

Wednesday, January 23, 2019
Building The Framework For IDD Quality Measures

Thank you for joining today's webinar "Building The Framework For IDD Quality Measures. Concepts for value-based quality measures for use in Medicaid managed care programs responsible for people with intellectual or developmental disabilities."

I'm Erica Lindquist, Senior Director at the National Association of States United for Aging and Disabilities (NASUAD). This webinar is presented through the Business Acumen Center, a part of the Business Acumen for Disability Organizations grant managed by NASUAD and made possible by the Administration on Community Living. Shortly after today's session, you will be able to find the PowerPoint and recording of this webinar (along with the archives of all of the Disability Network Business Acumen webinars) at hcbsbusinessacumen.org/webinars.

There will be time for Q&A at the end of the presentation. Please enter your questions in the Q&A box in the lower right hand corner of your screen.

Today's speakers are Kathy Carmody, CEO of the Institute on Public Policy for People with Disabilities, and Carli Friedman, PhD with CQL | The Council on Quality and Leadership. Carli will describe the roadmap for measures to support people with IDD to receive high-quality services and support.

Thank you, Erica. I'm glad to be joining you today. I'm going to provide an overview of some managed care topics and handed on to transcending who will and some insights. Before specifically talking about quality measures, I want to share some background on the state of managed care in IDD services.

You see a few of the considerations states make in evaluating. In some IDD organizations they have a healthy go to preservation regarding the managed care of arrangements. But looking at the goals states are seeking to accomplish, they generally align with those that most advocates support. And showing that those goals remains central. Guided by strong stakeholders essentially to one of the items I want to point is the lack of consistency of quality measures across dates system. In the waiver applications may vary from state to state and may be more profits orientation such as timeliness of service.

The term managed care tends to conjure up a fairly rigid and prescribed frame work for many of us. In fact there are a variety of ways states approach alternatives for a fee-for-service model pick a few considerations are highlighted on the slide. You see in the second point there is a great bit of variability about how states approach an alternative to fee-for-service payment models. Such as private insurance companies. Public agencies. Private nonprofit organizations, public entities are all among the types of organizations that manage long term services and supports.

As you may experience in your own state the population included in managed long term services and supports can vary. The next slide I

think is a helpful map. Showing managed-care operations for people with IDD across the country. The continuum starts where there is none. The rest is a dark space where LTSS is in a variety of different custom managed-care arrangement. These states have multi-frameworks in place from Iowa and Kansas where the systems are closely aligned with the traditional managed care model with heavy involvement with the insurance company. To Arizona with state overseas the managed-care system. And Wisconsin. You can see on the screen some of the factors that contribute to IDD services riding behind of the population including the lack of a creed upon quality measure. Some of the concerns expressed by stakeholders and advocates include the lack of potential policy.

Many providers would argue their rates are insufficient and further reduction in a managed-care arrangement in order to generate profit. Another distinction within the IDD system is the providers of service to the smaller, more independent and less technologically sophisticated than other organizations in the healthcare arena. The way how interconnected hospitals, physician practices, and pharmacies that become in the past decade with IDD providers tend to be much more silent in other parts of service delivery systems. While IDD services are distinct from physical health services, they are generally paid for through a health insurance program, medicare. So they are still connected. In a fee-for-service model providers are reimbursed for services. An ultimate payment model including managed-care arrangement the value of this service becomes important along with other considerations such as care coordination and incentivizing the outcome.

In many states Medicaid services operate in parallels but not intersected they can contribute the fragmented services and provide no incentive to keep people out of cost of psychiatric hospitalization is a good example. And HCBS provider may not have the resources. Or an inpatient hospitalization event which cost the state inside of medicare but doesn't necessarily pass through the. If those interests second they could be financial incentives to stabilize the person the community center with additional resources but still costs inpatient care. Another example of incentivizing services is in the implement arena where if that is an important policy objective for the state, then using HCBS resources to incentivize providers to focus on service program is something that is done in a different arrangement.

