

**June 28, 2017
12:45 pm CT**

Coordinator: Welcome and thank you all for standing by. At this time all participants lines will remain on a listen only mode. During the question and answer session, please press star and 1 on your touchtone telephone. Today's conference is being recorded. If you have any objections you may disconnect at this time. I would like to turn the call over to Meredith Raymond. You may begin.

Meredith Raymond: Good Afternoon! Thank you for joining us for the second event in our HCBS quality webinar series, *Home and Community-Based (HCBS) Quality Framework Development*.

This series consists of informational webinars occurring on a bi-monthly basis to build awareness of ACL's commitment to and development of HCBS quality measures and to provide a platform among internal and external stakeholders to share developments and collaborate on efforts concerning HCBS quality. Last month, we hosted our first webinar, What is ACL's interest in HCBS Quality? which provided an overview of ACL's quality initiatives.

Today, we will delve into the framework development initiative. The lack of an organizing framework used to analyze measurement gaps has caused

difficulties in determining where resources should be allocated for future measurement development. In an effort to help bridge this gap, ACL was a lead contributor for the Department of Health and Human Services in the development of the 2016 National Quality Forum Report: *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*.

The report was a 2-year project that involved the development of a standard HCBS definition, creation of a conceptual framework for HCBS measurement (including domains and subdomains of development, and also characteristics of high-quality HCBS). It also required NQF to produce an environmental scan of existing HCBS measures and instruments.

ACL also served in advisory an advisory capacity in the development of The SCAN Foundation publication, *What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs*. This publication includes four essential attributes of a high-quality system of care that supports system transformation and evaluation.

We are fortunate to have representatives from both the National Quality Forum and SCAN Foundation speak about these framework developments.

The agenda is as follows:

Kim Ibarra, Project Manager from the National Quality Forum will provide an in depth overview of the 2016 NQF Report: *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*.

Dr. Bruce Chernof, Executive Director of The SCAN Foundation will discuss the publication, *What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs*.

The presentations will be followed by a 15 minute question and answer session. At the conclusion of Dr. Chernof's presentation the operator will provide directions on how to enter your question into the Q&A queue.

To begin, I'd like to introduce Kim Ibarra. Kim is a Senior Project Manager at the National Quality Forum where she supports the Quality Innovation portfolio, including the NQF Measure Incubator and National Quality Partners work. Prior to joining NQF, Kim worked as a quality improvement consultant for one of the largest regional home and community-based care providers in Ontario, Canada. Thank you, Kim!

Kim Ibarra: Thanks Meredith. And thank you ACL for inviting me to represent today and for HHS this project, at the National Quality Forum. So as Meredith mentioned, what I want to do today is provide a brief introduction to the National Quality Forum and the HCBS Quality Project and then do a deeper dive into the HCBS Quality Committee's recommendations including their prioritized domains and sub domains and some example recommendations that they made to advanced quality measurement in this field. For - and then I'll wrap up with a conclusion before turning it over to Bruce Chernof.

The National Quality Forum is an independent nonprofit membership organization. We convene stakeholders with diverse expertise from across the US, to collaborate on improving health and healthcare quality through measurement. Traditionally, our work has been focused on clinical medical care and measurement. And so a few years ago we began to look outside of this area at quality measurements. And this HCBS project really represented a new frontier for NQS.

The purpose and objectives of this project were to convene multi (unintelligible) with the highest priorities for measuring home and community

based services quality to develop a framework for measurement including a definition for HCBS, to conduct an environmental scan for existing measures and measure concepts, in order to be able to identify where there are gaps in measures and where we need to develop high quality HCBS measures. And then finally, to make recommendations for further end quality measurement in this field.

I wanted to take a moment to recognize the multi stakeholder (unintelligible) work, as well as the federal advisory group and my NQF colleagues, who participated over this two years period. So you'll see displayed, I won't go through everyone's names, so we had a very diverse and very engaged committee involved in developing these recommendations and putting together this report. And a variety of federal partners who advise the work throughout the process and, my NQF colleagues who contributed to the product management delivery of end writing of the reports.

