NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Payment Advisory Group – Services for the Intellectually/Developmentally Disabled

I/DD VBP Advisory Group Meeting 2

Meeting Date: March 23, 2016 – 10a – 1pm

March 2016

Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

Meeting 1

- VBP Advisory Group Overview
- Role of VBP in Achieving Quality, Cost Effective Care
- I/DD Services in Transition
- System Platforms - High value care in a I/DD context

Meeting 2

- Review themes from first meeting
- Introducing new themes
- Exercise: Reflections on Value
- Special considerations for measuring quality
- Previewing Quality Measures

Meeting #2 Agenda

- Part I
  - A. Review Transformation Panel – platforms for change
  - B. VBP goals and timelines
  - C. Review total cost of care subpopulation arrangement
- Part II
  - Big picture evolution – important NEW themes
- Part III
  - Pinning down the value proposition – what is our value? Group exercise.
- Part IV
  - What do we need to consider generally when designing VBP arrangements, and with special populations?
- Part V
  - Where do we start? Reviewing some frameworks. Food for thought.

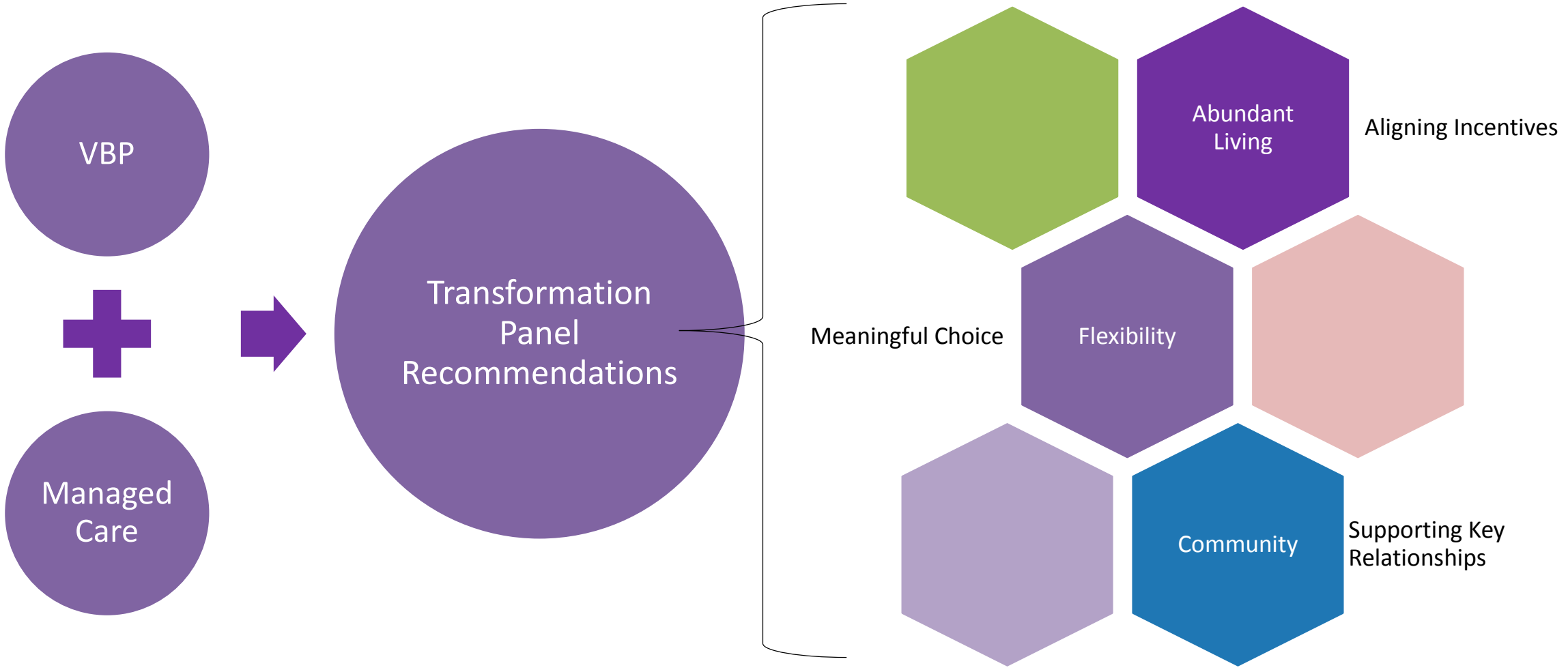
Part I

A. Review Transformation Panel – platforms for change

I/DD Services in Transition - The Transformation Agenda

- *"Changing complex systems is never easy or fast, but in Managed Care and Value Based Payments we have models based on the simple idea that rewarding good outcomes and containing costs in a measurably effective system works for all: it makes sense for each individual and for everyone who depends on the system of care, now and for years to come." (Draft Recommendations, p. 5)*

Transformation Agenda: Platforms for Change



Part I

B. VBP Goals and Timelines

A Value Based Payment Platform

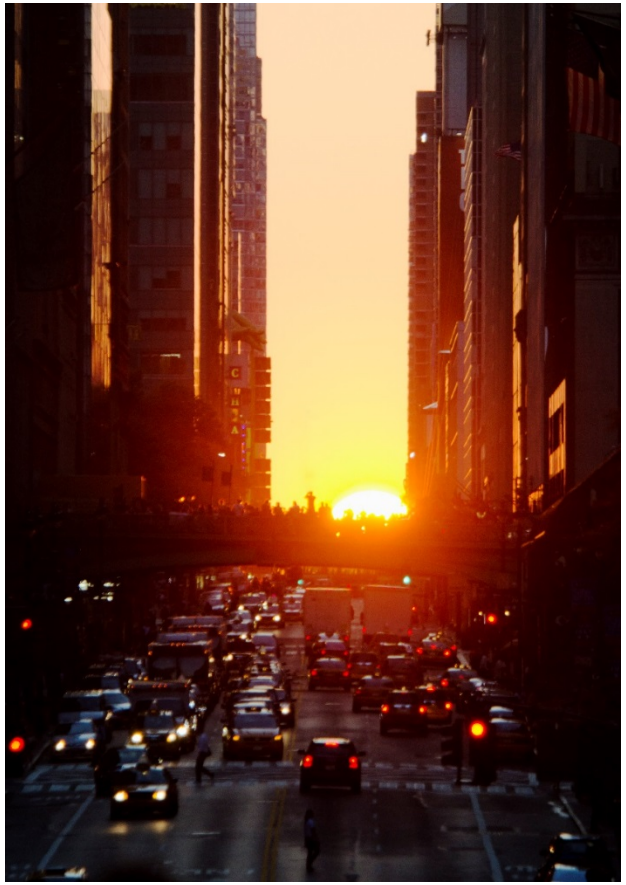
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- $6.4 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)
- Value Based Payment
  - Fundamental transformation of the Medicaid payment system, shifting away from volume and rewarding value
  - Development of Advisory Groups (I/DD)
  - Development of VBP arrangements (Episodic, chronic, subpopulations

NYS OPWDD Transformation Panel

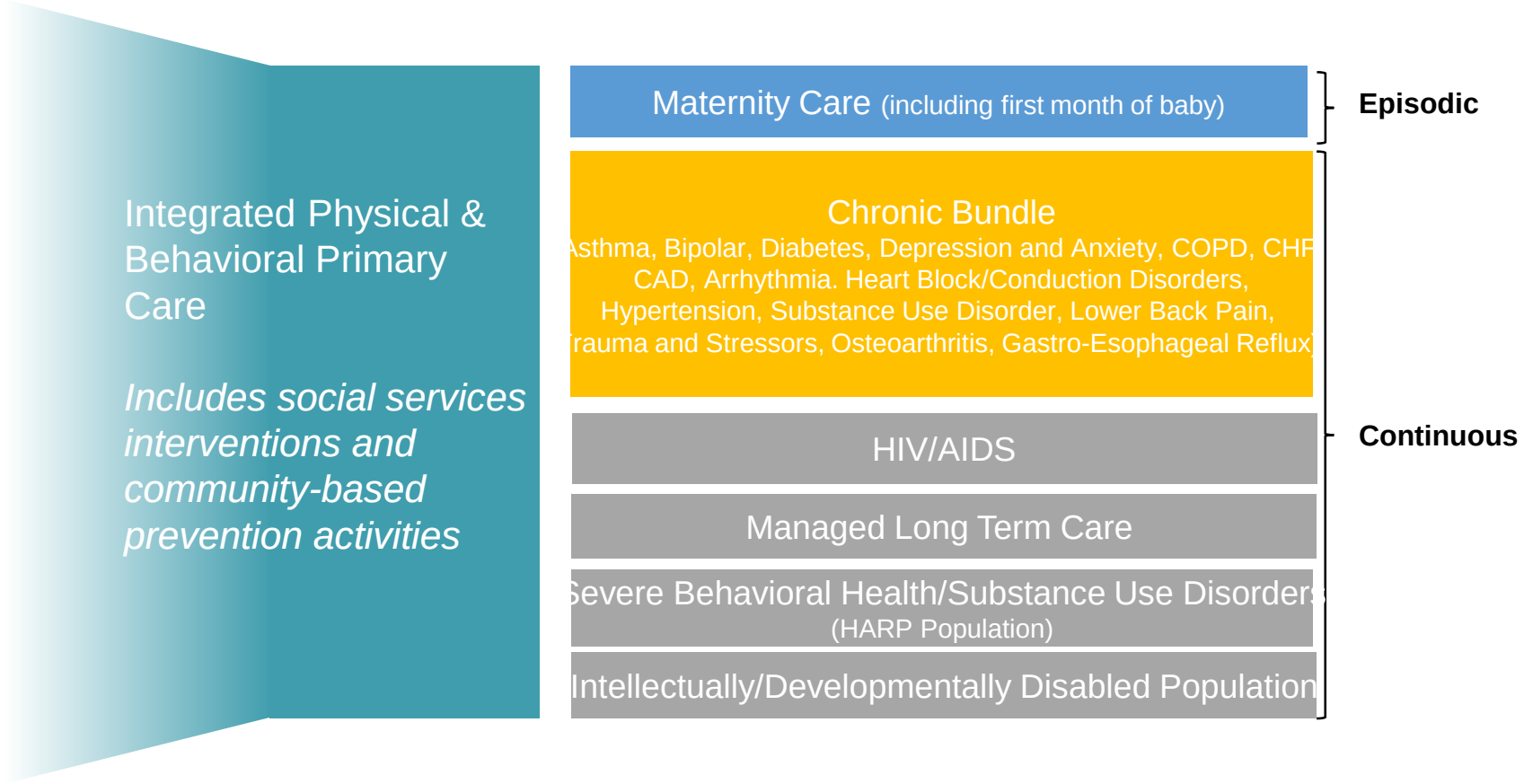
- Build on success of current system
- Offer support for family members and direct support professionals
- Involve individuals and families in system improvement