>> Value-based payment and paid for performance are increasingly being promoted in all aspects of healthcare long term services and supports the majority that trend three services across the country are paid for Medicaid dollop is helpful to consider that CMS [Indiscernible]. You can see some of the considerations that CMS identifies. Including shifting the focus from volume of care and incentivizing providers to improve coordination of care using quality measures to improve quality. We do see healthcare costs by reducing preventable this is and providing an incentive's to meet stated goals. While again the notion of managed care tends to be something that is not fully embraced in the transit community, looking at some of the reasons that payers think it is an approach to take attention to, they are hard to dispute and argue with the been described as a reentrant system. Someone that not some of

us think in a good way to describe the disservice delivery system we operate in. Yet it is where CMS could use a fee-for-service model at this point. It's something for us to pay close attention to is we see on the screen some of the systems and tools that are used to measure quality with other population the measures are probably something folks of her to be for a number of measures in five different domains. Heavily focused on preventive screening, medication management, etc. Social determinants of health is increasingly becoming a terminology that we hear in the healthcare arena. It includes metric that impact overall health and well-being by providing stability, security and social support. For example some hospitals and insurance programs are beginning to offer programs that help Subaru utilize our patients to maintain housing and food stability. We increasingly see rights with services partnering with physician practices to ensure patients attend appointments. This is a representative of some of the ways social determinants of health help contribute to overall quality. IDD organizations need to consider how we define and measure the quality of services we provide. For example people and residential services generally have higher risk of medication compliance because we are so heavily regulated in each agency providing the services have to assure that those outcomes are being met. I'm not suggesting we adopt strict medical model indicated of quality for the service we provide, but it is important for us to understand how others value those indicators and that we track and communicate the role as services playing achieving outcomes in these areas.

The final slide highlights some things IDD provider agencies can do to explore and prepare for alternate funding models. None of which are detrimental to organizations existing service delivery. For example being able to quantify the outcomes your services help people achieve is important regardless of payment source. I think one of the items that is most important for IDD organizations and I may have created a fake org is here, did find, demonstrate and devalue services bit we as an industry tend to rely on storytelling, to demonstrate the impact our services happen while that remains important, being able to talk about population impact and how your services really create meaningful outcomes for people is essential. Learning from other sectors of the healthcare industry, looking around and seeing how hospitals, other healthcare providers have organized themselves, to be able to continue to operate and provide services something that continues to be important. One of the things that encourage IDD organizations to think about is that to some degree the future is here. Self-directed services are increasingly becoming a prominent model in HCBS systems. This represents an alternative to the traditional fee-for-service model where providers are paid directly by the state people are much more selective about what they buy than what they get and regardless of whether the buyer is a person receiving services, a family, or a third party nonstate pair, being able to show the value in the service that are provided will be increasingly essential. I would now like to hear things over to Carli. Who will show with the value indicators could be. Carli? Payment thank you, Kathy.

Now let's look at value-based quality. What does this data tell us? In October 2018, organized symposium [Indiscernible] in the LTSS

industry. The stakeholder here organizations. The symposium was designed to develop an understanding of value-based quality measures for people with IDD to ensure that as the industry moved forward the quality metric [Indiscernible]. This presentation is a summary of those findings. It is a roadmap for the measures which would support people with IDD to receive high quality services and support. quantitative announcement was comprised of data from 28 mosaic agencies who supported a total of approximately 3000 people. The data was select it through. Fiscal year 2016 -2018. The main variables in the study was from the basic assurance that the basic assurance is an organizational assessment that ensures health, safety, and security [Indiscernible].