This officially began in the fall of 2014 and we conducted a series of meetings with our committee via the Web and also in person, in Washington, DC that resulted in the three interim reports and the file report published in September 2016. This is just a screen shot of the report and I would encourage people to go onto the NQF Web site and access it. It's really rich and its recommendations and information. And so I'll only be able to scratch a little bit of the surface here today even with my deeper dive.

At the last webinar, Eliza Bangit from ACL, spoke - interest in HCBS quality and she provided an overview of some of the key elements of the report including the definition for HCBS, characteristics of high quality HCBS, an overview of the conceptual framework for measurement, which included the 11 HCBS domains - barriers to measuring HCBS quality and provided an overview of some of the committee's global recommendations.

So I won't go through all of this here as I don't want to entirely repeat what Eliza presented, but I did want to just present the definition for HCBS that the committee came to consensus on over the two years. This definition included and feedback from our (unintelligible) framework which shows the 11 domains and at different levels, the system provider and consumer levels, and showing that continuous measurement and quality improvement, leads to our ultimate goal of improving consumer outcomes for people who are using HCBS.

And what I'll do now is a deeper dive from Eliza's presentation into the committee's recommendation for HCBS quality measurement. The committee made two types of recommendations. The first type were global recommendations. And these were overall approaches to quality measurement - stakeholder should think about doing across the board when thinking about quality measurements. And the second type of recommendation they made were domain specific recommendations.

And so they made recommendations for each of the 11 domains and they organized them into three categories - short term, which represented measures that were ready to be used or could be expanded on in the near future; intermediate recommendations where more development was needed to get the measures ready for use; recommendations which were areas where there was really more research needed, particularly where there wasn't quite enough evidence yet to support measure development and so the committee wanted to make sure that resources were devoted to support the research needed in those areas to eventually get to measures.

There were seven global recommendations and these applied across the board to quality measurement in HCBS. The committee really felt like quality

measurement needs to happen across all of these domains and sub domains. While they recognize that not everything can happen at once, they wanted to make sure that there is something happening in all of these areas. They also didn't think that - they also felt that it was important not to recreate or not to reinvent the wheel, that there is a lot of efforts going on around quality measurement and wherever possible, we need to be building on those efforts.

We emphasize the importance of standardizing approaches across HCBS around data collection, storage analysis and reporting and leveraging technology wherever possible; having different types of measures, so looking at structural measures, process types of measures, outcome measures and units of analysis. So looking at measures that can be used on an individual basis but also organizationally and at a system wide or even a state level.

And the last two were around developing a core set of standard measures that stakeholders across the HCBS system could use, so there was some sort of standardization, but also allowing and recognizing that there are different population settings and programs that might need their own types of measures and being able to select a tailorable set of measures for those specific situations. And convening a panel of experts in HCBS to evaluate and improve those measures was really important.

Now I wanted to go into the committee's prioritized domain sub domains and provide some examples of domain specific recommendations. And many of the domains and sub domains that I'll talk about here align nicely with the essential attributes that you'll hear Bruce speak about in the next presentation. The first domain was service delivery and effectiveness. And the committee defined this as the level to which services are provided in a manner consistent with a person's needs, goals and preferences that help that person achieve their desired outcomes.

And in this domain the committee prioritized two sub domains, one around delivery and one around whether a person's needs are met and their goals are realized. There were a number of recommendations and I just pulled out three here, to give you an idea of the type of recommendations the committee made in this domain. And I'll focus here on the first short term recommendation was expanding the use of process measure concepts. So the committee had recognized that process measures existed already for whether someone's needs were met and goals were realized.

And so it was important to build on this effort and in the short term, try to get these measure concepts used in more places. And then in the intermediate term, thinking through moving beyond process measures to measuring outcomes that are person centered, so trying to figure out what really matters most to patients and to people and to consumers and developing outcome measures that assess what matters most. Building on that, the next domain was around person centered planning and coordination, which was defined as an approach to assessing, planning and coordinating services and support focused on an individual's goals, needs, preferences and values.