Payment Reform: Moving Towards Value Based Payment

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver)
- The State and CMS have committed to the Roadmap
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced



The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

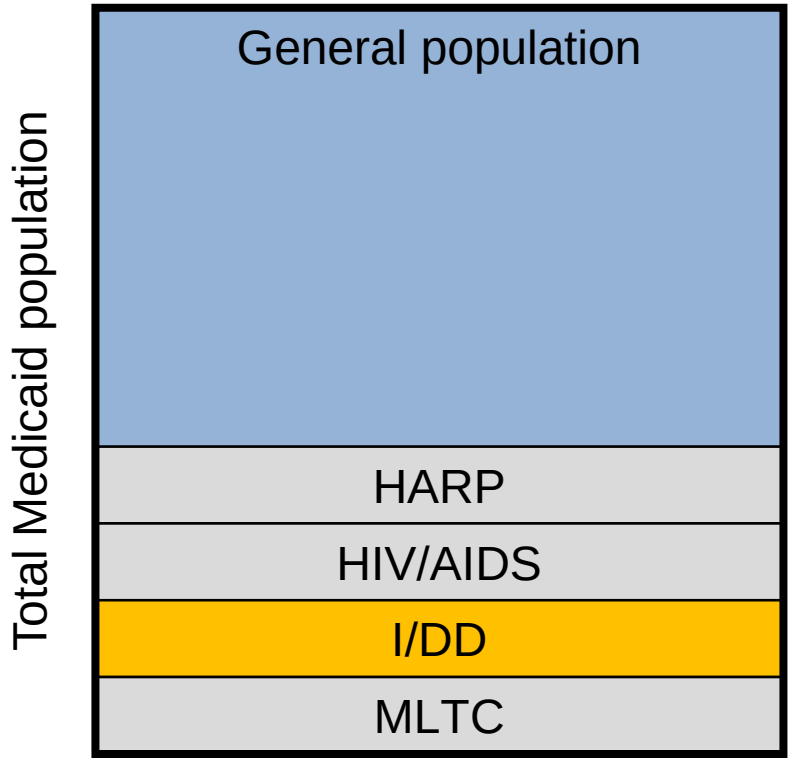


Part I

C. Review total cost of care subpopulation arrangement

Review: General Population and Subpopulations

- VBP arrangement for I/DD is a subpopulation total cost of care arrangement



- The total population is divided into the general population and four specific subpopulations
  1) HARP (Behavioral Health)
  2) HIV/AIDS
  3) I/DD
  4) MLTC

- Subpopulations are contracted for the total cost of care for their Medicaid members.

MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing what integrated services to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

I/DD VBP Advisory Group (I/DD VBP AG): Objectives

- Understand the State's vision for the Roadmap to Value Based Payment
- Review VBP arrangement for people with I/DD receiving services
- Make recommendations on:
  - Quality measures
  - Data and other support required for providers to be successful
  - Other implementation details related to VBP

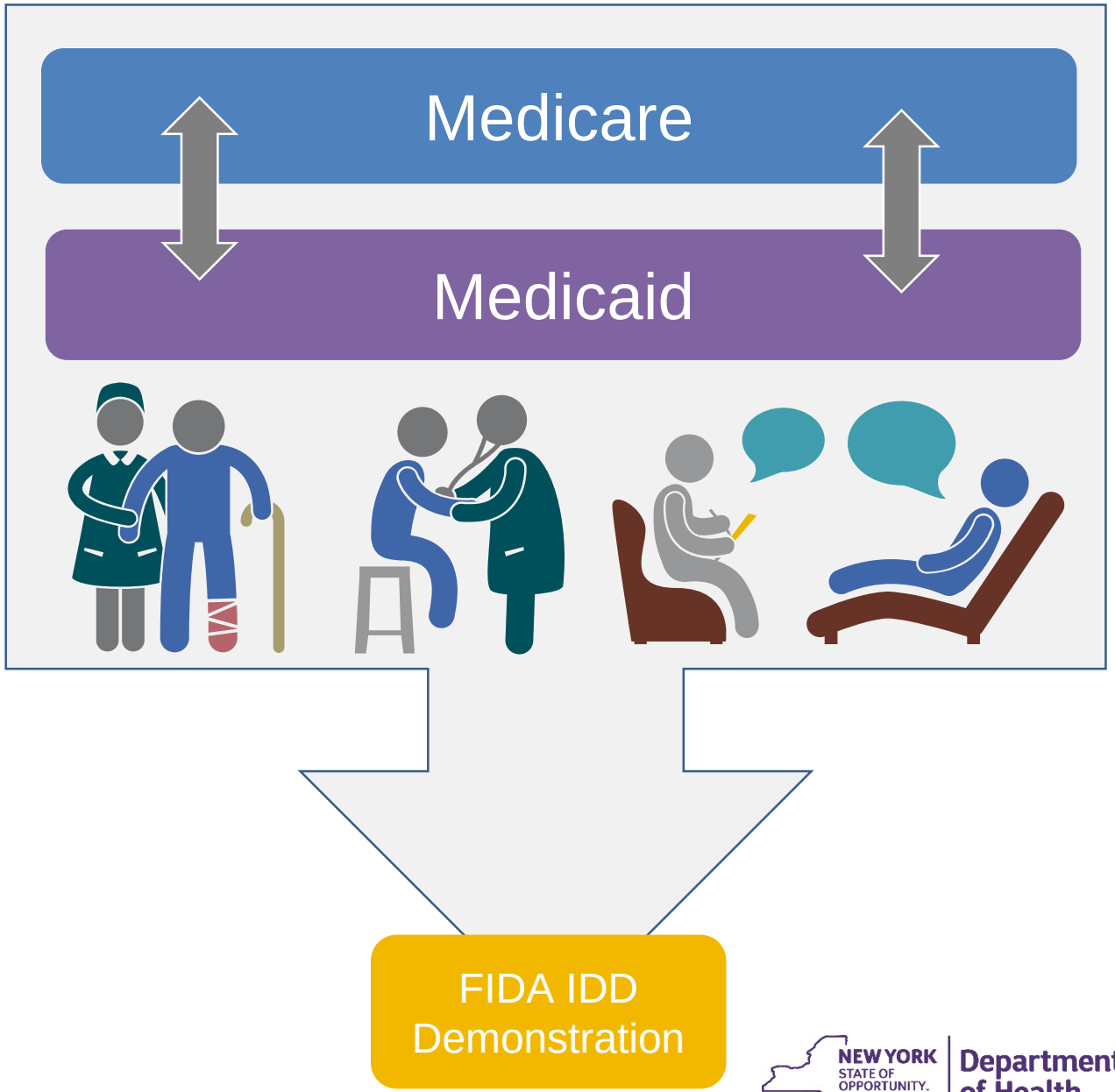
- Definitions are standard, but financial arrangements between plans and providers around the bundles are not set by the State

Part II

A. Big Picture Evolution - Important New Themes

Big Picture Evolution

- Medicare/Medicaid connection – alignment ultimately crucial
- Important to integrate full continuum of care - medical, BH, I/DD
- Align with efforts already underway – FIDA