The basic assurances are comprised of 10 factors ranging from staff resources. Within each of these factors there is 92 different indicators that cover a wide range of topics. We will see a number of them today. We looked at a number of more traditional health metrics while including hospitalizations data which was every visit to the hospital regardless if they were admitted or not. Medication errors switching to the documentation of every time there was a medication error regardless of who made them. And documented injuries. Redness, bruising, bleeding, so on. Behavioral issues which marked all behavioral or issues people had. We also controlled for agencies sign which is the number of people the agent reported [Indiscernible] both controls right into the dependent rate variables. Resulting in all the variables I just mentioned becoming great. When I say rate going for, I mean the number of events for every one person in the agency. For example, the hospitalization rate is the number of hospital visit for every one person [Indiscernible]. If I say the hospital rate was 1.5 for every one supported, for an agency that is supporting 100 people, it would be 100 hospitalization.

Now let's look at the highlight of some of the findings. Findings revealed when organization respect people's concern and respond accordingly agencies have [Indiscernible] pick when they do so they had hospitalization rate of 1.03 for every person reported in a three-year period versus 2.57's for when they did not report. Again, this is controlling for the [Indiscernible] agency. When you think of about an organization that supports 500 people, hospitalizations would be projected to drop from 1285 in a three-year period to 515 for an organization respecting people's concern. A pretty huge difference. These respect is a common theme across these analyses. When services support seriously [Indiscernible] respect agencies also have lower hospitalization rate. When organizations put this in place to ensure people had a meaningful day, hospitalization rates were lower at .65 and were supported in a three-year period versus 1.74. Natural supports also resulted in lower hospitalization rate. An organization who had policy practices to facilitate the continuity of natural support systems, there were only almost 2/3 fewer hospitalization however when organization facilitated the desire for natural support there were also significantly smaller hospitalization rates. When organizations had individualize emergency plans, hospitalization rate was 1.038 in the three-year period compared to 2.35 for when they did not have individualize plans. For an organization treated with psychoactive medication for mental health consistent with national standards and

care, hospitalization rates were lower. Furthermore when practices were in place to make sure people were free from unnecessary, intrusive, they were hospitalized less often. As I mentioned, although it's described as individual indicators, we also look at the total number of indicators and how they were practicing. While there wasn't a significant relationship with total hospitalization, there was when you just called out the hospital visits that were not actual admission. Where those unnecessary trips to the hospital are likely to fall. For example, an organization that 20% of the 92 indicators present is expected to have a hospitalization without rate of 2.8 for everyone personally support in a three-year period. There's an agency that has 100% of the 92 indicators present. Is expected to have a rate of point five for every one person to those of those indices supported 500 people, during the 20% on the basic assurances without 1400 hospitals in three years that did not result in admission. For the one that scored 100% would have to hundred 50. That's a huge difference. Especially if you think about expenditures. Medication errors is a big issue. However we found organizations respected people's concern and rate responded accordingly, there were significantly fewer medication error. Similarly, when systems are in place to assure support services and respect they were sick difficultly you were medication errors. When they did this the medication error rate was 3.13 in a three-year period. Whereas when they did not a medication error rate was 9.3%.

Other factors that reduce medication errors for an organization that treated people with psychoactive medication for mental health, according to national standards of practice, there were fewer medication errors. When they treated consistent with national standards of practice, there were three practice, there were 3.13 medication errors for every one person supported in a year. Versus when they did not pick there were 14.92 for every one person reported. Also when people were free from unnecessary intrusive interventions, there were fewer medication errors. Another variable we look at was injuries. With respect to the critical components. When organization had systems across in place respecting people's concerns and responded accordingly, the injury rate of people they supported was significantly lower. When they didn't respect people's concerns, there was a rate of 12.61 injuries in a three-year period for every one person reported. Whereas when they did respect the concerns it drop significantly to 5.5 for a person supported in a three-year period. Similarly when services and enhanced respect, the injury rate dropped from 12.772 5.98. When systems were in place to ensure people had meaningful work connect to the choices the injury rate dropped from 9.36 in a three-year. To 3.02 . When practices were in place to ensure people had meaning for work activities and choices the rate dropped from 7.062 2.06. When organizations tested and put in place to facilitate desire for natural sports, the injury rate was significantly lower. For example, for an organization to support 500 people, the number of injuries was 9600 and three-year. Two 3000 9600 and three-year. Two 3001 year.