And here there were three sub domains that the committee prioritized, each one focused on a key component of person centered planning and coordination - so assessment, planning and course coordination. And here again, a couple of example recommendations, just to give you an idea of where the committee thought measure development could focus and where resources should be allocated to support quality measurement in this domain. And here I'll just call out the intermediate recommendation which was around promoting a balanced approach to developing and using system and individual level measures.

So not wanting only person centered planning measures that look at individual care, but also seeing whether there can be some measures that are at an organizational level or a health system or home and community based services system levels. Choice and control was the next domain and this was around the level to which those who use HCBS make life choices - choose their services and support and really control how those services and supports are delivered.

Four sub domains were prioritized here around personal choices and goals, choosing services and support, personal freedoms and the dignity of risk and self-direction. And in the short term, one of the recommendations her was looking at the measure concept and instruments that are already in use and trying to determine their validity and reliability. So the committee recognized that there are a lot of tools and measurements that is currently happening to assess whether people are able to make choices, whether those choices are being respected. And so that was really a great foundation to be able to develop those into measures by looking at whether this was reliably assessing the concepts that were important.

The next domain is around community inclusion and this was the level to which people used HCBS are integrated into their communities and are socially connected in accordance with personal preferences. The committee recognized that everyone is different and has different preferences of how socially integrated or how socially connected they want to be. And the sub domains here were around that level of social connectedness, people's relationships, meaningful activity and whether there are resources and settings that facilitate community inclusion.

And here in the short term, an example recommendation, was around identifying and expanding the use of process and structure measures relating

to meaningful activities. So the committee noted that some measures already exist related to employment or education and thought it was important to build on these measures and make sure other people were aware of them and able to use these in practice.

Caregiver support was another domain and this was defined as the level of support available to and received by family caregivers or natural supports such as friends of individuals who use HCBS. And four sub domains were prioritized here - caregiver wellbeing, their training and skill building, their involvement in services and supports, and their access to resources. An example here of a long term recommendation was developing data collection and data management infrastructure for this measure - for measurement in this area.

So the committee recognized that it's important to be able to measure these things. But in order to do that, we need mechanisms to be able to collect data on caregivers. Currently the data that's collected related to consumers is consumer focused and focused on their care plans, the services they're receiving and their interactions with different providers. And there may not be areas where there are even fields to collect any information on caregivers and actual supports. The next domain was around workforce. So we looked at family caregivers and actual support and then we wanted to look at the paid workforce for HCBS.

And the definition of workforce as a domain here, was the adequacy, availability and appropriateness of the paid HCBS workforce. This domain has seven prioritized sub domains - person centered approach to services, demonstrated competencies including cultural competence, safety and respect for the worker, sufficient numbers, dispersion and availability of workers,

adequate compensation with benefits and workforce engagement and participation.

And an example here of a short term recommendation was developing worker retention and turnover measures, worker wages and benefits, satisfaction, training and skill competency. And it's a short term recommendation even though there's a lot here. The thought was a lot of these measures currently exist, they're just not specific to HCBS. And so it didn't seem like a - it seemed like more of a short term recommendation to make these measures into something that was specific for HCBS quality.

The next domain was around human and legal rights. And the definition here was the level to which human and legal rights of individuals who use HCBS, are promoted and protected. The five step domains were prioritized from a larger - that were identified as the highest priority from committee work freedom from abuse and neglect, optimizing the preservation of human and legal fights, informed decision making, privacy and supporting individuals and exercising their human and legal rights.

The committee noted that there were already measures that existed in HCBS programs that assess human and legal rights and so a short term recommendation here was thinking about trying to get those measures into more programs and having them expanded across states and across the country. Next was equity, and this was the level to which HCBS are equitably available to all individuals who need long term services and support. And this is contrasted with the concept of equality which is distributing an equal number and amount and type of services and supports to everyone regardless of need.

The committee thought it was really important to take into account and allocate resources based on who needs what - the greatest needs are. And the four sub domains here were around (unintelligible) access and resource allocations, transparency and consistency, availability of services and support and reducing health disparities and service disparities. And here again, similar type of short term recommendation is building on what currently exists related to in this case, housing, homelessness and transportation and trying to expand the use of those measures across HCBS.