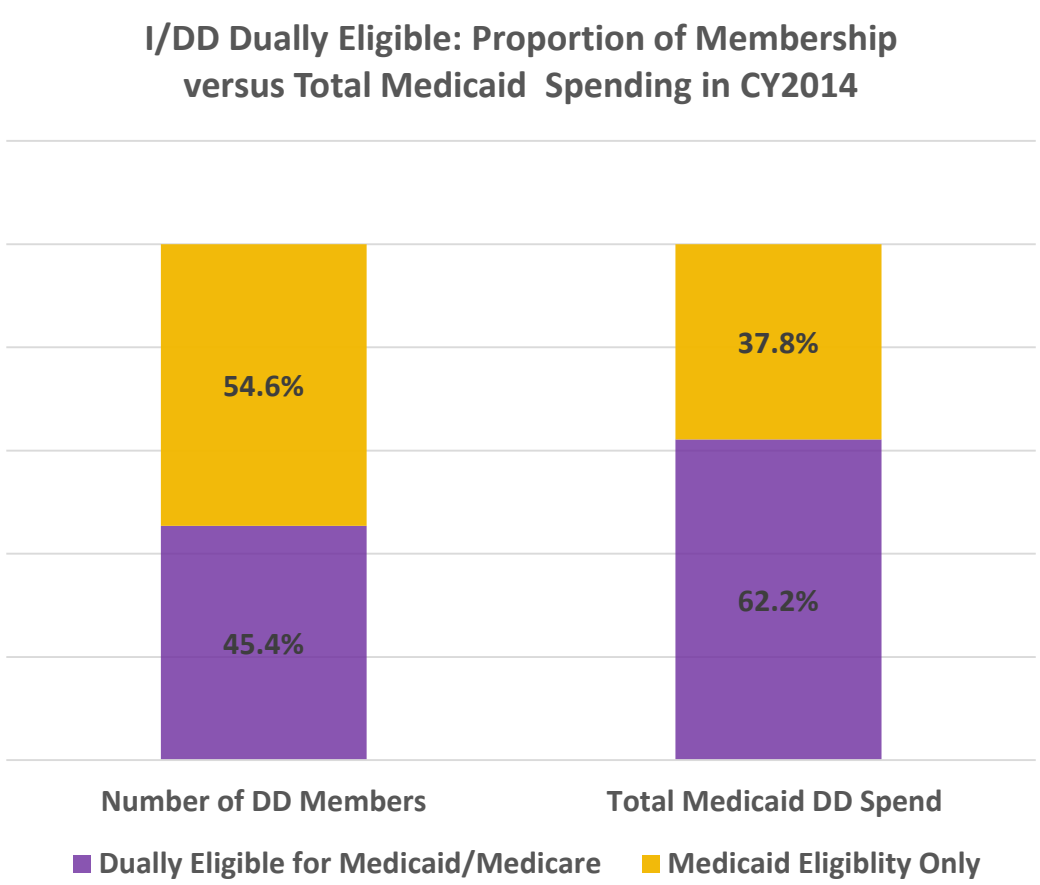


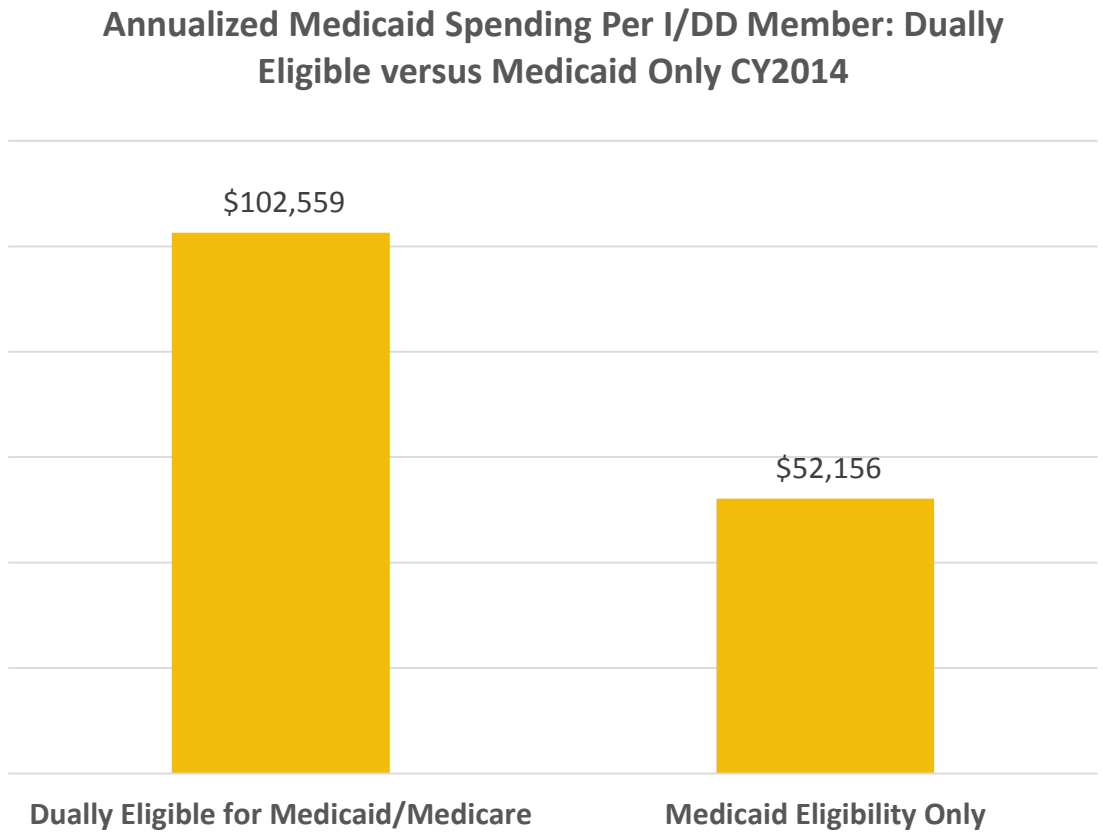
Importance of Medicare Alignment

Medicare Alignment

- New York State has submitted a proposal for aligning Medicaid and Medicare
- Medicare and Medicaid jointly pay for approximately 50% of all health care expenditures in NYS
- Aligning Medicaid VBP Roadmap with CMS VBP Innovations is best thinkable strategy to create momentum for aligned Statewide payment reform.
  - Opportunities for better, more cost-effective care are amplified in magnitude

The Dually Eligible I/DD Population





- CY2014 total Medicaid claims approximately $8B
- MA members with an OPWDD claim = 108,596

Note: This data is inclusive of all 2014 Medicaid fee-for-service claims and managed care encounters of all Medicaid members with at least one OPWDD rate code paid during 2014. This does not include payments made by Medicare or other state agencies. Annualized costs are calculated by PMPM spend x 12 months.

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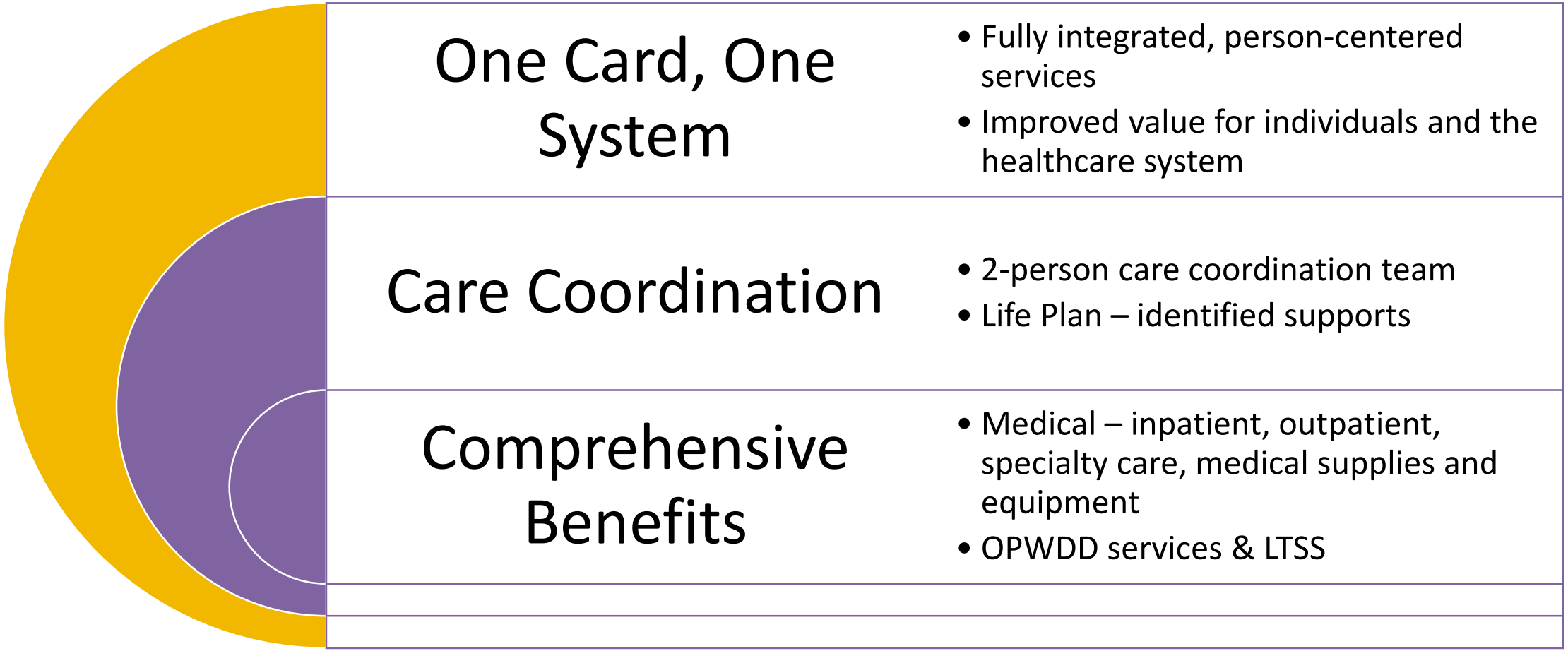
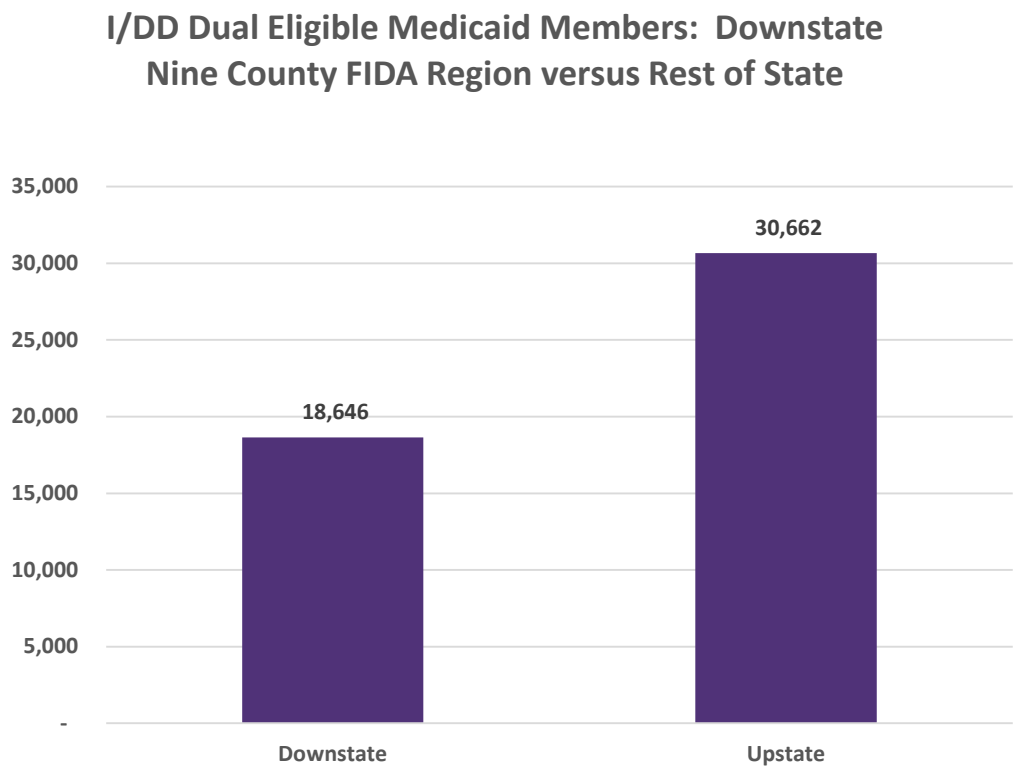
NYS Embarking on an Ambitious Medicaid-Medicare Alignment Project for I/DD Services in 2016 – I/DD FIDA