In terms of behavioral issues, when organizations respected people's concerns and responded accordingly, behavioral issues rate dropped 11.072 2.7 dropped 11.072 2.74 supported in a three-year period. Same as when there were people working activity choices. When organizations

people had meaningful days, there was significantly fewer procedural errors. When organizations are insured thorough, appropriate and prompt responses to substantiate a case of abuse, neglect, treatment and exploitation and other associated issues identified, behavioral issue rate dropped from 14.864 everyone supported to 2.74 everyone person supported in that three-year period.

Now most of the findings so far have examined have different rates organization support people with disabilities across the health metric. Here are some of the findings related to the way they treat their staff. When organization implemented ongoing staff development programs the behavioral issues rate amongst the people they supported dropped pretty significantly from 14.862 1.97 per person supported in a three-year period. Similarly when organizations treat their employees with dignity, respect and fairness, the rate dropped from 11 point from 11.582 1.97. For example an organization the supported 500 people, who did not treat their employees with respect, is expected have 5800 behavioral issues within a year. Where is if they did treat their employees dignity and respect the number dropped to 1000 or less. Indicated how that staff are treated trickles down. When organizations have shifted some and practice in place to ensure people were free from unnecessary and intrusive interventions, the behavioral issues rate dropped from 27.3 in a three-year period to everyone person supported to 2.7. This example to go down 12,000 in a year., To only 1400 .

Now that we have a better idea from the data of what type of factors can impact quality, let's switch gears slightly and examine the findings from our focus group about the leaders I mentioned we asked the thought leaders not only what quality is but how do we get there? Although health and safety in and of themselves do not fully encompass quality, it was seen as foundational building blocks upon which everything else is built. Once these foundational building blocks are in place, it is important to ensure people have a quality of life. People with IDD must be supported to reach their potential to live a life of quality. Quality necessitates a holistic approach which includes a wraparound, bus delivery service system. Especially during times of transition for quality services and supports attention should be paid toward social measures. Often called social determinants of health or SDOH, the social measures include those factors that contribute to health and quality of life such as central support and opportunities beyond traditional health.

One of the most commonly described aspects of quality is true informed choice. It was recognized that people with IDD must not only have choices but these choices must be based on information regarding the options and opportunities. Ultimately, informed choices about control over one's life. About services and support being person center. People with IDD must be supported to find their voice and power. People with IDD must also be centered in their own lives and have a say what is happening. At such a vast array of services must be designed around a person to meet their interests and choices rather than services and supports [Indiscernible]. Although a person centered approach is a cornerstone of quality, it was recognized that person centered is unfortunately still a [Indiscernible]. Community integration is also

considered a critical of quality. Community is not merely a place where I go or have a presence rather it's a place people have a stake in. A place people feel they belong. Community integration is about engagement and being embedded in the community a place people have connections and feel sociable. Another common theme regarding the quality was ensuring people with IDD have people base including community-based opportunities. People must be able to choose what they do during the day. And though activities these must be with people.

Relationships were also frequently mentioned as a marker of quality services and support. Especially because people with IDD often face isolation. Quality services and support involve ensuring people's IDD have a relationship that are most important to them. Quality services supports also help people with IDD build relationships beyond just that. Including extending into the community. Services and support should also facilitate creation of a natural network of support and lifelong connection. Dignity is respect recognize a vital aspect of quality. People should not only feel respected and valued but the part of dignity and respect people should have control over their lives and have real choices. People with disabilities are truly to have the opportunities which include the opportunities to take risk the best support involves balancing the care and dignity of respite continuity and security was also described as an aspect of quality for people with IDD. Stability and tenure is a critical component to continuity. While in the current service system some turnover is unavoidable. To ensure a lack of continuity does not result. Finally, attendees believe quality involved creative uses of technology. Technology should not only be [Indiscernible] but also utilize to reduce [Indiscernible].

