Incidence of decline on ADL long form	Failure to improve/Incidence of impaired locomotion in the home	Falls	Social isolation	Cognitive decline	Delirium	Negative mood	Failure to improve/Incidence of difficulty in communication	Disruptive or intense daily pain	Inadequate pain control among those with pain	Neglect/abuse	Any injury	Failure to receive influenza vaccination	Hospitalization	**Individual's total num. of flags**
Adams, Abigail	4/21/2005	NF	100										v	v			v								3
Franklin, Benjamin	6/16/2005	NF	55	v				v				v	v		v					v					6
Harrison, William H.	7/5/2005	NF	70																				v	v	2
Jefferson, Thomas	4/27/2005	NF	65				v								v										2
Ross, Betsy	5/23/2005	NF	56						v				v							v					3
Washington, Martha	5/16/2005	NF	96												v										1
Total # of participants with quality flag				1	0	0	1	1	1	0	0	1	3	1	3	0	1	0	0	2	0	0	1	1	17

VI. Critical Incident Reports

Critical incident reports track the prevalence and patterns of serious adverse events in the program population and inform strategies for risk management, error prevention and focused quality improvement projects. Incident data is aggregated and can be sliced in a number of different ways to show incidents by region, incidents by county or service agency and/or incidents by category. Incident reports may be generated on a regular or ad-hoc basis depending on whether they are produced as part of a routine management report or created in response to a specific probing question.

Critical Incident Reports at a Glance	
Purpose(s):	• To track the prevalence and patterns of serious adverse events in the program population. • To identify problems and inform strategies for risk reduction, error prevention and focused quality improvement projects.
Audience:	• Legislators • Committee, council and board members • State-level program managers • Service agencies/provider organizations • Care coordinators; frontline staff
Sample content:	• Frequency of critical incidents in the state by incident type. • Frequency of critical incidents within specific service agency by incident type. • Identification of agencies with particularly high or low rates of reported incidents. • Tabular or graphic presentation of trends over time by state and/or agency.
Level of specificity:	• ***State-level managers*** are interested in a breakdown of critical incidents by region and/or service agency, geographic and service specific trends and some indication of whether mandated reporters understand how and when to file an incident report. • ***State agencies and care coordinators*** will be interested in any program alerts or guidance issued by the state. Additionally, they will want to generate agency specific incident reports and review reports on repeat incidents, i.e. incidents involving the same consumer and/or provider or types of incidents occurring repeatedly.
Literacy:	• Limited jargon acceptable for sake of brevity
Frequency:	• Routine management level reports • Ad-hoc reports on specific problem areas or areas of interest

State Examples:

The *Ohio Department of Mental Retardation and Developmental Disabilities* has an internet-based centralized reporting system to report and track major and unusual incidents. Major and unusual incident reports on topics such as total incidents, total deaths, reporting rates and individuals with more than five incidents can be viewed at http://www.hcbs.org/moreInfo.php/nb/doc/1471.

North Carolina's Division of Mental Health, Developmental Disabilities and Substance Abuse Services prepares detailed quarterly management-level reports on critical incidents. A number of these reports are available on the Division's webpage: http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm.

Other Examples:

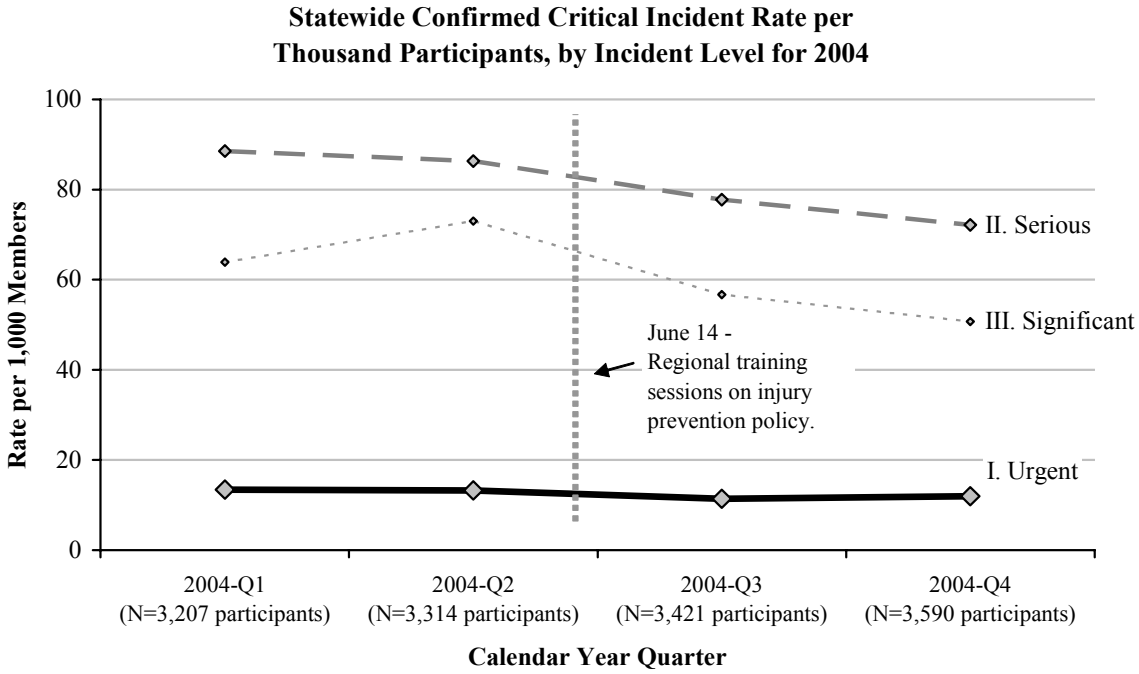
The following are a composite of forms and formats used by different states in HCBS and other settings of care as they report on critical incidents. These reports are meant to be read sequentially with each subsequent report "drilling down" on details of previous reports. Reports in this package include:

1. ***HCBS Waiver Quarterly Confirmed Incident Rates per 1,000***: presents statewide HCBS waiver-related critical incident rates over time.
2. ***HCBS Waiver Annual Confirmed Critical Incidents by Type***: provides an annual summary of the number and types of critical incidents in the program population.
3. ***HCBS Waiver Suspicious Deaths Among Participants***: drills down to the types and causes of all suspicious deaths occurring within a given year.
4. ***HCBS Waiver Alleged and Confirmed Critical Incidents by Agency***: summarizes the number and level of critical incidents by provider agency for one year.
5. ***HCBS Waiver Confirmed Critical Incidents by Participant***: identifies, within a single provider agency, which participants were involved in one or more confirmed incidents during the year.

VI. CRITICAL INCIDENT REPORTS SAMPLE (Report 1 of 5)
Report Audience: State program managers
Purpose: Identify trends in confirmed critical incident rates and assess changes in response to a targeted intervention.

STATE TRENDS: HCBS Waiver Quarterly Confirmed Critical Incident Rates per 1,000

Description: Displays the statewide HCBS waiver-related critical incidents rates as reported to DMS and confirmed by the DMS Quality Review Board.
Data Source: Confirmed critical incident reports
Reporting Period: 2004



Number of Participants	**3,207**	**3,314**	**3,421**	**3,590**

Statewide Confirmed Critical Incident Rate per 1,000 Participants by Incident Level	**2004-Q1**	**2004-Q2**	**2004-Q3**	**2004-Q4**
Level I – Urgent	13	13	11	12
Level II – Serious	89	86	78	72
Level III – Significant	64	73	57	51