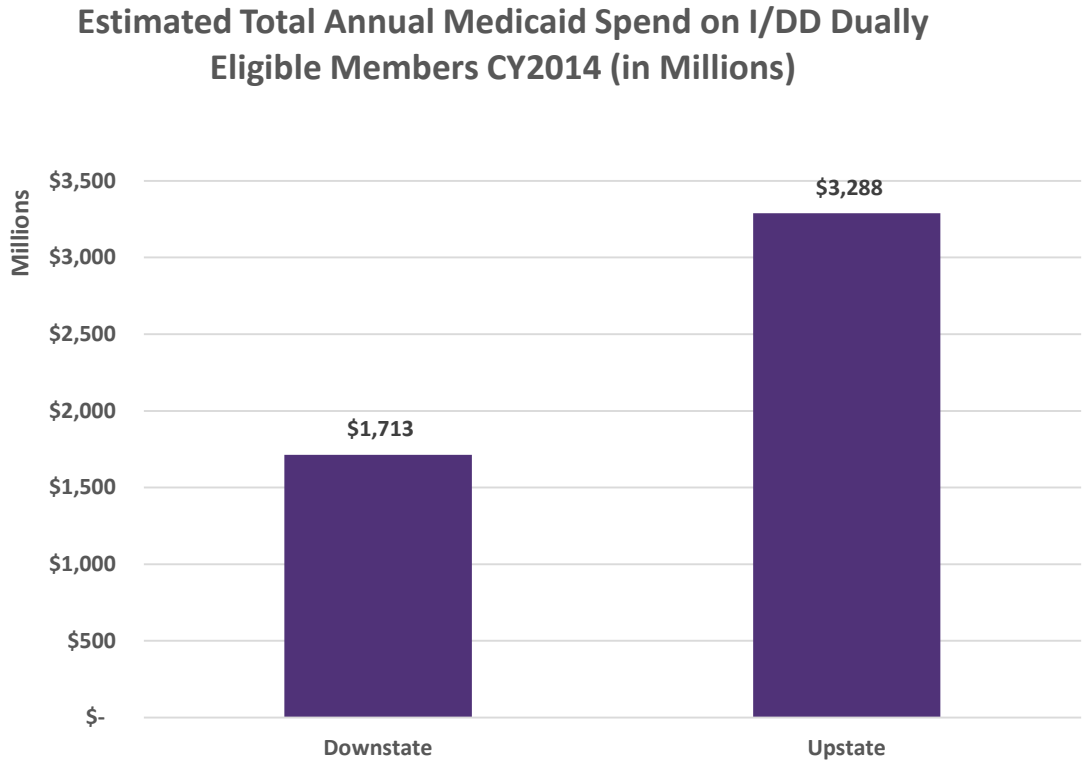
	NYS FIDA-IDD Demonstration
Objective	• To test new model to provide Medicare-Medicaid I/DD Enrollees in the NYS downstate region • NYC, Long Island, Rockland and Westchester
Stakeholders	• Partnership between NYS DOH, NYS OPWDD and CMS • CMS and NYS are contracting with Partners Health Plan
Enrollment	• Anticipated eligibility of 20,000 members; enrollment up to 5,000 • Voluntary • Start date for opt-in enrollment is no sooner than April 1, 2016
Care Coordination	• Person-centered, comprehensive array of services
Quality Measures	• CMS and NYS have established quality measures related to beneficiary's overall experience, care coordination and fostering and supporting community living

The FIDA Care Model



What's at Stake in I/DD FIDA





CY2014 Data, Downstate Counties (Bronx, Kings, New York, Richmond, Queens, Nassau, Suffolk, Rockland,

CY2014 Data, Downstate Counties (Bronx, Kings, New York, Richmond, Queens, Nassau, Suffolk, Rockland, Westchester)

Note: All fee-for-service and managed care claims and members included (CY2014). I/DD members identified as members who had 1 or more OPWDD RATE code billed in CY2014.

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Part III

B. Pinning down the value proposition - What is our value?

Group exercise- What is the value proposition?

Round 1: How do we want to be measured?
Qualitatively?
Quantitatively?

- Divide in four groups
- Brainstorm for 10 minutes on the question above
  - Be positive
  - Focus on the person at the center of the care circle
  - Hone in on unique value-add to the provider partnership
- Each person take 5 minutes to jot measurement thoughts on

Post-it notes, one idea per note

Part IV

B. What do we need to consider generally when designing VBP arrangements, and with special populations?

Brief review of literature/experiences in VBP to date

Important considerations for VBP measures

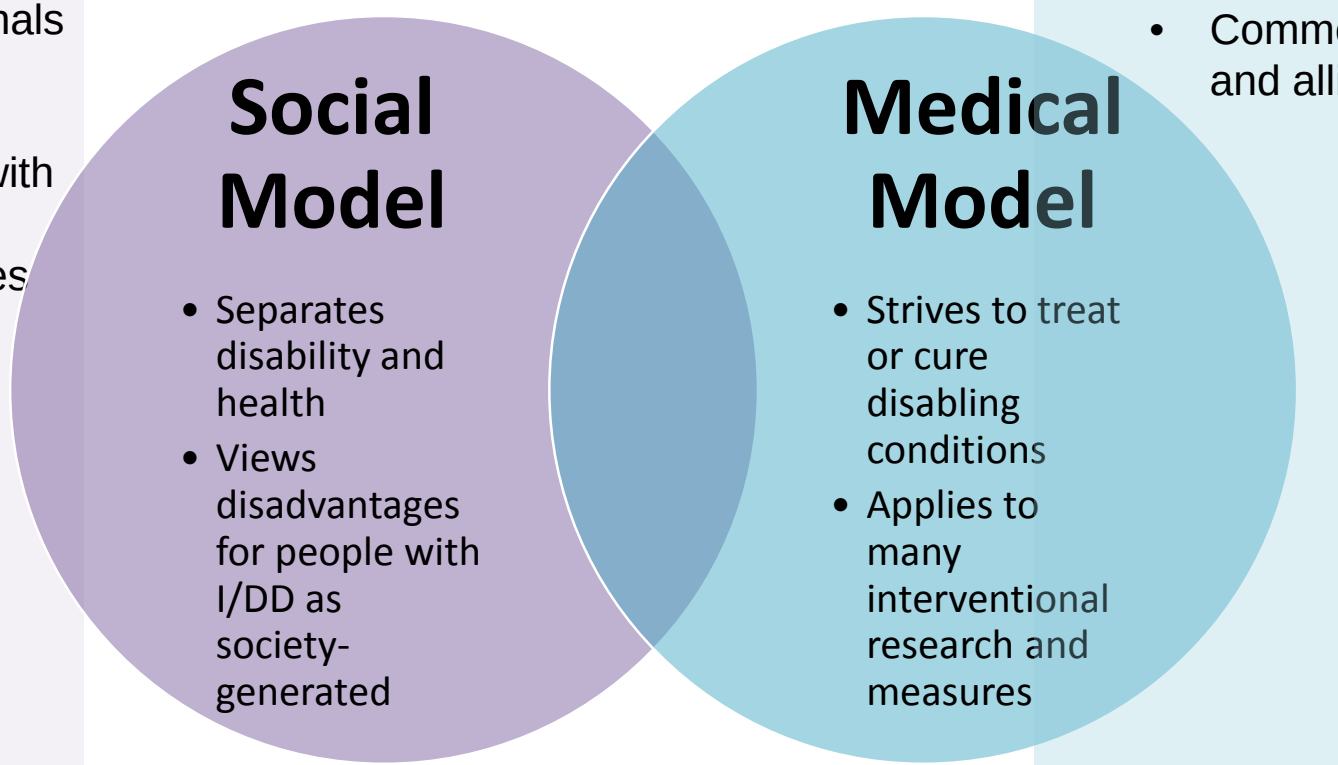
- Breadth of measures
  - Research shows 20 percent of care currently captured in VBP arrangements
- Maturity of measurement systems
- Capturing the value beyond acute care/reductions in inpatient care
- Claims and risk adjustment
- Threshold versus Counterfactuals
  - Pros & Cons
- Nimbleness, adjustment, and real-time actionable information

- Process versus Outcome
  - Process measures: Process measures assess steps that should be followed to provide good care.
  - Outcome measures: Outcome measures assess the results of healthcare that are experienced by patients. They include endpoints like well-being, ability to perform daily activities, etc.
- System needs versus person-centered services
- Room for improvement – lagging versus leading

Toggling lenses, incorporating various perspectives

Social Perspective

- Commonly used by professionals who:
  1. study I/DD
  2. provide care to people with I/DD
  3. focus on support services for people with I/DD
- Acknowledges medical and rehabilitative efforts
- But emphasizes supporting and empowering people with I/DD to be full participants in community and their lives



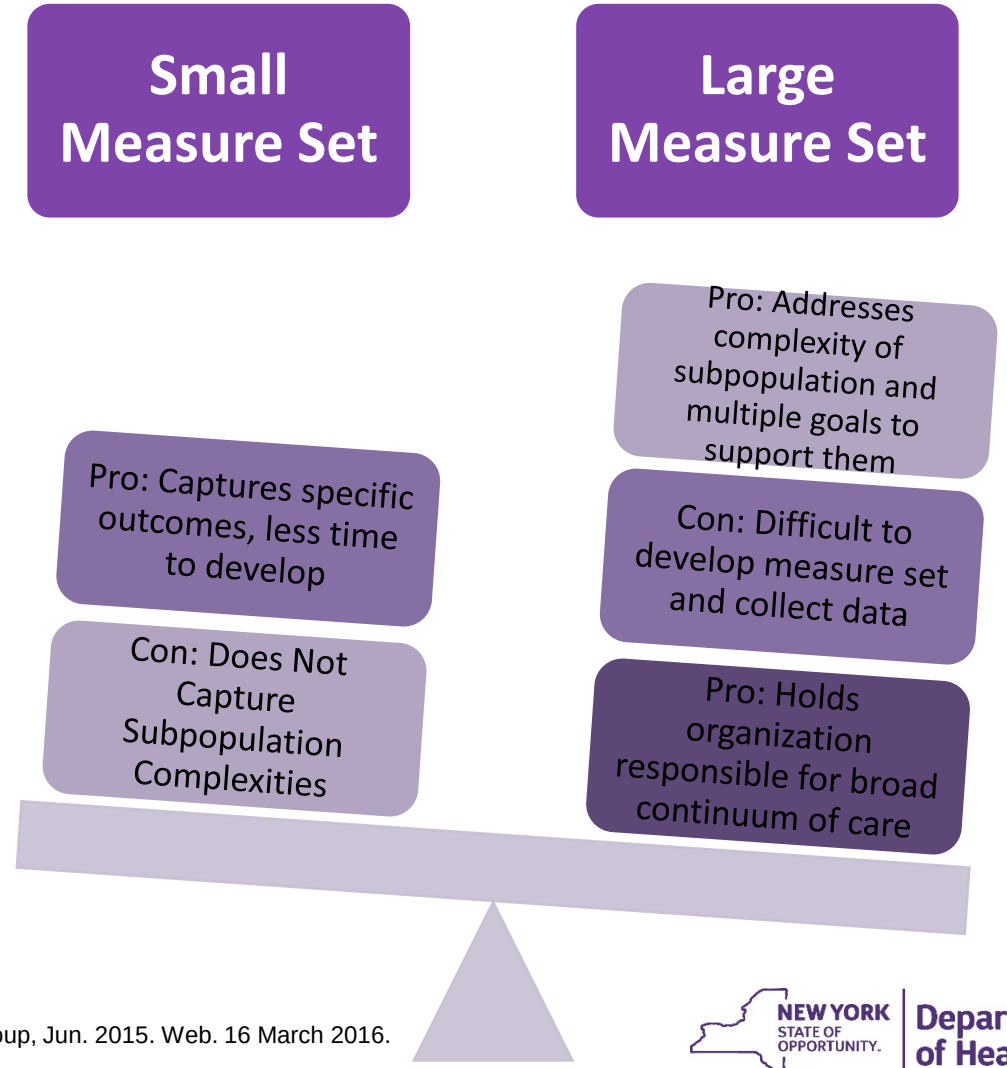
Rehabilitation Perspective

- Commonly used by medical and allied professional fields
  - Strives to maximize function and optimize potential opportunities for an individual to live life as desired

Source: Quality Improvement Measurement of Outcomes for People with Disabilities – Closing the Quality Gap: Revisiting the State of Science. The Agency for Healthcare Research and Quality (AHRQ), October 2012. Web. 16 March 2016.