Next is holistic health and functioning. And the committee took both an individual perspective of health, but also a population perspective of health and wellbeing to define this domain and the sub domain. So the definition here is the extent to which all dimensions of holistic health are assessed and supported. And the sub domains you'll note - the first is focused on the individual health and functioning, and the second is this concept of health promotion and prevention at more of a population level.

And the example recommendations here are kind of a step wise process to get us towards measure development. So in the short term, the committee thought there are tools that currently exist that are - that currently exist that are used in community settings. And let's figure out what those tools and then from there we can next develop quality measures using the tools that are already used. So we're not having to go out and create a new tool to assess holistic health. We're going out and seeing what people are currently using. Can we standardize this? And then can we build measures from it?

Next, the system performance and accountability, which was defined as the extent to which the system operates efficiently, ethically, transparently and effectively, in achieving desired outcomes. And this domain was really focused at that system level and so the sub domains are around financing and

service delivery structures, evidence based practice and data management end use. And an example here of a long term recommendation, is to use this HCBS quality framework, as a way to evaluate any new and innovative HCBS delivery systems that start to come into play.

And the final domain is consumer leadership and system development which the committee defined as the level to which those who use HCBS are well supported, to actively participate in designing, implementing and evaluating the system at all levels. And the three sub domains here where that assistance supports meaningful consumer involvement, that there is evidence of meeting consumer involvement and also evidence of meaningful caregiver involvement.

And a short term recommendation here is making sure there are resources available to develop consumer leadership reporting so that consumers are - feel they have the skills and ability to participate, that there are structures in place to facilitate their leadership in developing HCBS programs. That was a very quick overview of some of the committee's work over a two year period of time, to build a foundation for quality measurement in HCBS.

And while this begins to lay the groundwork, I think the committee and all of us involved recognize that there is still a lot of work to be done. Some next steps the committee recommended, were to develop and test measures that really look at all of the different aspects and facets of HCBS quality that we need NQF endorsed measures to be used, so that we know that they are the highest quality when they're being used in the field. We really need to strengthen data infrastructure in order to be able to support quality measurement in this area and to continue to use multi stakeholder collaboration.

I think I can't emphasize this enough. The - we had so many stakeholders involved and around the table contributing, and the value of hearing all of the different perspectives, from consumers, from caregiver advocates to health plan service providers, our federal advisory group and others, really made sure that we captured all of the different things that were important to improve the quality of HCBS and help consumers achieve their goals of living and receiving care in the community.

Some of the good news is that efforts are currently already underway to further HCBS quality measurement. You heard some of this already from the first presentation. And you'll hear some of this from Bruce and others who present after us, in further webinars. And so the continued work of ACL, National Quality Forum, SCAN and many others, will I think hopefully help advance quality measurement in HCBS and really improve the quality of care. So with that, thank you all and I will turn it over to Meredith.

Meredith Raymond: Thank you Kim for your comprehensive overview of the report. Now I'd like to introduce Dr. Bruce Chernof who currently serves as the President and Chief Executive Officer of The SCAN Foundation, whose mission is to advance a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. The SCAN Foundation is one of the largest foundations in the United States focused entirely on improving the quality of health and life for seniors.

Previously, Dr. Chernof served as the Director and Chief Medical Officer for the Los Angeles County Department of Health Services. Dr. Chernof has also served as a Regional Medical Director for Medicaid and SCHIP programs at Health Net, a network model HMO. In 2013, Dr. Chernof served as the Chair of the federal Commission on Long-Term Care, which produced a bipartisan report to Congress recommending reforms for our nation's long-term care

financing, delivery system, and workforce needs. Dr. Chernof completed his residency and chief residency in Internal Medicine as well as a Fellowship in Medical Education at UCLA. He earned his medical degree from UCLA and completed his undergraduate work at Harvard University. Currently, Dr. Chernof is an Adjunct Professor of Medicine at UCLA.