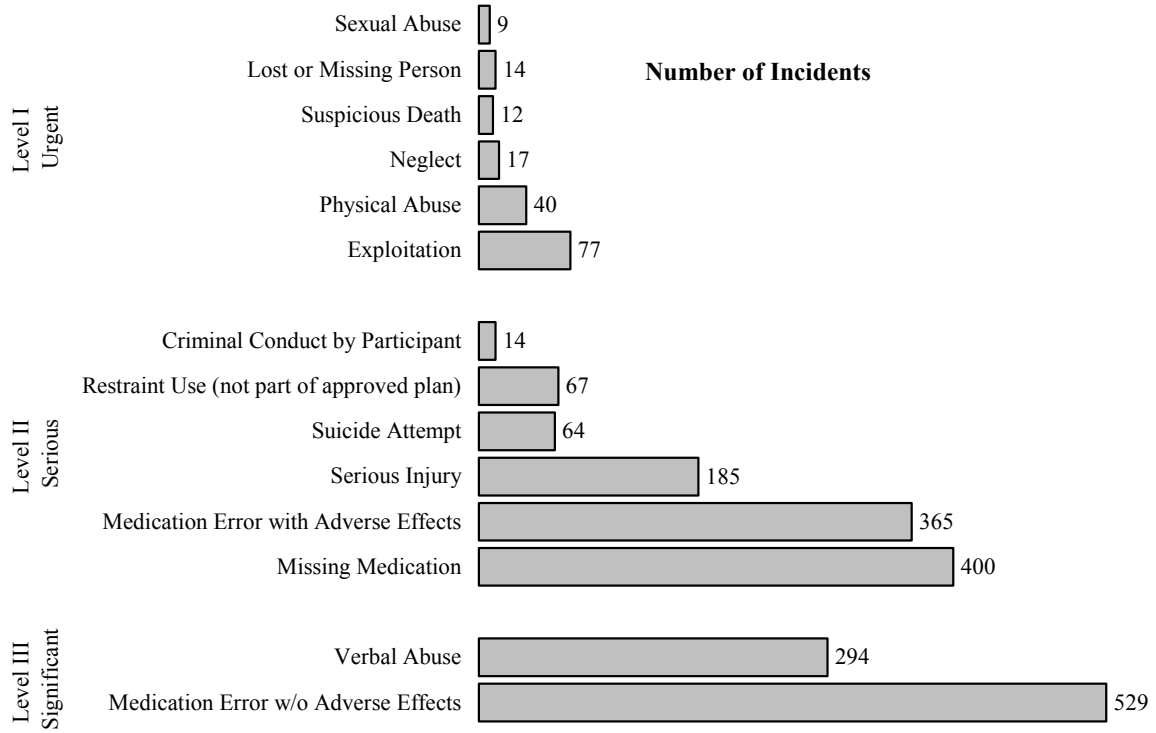
Note: The incident chart counts the number of distinct incidents occurring in each quarter. If one person suffered serious injuries on two different dates within the same quarter, then those injuries would have been counted as two separate serious injury incidents.

VI. CRITICAL INCIDENT REPORTS SAMPLE (Report 2 of 5)
Report Audience: State program managers
Purpose: Provide an annual summary of the number and patterns of critical incidents in the program population.

STATE TOTALS: HCBS Waiver Annual Confirmed Critical Incidents by Type

Description: Displays the statewide number of HCBS waiver-related critical incidents reported to DMS and confirmed by the DMS Quality Review Board.
Data Source: Confirmed critical incident reports
Reporting Period: 2004

Statewide Count of Confirmed Critical Incidents for 2004
(Unduplicated count of participants: 3,842)



Confirmed Incident Level	Number of incidents	Unduplicated number of participants involved
Level I: Urgent	169	133
Level II: Serious	1,095	752
Level III: Significant	823	711
Total	**2,087**	**1,404**

Note: The incident table counts the number of distinct incidents occurring throughout the year. If one person suffered serious injuries on two different dates, then those injuries would have been counted as two separate serious injury incidents.

VI. CRITICAL INCIDENT REPORTS SAMPLE (Report 3 of 5)
Report Audience: State program managers
Purpose: Track suspicious deaths by type.