Special considerations, special populations

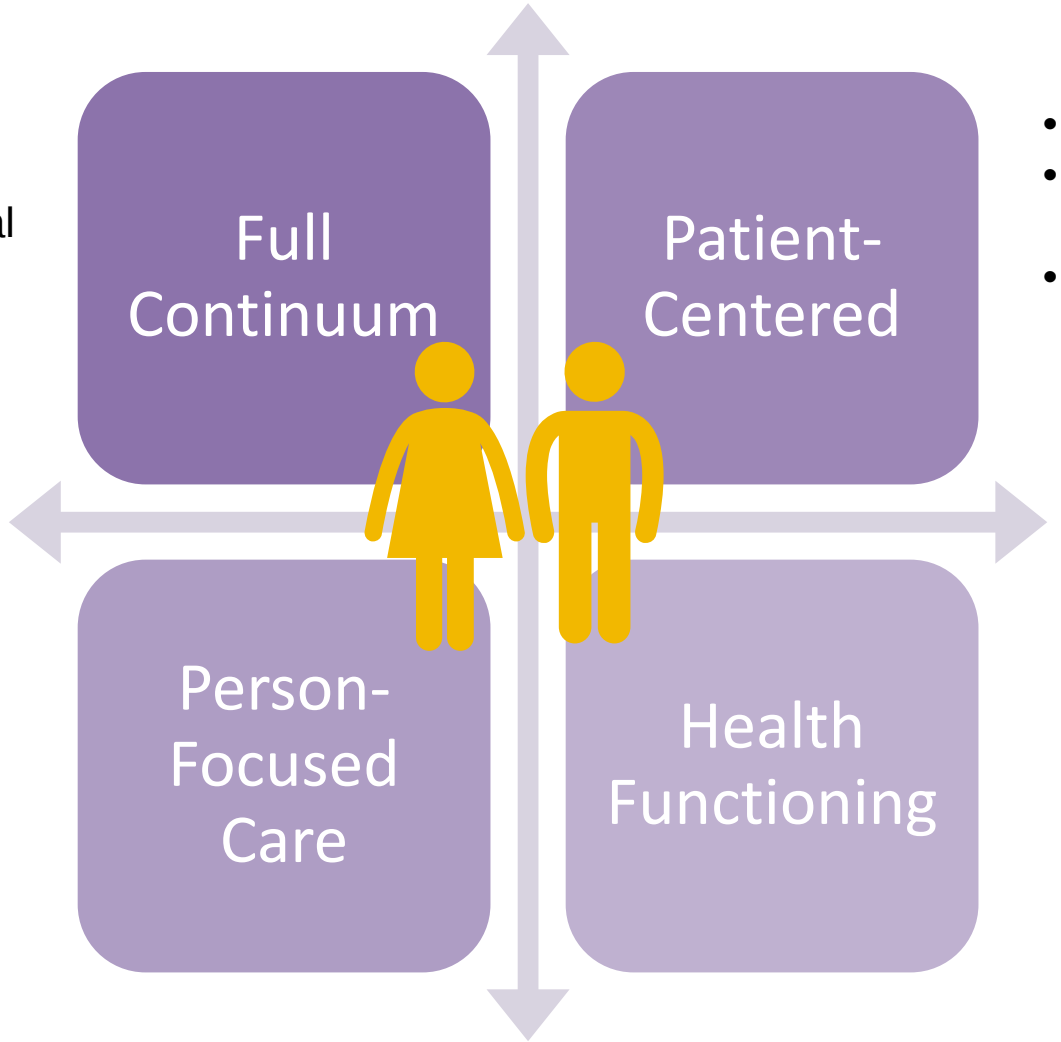
- Small Measure Set vs. Large Measure Set?
- I/DD TCTP is complex → likely need more measures to capture total care goals and comprehensive support system
- However, large measure sets are difficult due to:
  - Long lead time
  - Intensive resources and technical difficulties to develop, test and validate new measures
  - High burden and cost related to data collection



Source: Kodner, Dennis. *Value-Based Purchasing Health Care: Strategic Implications for Vulnerable Populations.* The ArthurWebbGroup, Jun. 2015. Web. 16 March 2016.

Special considerations, special populations

- Include not only all aspects of health care, but also behavioral health services and LTSS



- Disease-oriented care
- Responds to the individual's preferences, needs and values
- Ensures that patient values guide clinical decisions.

- Non-disease orientated care
- Focus on the whole-person to ensure comprehensive, continuous and coordinated care

- Measures that capture population-specific outcomes on physical activity
- For example:
  - Activities of Daily Living (ADLs)
  - Cognitive, psychological/mental and social functioning (interpersonal skills and community living)

Source: Kodner, Dennis. *Value-Based Purchasing Health Care: Strategic Implications for Vulnerable Populations.* The ArthurWebbGroup, Jun. 2015. Web. 16 March 2016.

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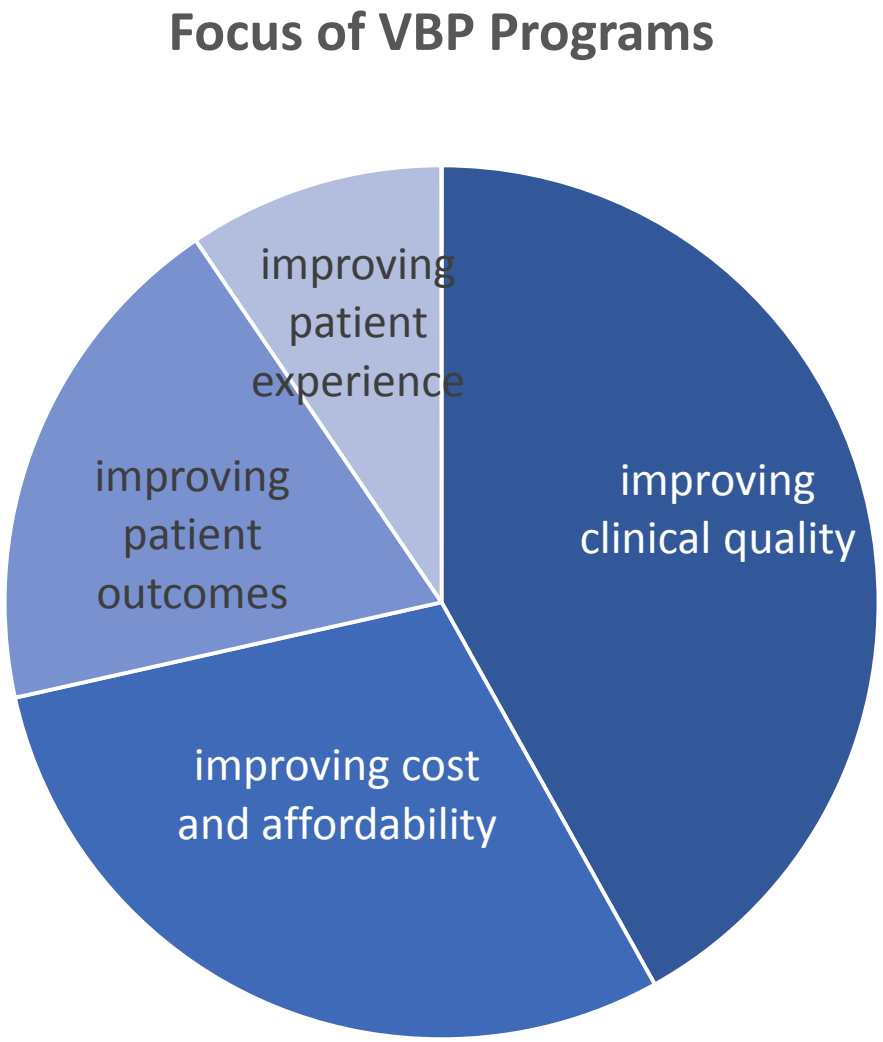
VBP Quality Measures In Practice…

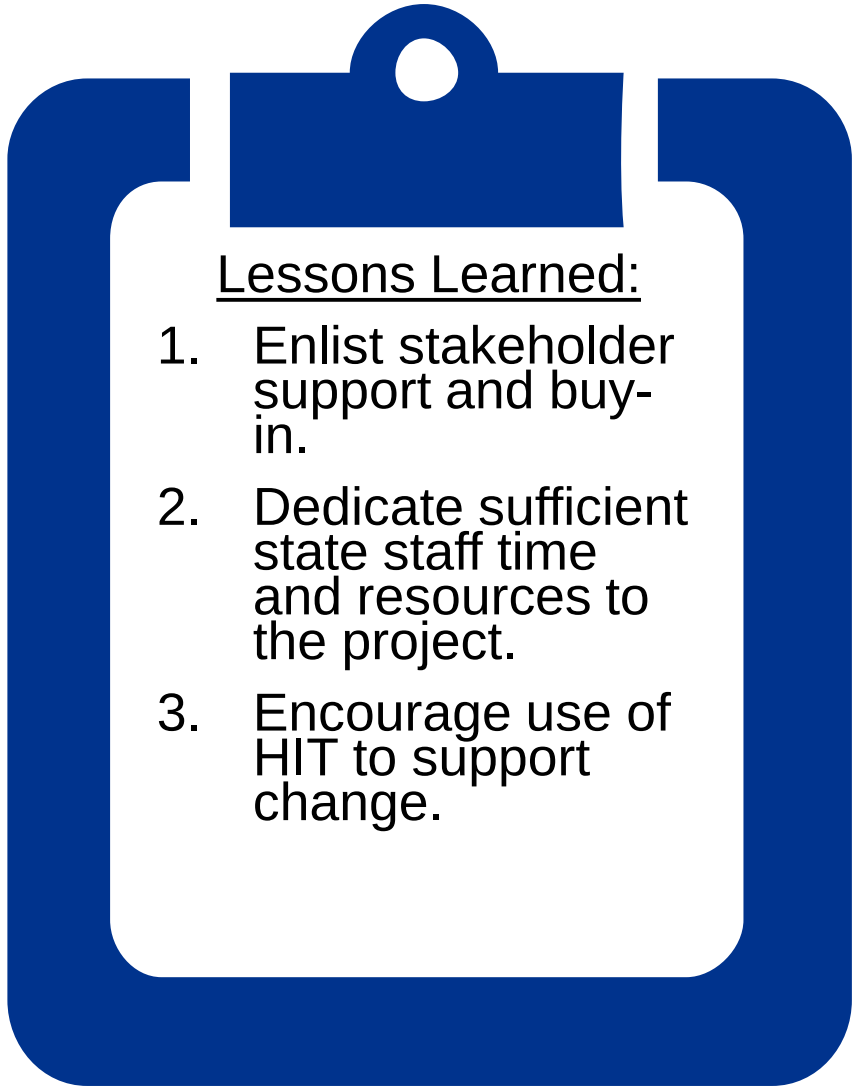
- Often they have narrow set of quality measures which may help specific outcomes… but can also lead to:
  - "Teaching to the test"
  - Limited data collection – >20% of all care delivered by providers is addressed by measures in VBP programs
    - An exception is "total cost of care" contracts
  - Topping out measures
  - Race to the top
- Important focuses:
  - Patient experience/Patient Focused
  - Care Coordination
  - Subpopulation specific definitions of health status and functional metrics