In addition to unearthing trends that what quality services port with people with IDD involved, the findings also revealed potential ways to build quality frameworks. One of the first steps in doing so is to create quality standards. The recognition across the country based on doing different things, but everyone would from a different perspective also these is perspectives were silent and not shared outside of the state or networks. As such it is recommended that best practices and Medicaid managed care not only be established but shared across the network system. It must be collaboration across groups and quality bodies. It is also recommended that quality standards should be based on data measured. How you measure it and consistency high measure. One way suggest it was to help set standards with accreditation.

Accreditation ensures consistency and quality standards across services for providers. In order to create quality standards and build better frameworks we must have cultural change. The current service system is very much entrenched in the culture for service medical models. Fee-for-service model space on number of services provided rather on the quality of services. Older models are often frequently used as well. In contrast, quality of value-based service should aim to build services around the person. Not the other way around. As such, there must be a vast array of services offered and available. When change occurs the must be provided by them. Providers must not only be informed [Indiscernible] but they also must be investing in these things happening. This organizational transformation is necessary at

every level of the organization. From the people writing the support, to organizational leash. Conversation about quality improvement without discussing cost and financing. Too often very intertwined. As noted there needs to be recognition that quality person centered services and support for people with IDD are an investment but however quality is often in conflict with funds. Truly committing to creating personalized services requires a robust and adequately funded survey's delivery system.

Now I know I've thrown a lot of information that you. In a rather short period of time. In essence, what does this all mean? While traditional measures of health are important, many of those factors. Rolling quality services and support and quality of life. I've indicated the finding above with respect, staff training and many more social determinants have an impact on hospitalization, injuries, medication errors and behavioral issues. We need to work to ensure measures of value are holistic and ensure quality metrics are not only value-based valuable to people with IDD. Taken together a findings imply that it may be possible to impact program at a cost by shining the focus on factors that impact quality pics such as dignity and respect and meaningful data. This analysis is the first step in bridging existing social determinants of health and value-based payments literature with long term services and supports, quality of life work. While it is preliminary, it is promising. And should be pursued bigger. If you're interested and information shared in this presentation, for more about the larger project of which this data is encompassed we actually released a report on and the link is on the screen.

Excellent. Thank you Carli and Kathy. We now have time for questions and answers. We have a few that have been submitted. If you have not submitted a question and you have them, please go ahead and start asking those questions in the lower right-hand side of your screen where the Q&A drops down. That is where is that where we can find the information? [Indiscernible] peer review publication? Payment the best place to look is considering a pod. It was 20 agencies with about 2000 people. Right now we're publishing it. We play we have plans to replicate. To work with a larger sample on that. We will move forward with peer reviewed applications when the time comes.

Going back to some of the slides, we had a question about the respect concerns. Can you define respect concerns?

As I mentioned, one of the main variables used in this analysis was basic assurances. Those not familiar, I will give you background. The basic assurances is often used on accreditation reviews. The agency will complete a self-assessment and then [Indiscernible] will come in and they will do observation, focus groups, interviews, and quality-of-life interviews as well. With all that information. All that information they go through decision trees using the basic assurances to decide these items are in place. With respect there is actually, a lot of [Indiscernible] that goes in deciding these items. For some examples, are people treated first? And people received needed support to report complaints? Concerns? They have privacy. And meaningful work activity choices. All of these types of factors are comprising what is respect

and how that's defined. There are all the sub items that I talked about today that cover dignity and respect. If you are interested in what the sub items are, you can find more information about this again, basic assurances on her website.

Can you provide an example of a holistic background services? >>

Kathy, do you want to jump in or do you want me to?