STATE TOTALS: HCBS Waiver Suspicious Deaths Among Participants

Description: Drills down to types and causes of suspicious deaths.
Data Source: Confirmed critical incident reports
Reporting Period: 2004

Data Category	Number	Percent of all suspicious deaths	Status of Investigation and Follow-Up
Suspicious Deaths			
Due to accident or injury	5	42%	
Due to homicide	0	0%	
Due to suicide	2	17%	
With multiple pressure ulcers	1	8%	
With no physician in attendance†	1	8%	
Due to malnutrition or dehydration in the absence of either cancer or an advanced directive for palliative care	0	0%	
Due to other suspicious causes	3	25%	
Total number of suspicious deaths	**12**	**100%**	
Total number of participants	**3,590**		
Total suspicious deaths as a percent of all participants	**0.3%**		

† *Under state law, "no physician in attendance" means the decedent had not been seen by a physician within the 15 days prior to the date of death.*

VI. CRITICAL INCIDENT REPORTS SAMPLE (Report 4 of 5)
Report Audience: State program managers
Purpose: Summarize the number and level of critical incidents by agency for one year.

ALL AGENCIES: HCBS Waiver Alleged and Confirmed Critical Incidents by Agency

Description: Displays the number of HCBS waiver-related critical incidents, by home care agency, reported to DMS and confirmed by the DMS Quality Review Board.
Data Source: Confirmed critical incident reports
Reporting Period: 2004

Home Care Agency	Participants Served	Level I: Urgent		Level II: Serious		Level III: Significant	
		Alleged	Confirmed	Alleged	Confirmed	Alleged	Confirmed
Acme Home Care Services, Inc.	360	28	19	188	99	92	62
Apple Valley Home Care	180	9	8	56	50	56	44
Columbia HomeServ	593	33	30	219	181	147	136
Community Home Care, Inc.	490	45	18	187	163	103	97
ELDOR, Inc.	58	‡	0	‡	0	10	10
Excel Elder Services	498	53	40	245	187	199	150
Happy Family Home-Aid	226	‡	0	89	69	62	57
Helping Hands at Home	154	20	14	45	25	39	30
Home Care Agency of Jackson	564	28	19	203	185	157	135
In-Your-Home, Inc.	120	16	11	41	33	22	21
UniTrust Help-at-Home	191	22	10	62	58	66	42
Visiting Home Aides of Durham	156	‡	0	49	45	45	39
State Total	**3,590**	**254**	**169**	**1,384**	**1,095**	**998**	**823**

Legend

‡ No reports received

Incident Levels

Level I - Urgent
Suspicious Death
Physical Abuse
Sexual Abuse
Exploitation
Neglect
Lost or Missing Person

Level II - Serious
Serious Injury
Restraint Use (not part of approved plan)
Suicide Attempt
Medication Error with Adverse Effects
Missing Medication
Criminal Conduct by Participant

Level III - Significant
Medication Error without Adverse Effects
Verbal Abuse

VI. CRITICAL INCIDENT REPORTS SAMPLE (Report 5 of 5)
Report Audience: Provider agency managers and state reviewers
Purpose: Within an agency, identify which participants were involved in confirmed incidents during the year.

SINGLE AGENCY: HCBS Waiver Confirmed Critical Incidents, by Participant *(sample page from longer report)*

Description: Lists critical incidents confirmed by DMS Quality Review Board for a single agency by participant.
Data Source: Confirmed critical incident reports
Reporting Period: 2004

Agency: **Acme Home Care Services, Inc.** **County:** Farmingdale **Town:** New Bryher

Participant Name	Level	Type	Reported by	Date Reported	Review Date	Special Circumstances	Action
Ross, Betsy	I – Urgent	Neglect	Family member	11/13/2003	1/7/2004		Employee terminated; Provider audit
	II – Serious	Med. Error	Family member	11/16/2004	12/29/2004	Third incident of this type in past 12 months	Remediation plan approved
Washington, Martha	II - Serious	Suicide Attempt	Police	03/13/2004	4/4/2004		
	III - Serious	Med. Error w/o Adverse Effects	Worker	08/20/2004	10/19/2004		Remediation plan approved
Webster, Daniel	II - Serious	Serious Injury	Worker	01/08/2004	3/2/2004	Injury resulted in hospitalization	Root cause analysis/case review
	III - Significant	Verbal Abuse	Worker	12/10/2003	1/7/2004		Referral to adult protective services
Adams, Abigail	II - Serious	Missing Medication	Family Member	09/02/2004	9/25/2004	Criminal conduct suspected	Police contacted
Franklin, Benjamin	III - Significant	Med. Error w/o Adverse Effects	Participant	10/07/2004	10/21/2004	Repeat incident by same employee	Employee terminated