Sources:
- Damberg, Cheryl, Melony E. Sorbero, Susan L. Lovejoy, Grant Martsolf, Laura Raaen, and Daniel Mandel. *Measuring Success in Health Care Value-Based Purchasing Programs – Findings from an Environmental Scan, Literature Review and Expert Panel Discussion.* RAND. 2014. Web. 15 March 2016.
- Houston, Rob and Tricia McGinnis. *Accountable Care Organizations: Looking Back and Moving Forward.* Center for Healthcare Strategies, Inc., Jan. 2016. Web. 16 March 2016.
- Kodner, Dennis. *Value-Based Purchasing Health Care: Strategic Implications for Vulnerable Populations.* The ArthurWebbGroup, Jun. 2015. Web. 16 March 2016.

Integration of Services for I/DD

- Integration of Services for I/DD - After interviewing six states, three general paths to integration of I/DD services emerged:
  1. Managed LTSS
  2. Integration through a case manager/coordinator
  3. Comprehensive managed care



Source: Hogan, Brendan, Kate Bazinsky and Beth Waldman. *Approaches to the Integration of Services for Individuals with Intellectual and Other Developmental Disabilities (I/DD)* Bailit Health Purchasing. Oct 2014. Web. 16 March 2016.

Emerging Themes from States…

Seven states and their approach in using both MLTSS programs and ACA vehicles to transform care for vulnerable LTSS populations…

Continuous stakeholder engagement: NJ

Investment in HCBS: TX, TN

Addressing housing and other social determinants of health: CA, TN

Integrating all services for individuals using LTSS: KS

Value-based purchasing in NF and HCBS settings: AZ, TN

Workforce development to strengthen LTSS purchasing and delivery systems: TN, TX

Medicaid/Medicare integration through both financial alignment demonstrations and D-SNPs

Part V

Where do we start?

Reviewing some frameworks. Food for thought.

The I/DD FIDA Measurement Model – A Helpful Theoretical Framework

THE WHOLE PERSON

Medicare Measures

- Acute care – inpatient etc.
- Medication management
- Medicare ACO +

I/DD Measures

- OPWDD specialty services
- Long-term support services
- Care coordination
- Personal outcomes
- Community inclusion
- Quality of life

Medicare ACO Measure set

- **Patient/Caregiver Experience**
  - Getting Timely Care, Appointments, and Information (ACO #1)
  - How Well Your Doctors Communicate (ACO #2)
  - Patients' Rating of Doctor (ACO #3)
  - Access to Specialists (ACO #4)
  - Health Promotion and Education (ACO #5)
  - Shared Decision Making (ACO #6)
  - Health Status/Functional Status (ACO #7)

- **Care Coordination/Patient Safety**
  - Risk Standardized, All Condition Readmissions (ACO #8)
  - ASC Admissions: COPD or Asthma in Older Adults (ACO #9)
  - ASC Admission: Heart Failure (ACO #10)
  - Percent of PCPs who Qualified for EHR Incentive Payment (ACO #11)
  - Medication Reconciliation (ACO #12)
  - Falls: Screening for Fall Risk (ACO #13)

- **Preventive Health**
  - Influenza Immunization (ACO #14)
  - Pneumococcal Vaccination (ACO #15)
  - Adult Weight Screening and Follow-up (ACO #16)
  - Tobacco Use Assessment and Cessation Intervention (ACO #17)
  - Depression Screening (ACO #18)
  - Colorectal Cancer Screening (ACO #19)
  - Mammography Screening (ACO #20)
  - Proportion of Adults who had blood pressure screened in past 2 years (ACO #21)

*Underline = first time to review measure

Medicare ACO Measure set (cont.)

- **At-Risk Population**
  - Diabetes (*make up Diabetes Composite)
    - Hemoglobin A1c Control (HbA1c) (<8 percent)* (ACO #22)
    - Low Density Lipoprotein (LDL) (<100 mg/dL)* (ACO #23)
    - Blood Pressure (BP) < 140/90* (ACO #24)
    - Tobacco Non Use* (ACO #25)
    - Aspirin Use* (ACO #26)
    - Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent) (ACO #27)
  - Hypertension
    - Percent of beneficiaries with hypertension whose BP < 140/90 (ACO #28)
  - IVD
    - Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl (ACO #29)
    - Percent of beneficiaries with IVD who use Aspirin or other antithrombotic (ACO #30)
  - Heart Failure
    - Beta-Blocker Therapy for LVSD (ACO #31)
  - CAD (composite)
    - Drug Therapy for Lowering LDL Cholesterol (ACO #32)
    - ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD (ACO #33

FIDA I/DD Demonstration measures

- **General/Holistic**
  - Person-Centered Life Plans
  - Documentation of Care Goals
  - Monitoring Physical Activity
  - Health Status/Function Status
  - Self-Direction Participant-level Measure
  - Improvement / Stability in Activities of Daily Living (ADL) Functioning
- **Access and Care Coordination**
  - Care Transition Record Transmitted to Health Care Professional
  - Real Time Hospital Admission Notifications
  - Risk stratification based on LTSS or other factors
  - Discharge follow –up
  - Plan All-Cause Readmissions
  - Access to Specialists
  - Getting Care Quickly
  - Being Examined on the Examination table
  - Help with Transportation
  - Long Term Care Overall Balance Measure
  - Nursing Facility Diversion Measure
  - Long Term Care Rebalancing Measure
  - Participants Referred to OPWDD Regional Office or Money Follows the Person (MFP) Program
- **Behavioral Health**
  - Antidepressant Medication Management
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Follow-up After Hospitalization for Mental Illness
  - Screening for Clinical Depression and Follow-up Care
  - Improving or Maintaining Mental Health
- **Physical Health**
  - Diabetes Care –Eye Exam
  - Diabetes Care –Kidney Disease Monitoring
  - Diabetes Care –Blood Sugar Controlled
  - Rheumatoid Arthritis Management
  - Reducing the Risk of Falling
  - Controlling Blood Pressure
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Influenza Immunization

FIDA I/DD Demonstration measures, continued

- **Medication/Medicare Part D**
  - Medication Reconciliation After Discharge from Inpatient Facility
  - Part D Call Center – Pharmacy Hold Time
  - Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability
  - Part D Appeals Auto–Forward
  - Part D Enrollment Timeliness
  - Part D Complaints about the Drug Plan
  - Part D Participant Access and Performance problems
  - Part D Participants choosing to leave the plan
  - Part D MPF Accuracy
  - Part D High Risk Medication
  - Part D Diabetes Treatment
  - Part D Medication Adherence for Oral Diabetes Medications
  - Part D Medication Adherence for Hypertension (ACEI or ARB)
  - Part D Medication Adherence for Cholesterol (Statins)
  - Comprehensive Medication Review
- **Care for Older Adults**
  - Care for Older Adults – Medication Review
  - Care for Older Adults – Functional Status Assessment
  - Care for Older Adults – Pain Screening
  - Getting Information about Prescription Drug Coverage and Cost
  - Getting Needed Prescription and Non-Prescription Drugs
  - Getting Needed Care
  - Getting Appointments and Care Quickly
  - Overall Rating of Health Care Quality
  - Overall Rating of Plan
- **Health Plan**
  - Plan Makes Timely Decisions about Appeals
  - Part D Appeals Upheld
  - Non-Part D Appeals Upheld
  - Call Center - Foreign Language Interpreter and TTY/TDD availability
  - Percent of High Risk Residents with Pressure Ulcers (Long Stay)
  - Participant Governance Board
  - Customer Service
  - Assessments
  - Plan Specific Measures
  - Complaints about the Plan
  - Participant Access and Performance Problems
  - Participants Choosing to Leave the Plan

Other Frameworks – Pros and Cons

- Survey tools
  - Sample size issues at the provider level potentially
  - Comfort with financial connection to survey tools

- Feasibility
- Validation protocols/timelines
- Is there anything we can tell from claims?
  Proper coding of claims issues

CQL: Personal Outcome Measures®

- Initially introduced in 1993, the tool and the information gathered through the interview process has helped to pave a path to outcomes based decision making in human services.

- What Sets CQL POMS® Apart:
  - The focus on the person
  - Service action is based on the person's criteria
  - Services and supports are designed for the person
  - Expectations for performance are defined by the person

- Instead of looking at the quality of how the services are being delivered, Personal Outcome Measures® look at whether the services and supports are having the desired results or outcomes that matter to the person.

Source: http://www.c-q-l.org/the-cql-difference/personal-outcome-measures

CQL: Life Plan and POMS® incorporation into FIDA I/DD demonstration

- **Life Plans (LP or Individual Service Plan (ISP)) –** are individualized person-centered care and service plans, collaboratively developed with the participant, his or her family/caregivers, and other IDT members to address the full continuum of covered and non-covered physical, behavioral, and long-term services and supports.

- **The Council on Quality and Leadership (CQL) Personal Outcome Measures (POMS®) will be used to monitor/reassess the effectiveness of a participant's LP** to determinate whether his or her goals are being met and valued outcomes achieved.

- An interview with the participant by a certified interviewer who is employed by the FIDA I/DD Plan will be completed for a State defined sample. The results of the POMS® interviews will inform individual planning and organizational quality improvement activity and will be provided to OPWDD for quality oversight data.

Source: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOUIDD.pdf

CQL: Personal Outcome Measures® s

My Dreams - How I want my life (self and world) to be

- People choose personal goals
- People realize personal goals
- People participate in the life of the community
- People have friends
- People are respected

- **My Self** - *Who I am as a result of my unique heredity, life experiences and decisions.* Person-Centered Life Plans
  - People are connected to support networks
  - People have intimate relationships
  - People are safe
  - People have the best possible health
  - People exercise rights
  - People are treated fairly
  - People are free from abuse and neglect
  - People experience continuity and security
  - People decide when to share personal information

My World - Where I work, live, socialize, belong or connect.