That goes back to the discussion of that Carli and I talked about integrated care systems. Where both sides of the service delivery system, federal health care, long term services and supports, there is some intersection. This is an area I think that IDD organizations do a good job at. And would do well to promote that aspect of their service model. So we and many of our services in the system have wraparound services.

Meaning we have a lot of contact with people. Love access to family pick a lot of history people. We are involved in people's healthcare services. We are involved in people's community activities. We are quite invested and in contact with people and that again is one of the advantages of our service model. Again in many places that is not yet integrated in state plan services. But to the degree that those two intersect, we as providers really have an advantage over any other entity in that arena because of our overwhelming involvement with people and in people's lives. And that compared to other populations which have more segmented service providers, don't necessarily have somebody in that case manager role who is directing traffic in the person's life. That would be less holistic in comparison to our system. Again, if you think of behavioral health, elders, people with physical disabilities, their long-term service and support providers don't tend to be as fully involved and is fully integrated in people's lives is in the IDD system.

Thank you. I understand that many IDD providers are mom and pop shops. Can you comment on the level of help small providers perform assessments on assurances. Similarly, what % of small agencies?

We have actually worked with small mom-and-pop agencies. Is not necessarily more effort [Indiscernible]. It still takes the same amount of time to go in and do the review. So our staff do the review in three or four days of each of these agencies. Sometimes we can tailor the accredited agency depending on the services. In terms of what percent of providers are affiliated that are small agencies. I would have to get back with you to in this case [Indiscernible]. It is not representing all the agencies. It was just a pilot. I should also mention, I did not get to this when I was talking about the focus group, but it is a great fit for your question. One of the things that did come up was the participants in the focus group believe that to build quality framework, payment systems needed to be structures for their NCOs could assure smaller providers are able to provide and not left behind the challenging landscape of larger acquisitions. That is often when the providers [Indiscernible] be able to provide dynamic and personalized systems in support because of their size. It was recognized when we move

forward and managed care to make sure these small providers are not left behind.

Erica, that I tag onto that. I think that concern is something that is prevalent among IDD organizations across the country. I don't have this statistic but I know the national core indicator staff's ability survey what we heard from some of the folks involved with that, was that the number of organizations participating that served a small number of people was a little surprising. What I think in fact it reflects the framework of the IDD system. I think that is one of the issues that our system is a little sister different than some of the other players in healthcare industry which are much larger again. Much more network. Much more affiliated already. But I do think that there are a lot of opportunities for the organizations of all size to look into the future and as I said, whether your payment model changes or remains the same, there is certainly some things we can look to other industries to see how they might work and hours. And be able to recognize the value of that.

I also think one of the things that we really try to emphasize and I will give a plug is part of the learning development quality in Illinois. The focus is to help organizations look to the future. To think about what they may need to do as an entity to continue to be able to provide the mission-based services that they are. There's a lot of different types of provider arrangements beyond simply that activity. People are familiar with the models breaking out in Arkansas are, and New York were provider led efforts in partnership with some hospital services, with some funders, but really keeping provider agencies that are essential and central to the lives of people with disabilities. Very much involved. And helping to shape what those systems are going to look like moving forward. So I think that is a common concern that IDD organizations expect. But I think in preparing for recognizing what could be possible in the future and preparing ourselves as best as possible is the best way to assure that you continue to be able to provide services.

>> On the data component, how do you quantify something like meaningful days?

>> Meaningful days is quantified by the decision tree. You take the qualitative information and you end up with a qualitative [Indiscernible]. Some of the topics included in activities were connectivity choices. To decide [Indiscernible]. Do personal [Indiscernible] identify the work and recreational activities people want. You people receive the support needed to make choices about the kinds of work and activities they prefer? Are services and support focused on the people to achieve their goals and desires? Are the act entity and work options available to people age-appropriate and cultural normative? And promoted positive self-image? Are people paid fairly for the work they perform? Are people to supported to rid of setting are people actively supported to engage in community life? Are people supported to control the personal resources? While all of this information is used [Indiscernible] .