Total Confirmed Incidents for the Year	
Level I - Urgent	19
Level II - Serious	99
Level III - Significant	62
Total Incidents	**180**

VII. Consumer Survey Reports

A consumer survey report presents the results of participant survey and provides important information about the degree to which services meet participants' requirements and expectations. Typically, indicators representing key quality domains, such as access, choice and safety, are calculated from survey data. Survey-based quality indicators are used to identify areas where program participants are experiencing unmet needs and/or other quality problems.

Consumer Survey Reports at a Glance	
Purpose:	• To assess the performance of the program on features of particular interest to participants.
Audience:	• Legislators • Committee, council and board members • State-level program managers • Service agencies/provider organizations • Consumer advocacy groups • Program participants and family members
Sample content:	• Discussion of survey methodology • Participant experience indicators in focal areas such as: access; choice and control; respect; community inclusion; staff competence; health, welfare and rights; etc. • Comparison of consumer responses by service agency (*e.g.,* consumer report card) • Comparison of agency or state responses to state and/or national benchmarks • Trends over time • Recommendations for quality improvement
Level of specificity:	• ***State-level program managers and provider agencies*** will be interested in survey-results across all quality domains and indicators and may want to break-out results by region and/or by agency. • ***Program participants and family members*** may be more interested in comparing participant responses across service agencies on a small number of key indicators, such as health promotion, community involvement and respectful staff.
Literacy:	• Fifth grade literacy • No jargon
Frequency:	• Annual

State Examples:

Georgia's 2005 Child and Adolescent Mental Health Family Survey measures the degree to which Georgia's Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) engages families in the planning, delivery and evaluation of the service delivery system. Families are asked questions in the following five domains: access; cultural sensitivity; family participation; overall satisfaction and outcomes. This report summarizes fiscal year 2005 survey results and compares those

findings to state data from previous years as well as the most recent national benchmarks. For more information, visit http://www.survey.uga.edu/permes/dhrreportsindex.cfm.

Results of Maine's Experience Survey: Adults with Physical Disabilities Consumer-Directed Waiver – A Statewide Summary. This report presents the results of an in-person survey of adults on Maine's consumer directed physically disabled waiver. For more information, visit: http://www.hcbs.org/moreInfo.php/state/159/sby/Date/doc/1463/Results_of_the_Maine_Experience_Survey_Adults_with.

North Carolina Consumer Satisfaction Survey Report – Statewide Summary and Information on Local Programs displays information from a Consumer Satisfaction Survey of the state's mental health, developmental disabilities and substance abuse services programs. The report is organized around six general areas of consumer satisfaction: overall satisfaction, access to services, participation in treatment, cultural sensitivity of staff, appropriateness of services and self-assessed outcomes. For each area, the report provides information on state levels of consumer satisfaction, as well as satisfaction levels for particular local programs. For more information, visit http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm.

Independent Monitoring for Quality – a Statewide Summary presents a statewide overview of information collected from fact-to-face interviews with 5,298 individuals receiving supports though Pennsylvania's Office of Mental Retardation. For more information, visit http://www.openminds.com/indres/padata.pdf.

The Core Report: Factors Influencing Access to Health Care uses consumer survey data collected as part of the National Core Indicators project (www.hsri.org/nci) to investigate variables that may affect access to health care. Factors such as race, access to transportation, presence of a mental health diagnosis and type of living arrangement are explored. The analysis also compares findings from the National Core Indicators to national norms. For more information, visit http://www.hsri.org/docs/786_Core_Report_4.1_Health_Access.pdf.