- People choose where and with whom they live
- People choose where they work
- People use their environments
- People live in integrated environments
- People interact with other members of the community
- People perform different social roles
- People choose services

Personal Outcome Measures® January 2010 (N=7,879)	Outcomes
People are Safe	86.5%
People are Free From Abuse and Neglect	84.0%
People Realize Personal Goals	82.7%
People are Respected	78.7%
People Experience Continuity and Security	78.5%
People Decide When to Share Personal Information	78.2%
People Use Their Environments	76.7%
People have the Best Possible Health	74.4%
People Interact with Other Members of the Community	72.2%
People have Intimate Relationships	70.4%
People Participate in the Life of the Community	70.0%
People Remain Connected to Natural Support Networks	61.7%
People have Friends	56.3%
People are Treated Fairly	55.7%
People Choose Personal Goals	51.3%
People Choose Services	50.3%
People Exercise Rights	49.8%
People Choose Where and With Whom they Live	46.2%
People Choose Where they Work	40.6%
People Live in Integrated Environments	37.5%
People Perform Different Social Roles	32.5%

Source: CQL data compendium available at http://www.c-q-l.org/app/webroot/files/DOCUMENTS/DQ%20-%20Personal%20Outcome%20Measures%20National%20Database.pdf

CQL Analysis: Some Outcomes Correlate Better with Total Care

HIGHEST (Presence correlated with total outcome)

Exercise rights	.537
Choose where and with whom they live	.528
Treated fairly	.521
Choose where to work	.507
Interact with other members of the community	.500
Perform different social roles	.487

LOWEST (Presence less correlated with total outcome)

Decide when to share personal information	.332
Have the best possible health	.309
Free from abuse and neglect	.287
Experience continuity and security	.276
Are safe	.189

National Core Indicators™

- NCI™ is a voluntary effort by public developmental disabilities agencies to measure and track their own performance.
  - Core Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.

- Collaboration of participating states (45 states + DC), Human Services Research Institute (HSRI), and National Association of State Directors of Developmental Disabilities Services (NASDDDS).

- Core Indicators consist of both System and Individual survey measures.
  - System measures are designed to measure indicators at the plan and/or organization level.
    - Examples under NCI include staff stability, service availability, and service coordination.
  - Individual survey measures focus on member specific outcomes.
    - Examples include having a job in the community, using self-directed supports, and satisfaction with they way they live.

National Core Indicators™ framework

Other OPWDD Measures Efforts - Under Development

- OPWDD led multiple stakeholder engagement sessions to identify performance measures/metrics.
  - Joint Application Design (JAD) sessions started in December 2013. Comprised of 72 internal stakeholders & overseen by Optumas.
    - Goal: Identifying and prioritizing quality monitoring and Identifying Day 1 specific performance measures and IT specifications.

- Possibilities from Coordinated Assessment System (CAS) – InterRAI tool development
  - Individual point-to-point measurement
  - Plan for roll-out

  - DQI Agency Quality Performance
    - Goal: Identifying Quality Performance-Standards across the entire continuum of care and plan/service level.

I/DD VBP Advisory Group Meeting # 3

Meeting 3: Defining High Value Care for the I/DD population

- Goal is to select quality measures to incentivize strategic goals
- Process and method for selection
- Detailed review of quality measures – definition and method for collection and calculation
- Facilitated quality measure selection

Appendix

Medicare ACO Quality Measure Set

Medicare ACO Measures

Measure	Category
Getting Timely Care, Appointments, and Information	Patient/Caregiver Experience
How Well Your Doctors Communicate	Patient/Caregiver Experience
Patients' Rating of Doctor	Patient/Caregiver Experience
Access to Specialists	Patient/Caregiver Experience
Health Promotion and Education	Patient/Caregiver Experience
Shared Decision Making	Patient/Caregiver Experience
Health Status/Functional Status	Patient/Caregiver Experience
Risk Standardized, All Condition Readmissions	Care Coordination/Patient Safety
ASC Admissions: COPD or Asthma in Older Adults	Care Coordination/Patient Safety
ASC Admission: Heart Failure	Care Coordination/Patient Safety
Percent of PCPs who Qualified for EHR Incentive Payment	Care Coordination/Patient Safety
Medication Reconciliation	Care Coordination/Patient Safety
Falls: Screening for Fall Risk	Care Coordination/Patient Safety
Influenza Immunization	Preventive Health
Pneumococcal Vaccination	Preventive Health
Adult Weight Screening and Follow-up	Preventive Health
Tobacco Use Assessment and Cessation Intervention	Preventive Health

Medicare ACO Measures

Measure	Category
Depression Screening	Preventive Health
Colorectal Cancer Screening	Preventive Health
Mammography Screening	Preventive Health
Proportion of Adults who had blood pressure screened in past 2 years	Preventive Health
Hemoglobin A1c Control (HbA1c) (<8 percent)	At-Risk Population Diabetes (Diabetes Composite)
Low Density Lipoprotein (LDL) (<100 mg/dL)	At-Risk Population Diabetes (Diabetes Composite)
Blood Pressure (BP) < 140/90	At-Risk Population Diabetes (Diabetes Composite)
Tobacco Non Use	At-Risk Population Diabetes (Diabetes Composite)
Aspirin Use	At-Risk Population Diabetes (Diabetes Composite)
Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	At-Risk Population Diabetes
Percent of beneficiaries with hypertension whose BP < 140/90	At-Risk Population Hypertension
Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	At-Risk Population IVD
Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	At-Risk Population IVD
Beta-Blocker Therapy for LVSD	At-Risk Population HF
Drug Therapy for Lowering LDL Cholesterol	At-Risk Population CAD Composite
ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	At-Risk Population CAD Composite

FIDA-IDD Demonstration Measure Set

FIDA I/DD Demonstration measure set

Measure Name	Measure Description
Antidepressant Medication Management	Percentage of Participants 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult Participants with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of Participants who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of Participants who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.
Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.
Care Transition Record Transmitted to Health Care Professional	Percentage of Participants, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

FIDA I/DD Demonstration measure set (cont.)

Measure Name	Measure Description
CAHPS, Health Plan plus supplemental items/questions (TBD): Getting Information about Prescription Drug Coverage and Cost	The percent of the best possible score that the plan earned on how easy it is for Participants to get information from their plan about prescription drug coverage and cost. A. In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? B. In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? C. In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? D. In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine? Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?
CAHPS, Health Plan plus supplemental items/questions (TBD): Getting Needed Prescription and Non-Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for Participants to get the prescription drugs and non-prescription drugs they need using the plan. A. In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? B. In the last six months, how often was it easy to use your health plan to fill a prescription or obtain a non-prescription drug at a local pharmacy?
CAHPS, Health Plan plus supplemental items/questions (TBD): Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. A. In the last 6 months, how often was it easy to get appointments with specialists? B. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan? C. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?
CAHPS, Health Plan plus supplemental items/questions (TBD): Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Participants can get appointments and care. A. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? B. In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? C. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

FIDA I/DD Demonstration measure set (cont.)

Measure Name	Measure Description
CAHPS, Health Plan plus supplemental items/questions (TBD): Overall Rating of Health Care Quality	Percent of best possible score the plan earned from Participants who rated the overall health care received. A. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
CAHPS, Health Plan plus supplemental items/questions (TBD): Overall Rating of Plan	Percent of best possible score the plan earned from Participants who rated the overall plan. A. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health plan?
Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the plan's pharmacy help desk
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were Available when needed by Participants who called the plan's customer service phone number.
Part D Appeals Auto–Forward	How often the plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto forwarded to the IRE) / (Average Medicare Part D enrollment)] *10,000.
Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 calendar days of receipt of a completed enrollment request.
Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 /(Number of Days in Period).
Part D Participant Access and Performance problems	To check on whether Participants are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.
Part D Participants choosing to leave the plan	The percent of Participants who chose to leave the plan in 2013.

FIDA I/DD Demonstration measure set (cont.)

Measure Name	Measure Description
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.
Part D High Risk Medication	The percent of the Participants who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.
Part D Diabetes Treatment	Percentage of Medicare Part D Participants who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.
Part D Medication Adherence for Oral Diabetes Medications	Percent of Participants with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of Participants with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Part D Medication Adherence for Cholesterol (Statins)	Percent of Participants with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
Plan Makes Timely Decisions about Appeals	Percent of Participants who got a timely (per timelines in section IX) response when they made a written appeal to the plan about a decision to refuse payment or coverage.
Part D Appeals Upheld	How often an independent reviewer agrees with the plan's decision to deny or say no to a Participant's Part D appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' Part D decisions. This is calculated as: [(Number of Part D cases upheld) / (Total number of Part D cases reviewed)] * 100.
Non-Part D Appeals Upheld	How often an Integrated Administrative Hearing Officer agrees with the plan's non-Part D decision to deny or say no to a Participant's non-Part D appeal. This measure is defined as the percent of FIDA Administrative Hearing Unit confirmations of upholding the plans' decisions. This is calculated as: [(Number of non-Part D cases upheld) / (Total number of non-Part D reviewed)] * 100.

FIDA I/DD Demonstration measure set (cont.)

Measure Name	Measure Description
Call Center - Foreign Language Interpreter and TTY/TDD availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by Participants who called the plan's customer service phone number.
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).
Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with contract requirements.
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. A. In the last 6 months, how often did your health plan's customer service give you the information or help you needed? B. In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? C. In the last 6 months, how often were the forms for your health plan easy to fill out?
Assessments	Percent of Participants with initial assessments completed within 90 days of enrollment.
Person-Centered Life Plans	Percent of Participants with care plans within 30 days of initial assessment.
Documentation of Care Goals	Percent of Participants with documented discussions of care goals.
Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.
Risk stratification based on LTSS or other factors	Percent of risk stratifications using behavioral health (BH)/LTSS Data/indicators.
Discharge follow -up	Percent of Participants with specified timeframe between discharge to first follow-up visit.
Care for Older Adults – Medication Review	Percent of Participants whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and nonprescription drugs, vitamins, herbal remedies, other supplements) at least once a year.

FIDA I/DD Demonstration measure set (cont.)

Measure Name	Measure Description
Care for Older Adults – Functional Status Assessment	Percent of Participants whose doctor has done a —functional status assessmentll to see how well they are doing —activities of daily livingll (such as dressing, eating, and bathing).
Care for Older Adults – Pain Screening	Percent of Participants who had a pain screening or pain management plan at least once during the year.
Diabetes Care –Eye Exam	Percent of Participants with diabetes who had an eye exam to check for damage from diabetes during the year.
Diabetes Care –Kidney Disease Monitoring	Percent of Participants with diabetes who had a kidney function test during the year.
Diabetes Care –Blood Sugar Controlled	Percent of Participants with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.
Rheumatoid Arthritis Management	Percent of Participants with Rheumatoid Arthritis who got one or more prescription(s) for an anti rheumatic drug.
Reducing the Risk of Falling	Percent of Participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.
Plan All-Cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.
Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
Comprehensive Medication Review	Percentage of Participants who received a comprehensive medication review (CMR) out of those who were offered a CMR.
Complaints about the Plan	How many complaints Medicare received about the health plan. Rate of complaints about the plan per 1,000 Participants. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).