>> Thank you. Did you take a baseline of where agencies were functioning prior to making changes?

This was not a pre-post examination. We were not looking to standardize action to see the change. We were just looking at the relationships between having these items present and how that related to hospitalizations, etc. There was no baseline. Just everything was taken it one time.

Do you have detail on what type of provider participated? Residential, employment, state programs? Been it was all of mosaics agency. They have a network of different agencies across the nation. And they did provider range of services, residential appointment. A wide range of services, agency sizes, type, location.

>> Did you take into consideration how many IDD providers have an electronic health record? Or other use of technology?

No, that was not a component. We were limited by the data. We did not have information on technology. Moving forward we will expand the study we are interested in. Especially all the literature talks about how technology can be really useful in quality and managed care.

>> What role can public payers, commercial payers play in building the framework of providers

This is Kathy. I will jump in first. I think one of the, that I would say one of the most essential roles that the public and commercial players payers can play is assuring broad and deep stakeholder engagement. So the IDD system is acknowledged as being dramatically different from other service delivery systems that are further along in their evolution of funding models. And not acknowledging and appreciating, understanding the system that exists today, and where it came from, and role that public policy has played in shaping it, families have played in shaping, the role that the smaller provider organizations played to not fully appreciate and consider that, I think that is where we see a great deal of concern about what the future may hold. So that to me is just one of the most essential considerations that any payer would want to make. I think from CMS and the HCBS system, the importance of a person focus on plan and service delivery, it is again essential.

Again I think in some ways thing I think CMS has put out guidance on the process that states should follow if they are considering a alternative to the fee-for-service model. The most important is that it be thoughtful. That it be engaged and that it not be something that is done in the short term, or something done exclusively or primarily in the interest of cost savings. It is rebalancing a consideration? If concern centralizing? Or looking at being able to serve more people with the resources that exist, those are some of the public policy considerations. But if the chief motivation in wanting to look at an alternate payment model is to save money, I think it is destined to be a very bumpy ride for everybody who is involved with that service delivery system. And from what we have seen from other states at least

in early phases, difficult to demonstrate that indeed savings have been yielded for going through the managed care system through IDD system. Carli you may want to add to that?

Unmuting my cell. You covered my thoughts.

More on the application. Quality agencies use the [Indiscernible] to cross index to better serve populations with limited English proficiency. In immigrant populations. And [Indiscernible] in IDD look like for potential [Indiscernible] purchasing

For the special determinants of health index I did not cover that. But basically that is the new way we created to measure people with social determinants of health and help facilitate that. The service providers. That is in the report as well as a newsletter that is coming out this month. It is specifically designed to work with people with disabilities. I'm not sure if I would necessarily recommend it with people with limited English. Especially because the personal outcome measures hasn't been really utilize. It is aimed at targeting for facilities especially for people with IDD. I will put that copy it aside. It wasn't designed specifically to work with other populations. In terms of what might a social determinant for cost intervention in IDD look like? I think it would be once we have this data, this is the pilot. Once we are able to replicate and fineness topics, it will help facilitate social determinants of health.

For example reduce hospitalizations which we know is tied to [Indiscernible]. Once we have those items such as dignity and respect that is the areas we can target. When you get to the sub levels I was mentioning, for example when someone asked about weaning for work in a dividend choices and I talked about the subtopics, I think we could target the specific areas and that would be a great study also. To examine how those interventions improve the overall, not only social determinants of life but the quality of life of the people being supported.