Other Examples:

Two additional examples provide a one page snapshot of statewide and regional survey results:

1. ***HCBS Waiver Survey-Based QI Results Compared to National Averages***: presents state and national QI scores from annual participant and family surveys.
2. ***HCBS Waiver Survey-Based Quality Indicator Scores by Region***: compares specific survey-based measures by region.

VII. CONSUMER SURVEY REPORTS SAMPLE (Report 1 of 2)
Report Audience: State waiver program managers, legislators, program participants, others
Purpose: Assess waiver program quality from participants' and families' perspective and target issues and services for remediation and improvement.

STATEWIDE: HCBS Waiver Survey-Based QI Results Compared to National Averages

Description: Statewide and national QI scores from the annual National Core Indicators survey.
Data Source: Consumer and family versions of the Core Indicators survey conducted with a random sample of HCBS MR/DD waiver participants and families and compared to the 2003-2004 national results published by the Core Indicators Project at: http://www.hsri.org/nci
Reporting Period: Surveys conducted between November 10 and December 18, 2004

Number of MR/DD waiver participants and number of surveys completed

Number of…	State
Waiver participants	3,590
Participant surveys completed	402
Family surveys completed	326

Quality Domain: Participant-centered service planning and delivery

Higher percentages indicate better outcomes →

Indicator		Den.†	Num.	Percent
The proportion of people reporting that service coordinators help them get what they need.	State	394	280	71%
	National	5,409	4,165	77%
The proportion of people who report that their service coordinators asked about their preferences.	State	397	317	80%
	National	5,241	3,606	69%
The proportion of people who know their service coordinators.	State	400	374	94%
	National	5,694	4,709	83%
The proportion of families who report they have the information needed to skillfully plan for their services and supports.	State	322	139	43%
	National	4,416	2,292	52%
The proportion of families reporting that their support plan includes or reflects things that are important to them.	State	301	247	82%
	National	3,950	2,915	74%

† The denominator varies for each question because some interview subjects did not answer every question

VII. CONSUMER SURVEY REPORTS SAMPLE (Report 2 of 2)
Report Audience: State-level program managers
Purpose: Compare specific survey-based quality measures by region.

ALL REGIONS: HCBS Waiver Survey-Based Quality Indicator Scores by Region

Description: Region-specific QI scores compared to the state average.

Data Source: Consumer and family versions of the Core Indicators survey conducted with a stratified† random sample of HCBSMR/DD waiver participants and families in each region‡

Reporting Period: Surveys conducted between November 10 and December 18, 2004

Number of MR/DD waiver participants and number of surveys completed

Number of…	State
Waiver participants	3,590
Participant surveys completed	402
Family surveys completed	326

Quality Domain: Participant-centered service planning and delivery

The proportion of people reporting that service coordinators help them get what they need.

Higher percentages indicate better outcomes →

State Regions	Den.	Num.	Percent
State Average	**394**	**280**	**71%**
Region 1	131	89	68%
Region 2	128	107	84%
Region 3	135	84	62%

The proportion of people who report that their service coordinators asked about their preferences.

Higher percentages indicate better outcomes →

State Regions	Den.	Num.	Percent
State Average	**397**	**317**	**80%**
Region 1	130	91	70%
Region 2	134	124	93%
Region 3	133	102	77%

The proportion of people who know their service coordinators.

Higher percentages indicate better outcomes →

State Regions	Den.	Num.	Percent
State Average	**400**	**374**	**94%**
Region 1	133	130	98%
Region 2	131	126	96%
Region 3	136	118	87%

The proportion of families who report they have the information needed to skillfully plan for their services and supports.

Higher percentages indicate better outcomes →

State Regions	Den.	Num.	Percent
State Average	**322**	**139**	**43%**
Region 1	118	66	56%
Region 2	106	35	33%
Region 3	98	38	39%

† To enable a better comparison between state regions, all waiver participants were first divided into groups by state region. Then, random sampling was used to select 140 partipants from each region. Statewide averages were computed as weighted averages.

‡ The closest relative or legal guardian was interviewed when a participant was unable to participate due to disability.

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