FIDA I/DD Demonstration measure set (cont.)

Measure Name	Measure Description
Participant Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.
Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2014.
Breast Cancer Screening	Percent of female Participants aged 40-69 who had a mammogram during the past 2 years.
Colorectal Cancer Screening	Percent of Participants aged 50-75 who had appropriate screening for colon cancer.
Annual Flu Vaccine	Percent of Participants who got a vaccine (flu shot) prior to flu season.
Improving or Maintaining Mental Health	Percent of all Participants whose mental health was the same or better than expected after two years.
Monitoring Physical Activity	Percent of senior Participants who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists
Getting Care Quickly	Composite of access to urgent care.
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.
Help with Transportation	Composite of getting needed help with transportation.

FIDA I/DD Demonstration measure set (cont.)

Measure Name	Measure Description
Health Status/Function Status	Percent of Participants who report their health as excellent.
Self-Direction Participant-level Measure	Percent of Participants, advocates and/or their legal guardians directing their own services through self-direction or the consumer-directed personal assistance option at the plan each Demonstration Year.
Long Term Care Overall Balance Measure	Reporting of the percent of Participants who did not reside in a nursing facility for a long stay at the time of enrollment and did not reside in a nursing facility for a long stay during the reporting period.
Nursing Facility Diversion Measure	Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year.
Long Term Care Rebalancing Measure	Reporting of the number of Participants who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Participants who resided in a NF during the previous year. Monthly Long Term Care Rebalancing Rate: Numerator: of those Participants in the denominator, those who were discharged to a community setting from a NF and did not return to the NF during the current measurement year. Denominator: Participants enrolled in a plan eleven out of twelve months during the current measurement year who resided in a NF for 100 continuous days or more during the previous year and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.
Improvement / Stability in Activities of Daily Living (ADL) Functioning	Participants in the FIDA-IDD Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.
Participants Referred to OPWDD Regional Office or Money Follows the Person (MFP) Program	Percent of Participants in the FIDA-IDD Demonstration who reside in a nursing facility, wish to return to the community, and were referred to OPWDD Regional Office or the MFP Program.

National Core Indicators™ measure set

National Core Indicator measures (cont.)

- Individual Outcomes
  - Self Determination
    - The proportion of people self-directing who get the help they need to work out problems with their support workers.
    - The proportion of people self-directing who have help in deciding how to use their individual budget/services.
    - The proportion of people self-directing who receive information about their budget/services that is easy to understand
    - The proportion of people self-directing who report that someone talked with them about their individual budget/services.
    - The proportion of people self-directing who report that they can make changes to their budget/services if they need to.
    - The proportion of people self-directing who report that they need more help in deciding how to use their budget/services.
    - The proportion of people self-directing whose support workers come when they are supposed to.
    - The proportion of people who are currently using a self-directed supports option.
  - Relationships
    - The proportion of people who are able to see their families and friends when they want.
    - The proportion of people who feel lonely.
    - The proportion of people who have a close friend, someone they can talk to about personal things.
    - The proportion of people who have friends and caring relationships with people other than support staff and family members.
    - The proportion of people who report that they get to help others.
    - The proportion of people who talk with their neighbors.

National Core Indicator measures (cont.)

- Individual Outcomes (cont.)
  - Satisfaction
    - The proportion of people who are satisfied with their day program or other daily activity.
    - The proportion of people who are satisfied with their job.
    - The proportion of people who are satisfied with where they live.
    - The proportion of people who go to a day program or have other daily activity who would like to go somewhere else or do something else during the day.
    - The proportion of people who have a community job who would like to work somewhere else.
    - The proportion of people who report that they would like to live somewhere else.
  - Choice and Decision-Making
    - The proportion of people who make choices about their everyday lives, including: housing, roommates, daily routines, jobs, support staff or providers, what to spend money on, and social activities.
    - The proportion of people who report having been provided options about where to live, work, and go during the day.
  - Community Inclusion
    - The proportion of people who regularly participate in everyday integrated activities in their communities.
  - Work
    - Of people who have a job in the community, the average length of time they have been working at their current job.
    - Of people who have a job in the community, the percent who receive vacation and/or sick time benefits.
    - Of people who have a job in the community, the percent who were continuously employed for 10 out of the last 12 months

National Core Indicator measures (cont.)

- Work (cont.)
  - The average bi-weekly earnings of people who have jobs in the community.
  - The average number of hours worked bi-weekly by people with jobs in the community.
  - The percent of people earning at or above the State minimum wage
  - The proportion of people who do not have a job in the community but would like to have one.
  - The proportion of people who do volunteer work.
  - The proportion of people who go to a day program or have some other daily activity.
  - The proportion of people who have a goal of integrated employment in their individualized service plan.
  - The proportion of people who have a job in the community.

- Health, Welfare, and Rights
  - Health
    - The proportion of men over 50 who have had a PSA test within the past year.
    - The proportion of people age 50 and older who have had a screening for colorectal cancer within the past year.
    - The proportion of people described as having poor health.
    - The proportion of people reported as having a primary care doctor.
    - The proportion of people who have ever had a vaccination for pneumonia.
    - The proportion of people who have had a complete annual physical exam in the past year.
    - The proportion of people who have had a flu vaccination within the past 12 months.

National Core Indicator measures (cont.)

- Health (cont.)
  - The proportion of people who have had a hearing test within the past 5 years.
  - The proportion of people who have had a routine dental exam in the past year.
  - The proportion of people who have had a vision screening within the past year.
  - The proportion of women 18 and over who have had a Pap test screening in the past year.
  - The proportion of women over 40 who have had a mammogram within the past 2 years.
- Wellness
  - The proportion of people who maintain healthy habits in such areas as smoking, weight, and exercise.
- Restraints
  - The incidence of restraints reported in the past year, by type of restraint and by living arrangement.
  - The incidence of serious injuries resulting from the use of restraints.
- Respect/Rights
  - The proportion of people indicating that most staff treat them with respect.
  - The proportion of people who feel their support staff treat them with respect.
  - The proportion of people who have participated in a self-advocacy group meeting, conference, or event.
  - The proportion of people who report satisfaction with the amount of privacy they have.
  - The proportion of people whose basic rights are respected by others.

National Core Indicator measures (cont.)

- Health, Welfare, and Rights (cont.)
  - Safety
    - The incidence of serious injuries reported among people with MR/DD in the course of service provision, during the past year.
    - The mortality rate of the served ID/DD population compared to the general area population, by age, by cause of death (natural or medico-legal), and by ID or DD diagnosis.
    - The proportion of people who report having someone to go to for help when they feel afraid.
    - The proportion of people who report that they feel safe in their home, neighborhood, workplace, and day program/ at other daily activity.
    - The proportion of people who were victims of selected crimes reported to a law enforcement agency during the past year, by type of crime (rape, aggravated assault, and theft).
  - Health
    - The proportion of men over 50 who have had a PSA test within the past year.
    - The proportion of people age 50 and older who have had a screening for colorectal cancer within the past year.
    - The proportion of people described as having poor health.
    - The proportion of people reported as having a primary care doctor.
    - The proportion of people who have ever had a vaccination for pneumonia.
    - The proportion of people who have had a complete annual physical exam in the past year.
    - The proportion of people who have had a flu vaccination within the past 12 months.

National Core Indicator measures (cont.)

- Health (cont.)
  - The proportion of people who have had a hearing test within the past 5 years.
  - The proportion of people who have had a routine dental exam in the past year.
  - The proportion of people who have had a vision screening within the past year.
  - The proportion of women 18 and over who have had a Pap test screening in the past year.
  - The proportion of women over 40 who have had a mammogram within the past 2 years.

- Service Coordination
  - The proportion of people who get the help they need to work out problems with their support workers.
  - The proportion of people whose support workers come when they are supposed to.
  - The proportion of people reporting that service coordinators ask them what they want.
  - The proportion of people reporting that service coordinators help them get what they need.
  - The proportion of people who have met their service coordinators.
  - The proportion of people who report that their service coordinators call them back right away.
  - The proportion of people who were involved in creating their service plan

- Staff Stability
  - Average length of service for all direct contact staff who separated in the past year, and for all currently employed direct contact staff.
  - The crude separation rate, defined as the proportion of direct contact staff separated in the past year.
  - The vacancy rate, defined as the proportion of direct contact positions that were vacant as of a specified date.

National Core Indicator measures (cont.)

- Family Indicators
  - Community Connections
    - The proportion of families who report they are supported in utilizing natural supports in their communities (e.g., family, friends, neighbors, churches, colleges, recreational services).
    - The proportion of families/family members who participate in integrated activities in their communities.
  - Access and Support Delivery
    - The proportion of eligible families who report having access to an adequate array of services and supports.
    - The proportion of families reporting that staff or translators are available to provide information, services and supports in the family/family member's primary language/method of communication.
    - The proportion of families who indicate that services/supports provided outside of the home (e.g., day/employment, residential services) are done so in a safe and healthy environment.
    - The proportion of families who report that service and support staff/providers are available and capable of meeting family needs.
    - The proportion of families who report that services/supports are available when needed, even in a crisis.
    - The proportion of families who report that services/supports are flexible to meet their changing needs.
  - Choice and Control
    - The proportion of families reporting that they control their own budgets/supports (i.e. they choose what supports/goods to purchase).
    - The proportion of families who report that staff are respectful of their choices and decisions.
    - The proportion of families who report they choose, hire and manage their service/support providers.

National Core Indicator measures (cont.)

- Family Indicators (cont.)
  - Family Outcomes
    - The proportion of families who feel that services and supports have helped them to better care for their family member living at home.
  - Information and Planning
    - The proportion of families reporting that their support plan includes or reflects things that are important to them.
    - The proportion of families who report that staff who assist with planning are knowledgeable and respectful.
    - The proportion of families who report they are informed about the array of existing and potential resources (including information about their family member's disability, services and supports, and public benefits), in a way that is easy to understand.
    - The proportion of families who report they have the information needed to skillfully plan for their services and supports.
  - Satisfaction
    - The proportion of families who report satisfaction with the information and supports received, and with the planning, decision-making, and grievance processes.
  - Family Involvement
    - The proportion of families/guardians of individuals not living at home who report the extent to which the system supports continuing family involvement.