>> Erica, this is Kathy. More generically I would respond that this area of interest is where IDD organizations in many cases really are at an advantage. And should seek to highlight that. And to seek to grow that. And seek to quantify that. Again, we are somewhat unique from other service delivery systems in the robust development we have in people's lives. Many people, not all, who receive services from provider organization. It has been an area where we have regular contact with folks. The more traditional case manager for a health insurance company. Who might not ever see a person in person. But we see our folks on a very regular basis. Intend to have a lot of information and involvement in a variety of aspects of their lives. I think it is one of the places where IDD organizations are ahead of the curve. That want to be able to demonstrate the impact that they have on people's lives. And do so in a way that is meaningful for people who may not fully understand what we do. I kind of think there are two languages out there. Not everybody understands our language and may not be in a position to learn it. We want to think about what language they speak

in and how we can help them understand the value and services we provide in a way that is meaningful for them.

Thank you. Point us toward information about determination of meaningful work and choices. Who made the decisions? Did participants respond and who supported their participation?

So I would recommend going to our website. And just searching the basic assurances. You can see the full report and the information is in there. To recap, it is a review from the staff. They go on site. They do interviews with people receiving support. They do focus groups of people receiving support. They do interviews with support staff that they talk with organizational leader step that they do observation and employment and home settings. They look at records and may take a combination of all this information. A triangulation pick and the look at that information following the guidelines in the basic assurances. So it's a lot of information getting boiled down into what I presented. Numerically yes like 500 probes within the basic assurances.

>> We have a question going back to slide five. The snapshot of MLTSS. Cathy, can you recap that slide and talk about the number of states including IDD and their LTSS, MLTSS programs quick

We've got slide five in front of us. If you go to the bottom of the chart indicators you will see the dark blue state description. The statewide managed MLTSS. Manage medical care. MLTSS. Those of the states that have essentially they are direct systems incorporated into some sort of a non-fee-for-service model. Again, I prefer the term alternate payment model because I think the term managed-care is very prescriptive and some of the ways that these states operate does not conform to that more traditional medical managed-care model. So this states that do include Iowa and Kansas. And I described some of the other models in other states. You see the next show is where there are some emerging different approaches to services. So New York and Arkansas have some provider led and involved organizations that are just emerging and will play a role in managing service delivery for people that again doing so in partnership with an insurance company, health providers, a little different approach than I think what we typically think of as a managed care model. Again, you see some of this states that are white that don't have managed-care. EC states in the light blue with IDD.

Thank you. I think that closes out the questions. This will be our last call for questions for Carli and Kathy. In the meantime, do either of you have any final words that you would want to share with the audience?

So this is Kathy. I think the data that Carli presented is helpful to organizations thinking about how could I organize myself as an organization? What should I be focusing on? What are some things we can look toward to quantify that we do effectively? I think it is a good starting point for looking at some of those. I certainly would put a shout out for the business acumen center. And the resources that are available to that through agencies to begin to look at what are some of the things that we might need to think about. Procedurally.

Organizationally. As we think about how we might position ourselves to be as successful and as continuing to thrive in an alternate funding model. And we don't know what that might be necessarily but we want to explore and understand what possibilities are out there. And how your organization is prepared or could be better prepared to be able to function in a model like that.

I would also add we are in the preliminary stages of this. The majority of states are not doing managed-care for people with IDD. So as we look forward and that direction, I would say try to make [Indiscernible] with agencies is much as you can. If you're not at the table, you are on the menu. We have a real opportunity to make sure the list of providers being supported are heard and followed as we move in this direction. Especially I think there are necessarily standards for managed care for people with IDD. There are more opportunities to help determine the direction that things go. And ensure that the items that are selected as priorities are really the most valuable to people being supported.

I echo that strongly. Well thank you both for today's presentation. And thank you to everyone who joined us today. I want to remind everyone that this webinar including the slides and the recording are saved and can be found on the www.hcbsbusinessacumen.org website. There is a good archive of many of our archives on that site. You can also email us with any additional questions after this webinar at businessacumen@nasuad.org. Thank you all and we will talk you talk to you again in February. >>