Dr. Bruce Chernof: Okay. That introduction just makes me scared. It's such a pleasure to be here with all of you today. Thank you so much Kim, for that - Meredith, for that kind introduction. Kim, thank you for an outstanding presentation. The leadership of NQF In this space, is incredibly important. For all of you who joined us today, I want to pick up on a word that sort of threaded through Kim's entire presentation. And the word is person. So if you take one thing away from today as we think about the future of value based measurement and new models of care, if we could see the person and not the patient, that's a huge step forward.

So on behalf of the SCAN Foundation, I'd like to thank the Administration for Community Living for creating and hosting a webinar series on elevating the person and what's really important to them in quality measurement and evaluation. I'm not going to reintroduce myself. Meredith has said more than needs to be said about me. But what I do want to say about the foundation is that we care very deeply about getting the voice of the individual, their caregiver and their community inserted into this discussion.

The challenge for quality metrics now is they're predominantly developed for and by those who provide care and those who pay for care. And really, we're not going to get to a value based model, a value based system of care until we actively engage individuals around their goals and aspirations for the outcomes that they want. So today I'll be presenting work that we

participated in that we help support, entitled What Matters Most - Essential Attributes of a High Quality System of Care for Adults with Complex Needs.

I think it's really important to elevate the characteristics of high quality HCBS delivery systems. And Kim has really outlined them pretty nicely for us. But again, you'll see that they're very well echoed in the essential attributes which are the backbone of the document that I want to share with you today. While each essential attribute elevates what's most important from the person's perspective, the workgroup that we work with also outlined what a delivery system would need to look like to achieve each of these essential attributes.

So the takeaway here for all of you is that a high quality HCBS delivery system includes and is responsive to what matters most to people with complex care needs. And it's the thing that I just think the NQF folks - in the work that Kim just presented. Before I dive into the four essential attributes in particular, I just want to talk a little bit about the process that came to these recommendations. We really agree with NQF that stakeholders are key and the engagement process is key. So with the support from the alliance for health policy and the organization health management associates, SCAN Foundation convened a workgroup of diverse experts representing the interest of adults with complex care needs.

But again, really coming at this if you were to think about what Kim has shared with you and what I'm sharing with you is the same issue but with different eyeballs. Right? So if Kim's perspective was really from the delivery system perspective, trying to be deeply engaged and inquisitive into the lives of high needs individual and their caregivers, we really try to have this discussion start with the individuals with needs and their caregivers and sort of look into the delivery system and what they would hope to achieve.

As you can see, the workgroup members are a really wonderful and diverse group and they've all affirmed their support and commitment to advancing the essential attributes. And that represents about 90% of all of the participants who work on this project with us. In addition to the workgroup members, we had federal officials working on relevant programs participate in an ex officio role and their ideas and expertise are reflected in this document as well. So the first order of this group was to examine a comprehensive literature review on quality frameworks and measurements for serving people with complex needs.

And that based on this review, the workgroup members recognize the gap, which was a statement of what a delivery system must have to effectively serve adults with complex care needs. So on this slide you can see a couple of key definitions that were developed in the workgroup consensus process. And I'll tell you this kind of work is hard. And to get there we involved - we used in person meetings, webinars, individual interviews, to really capture a full range of perspectives.

And what you can see is that we defined an essential attribute as a feature regarded as a characteristic or inherent part of care delivery by providers serving adults with complex care needs which affect its success or failure. And an adult with complex care needs is an individual having two or more mental and/or physical chronic conditions and additional functional limitations that collectively have an effect on health status and quality of life. So let's get right to the attributes.

Here's a nice summary table and this is present in the document as well. I'm going to walk through each of them, so you all don't need to pull out your magnifying glasses to try to read everything that's up on the screen at this point. I think what's really important here is that the group developed a goal

statement for the essential attributes as a whole. And that goal statement says that individuals are able to live their lives with services and supports reflecting their values and preferences into least restricted, most independent setting possible, with access to a delivery system that respects and supports their choices and decisions.

So one of the things that was really nice about this definition is I think it really touches and overlaps and harmonizes with what Kim shared earlier. And I think that's a very powerful observation, that providers, payers, delivery systems, thought leaders in quality, really see it the same way as those receiving care and those who serve in a caregiver role. Moving onto the next slide, I just want to touch on each of the attributes quickly. So the foundation partner with the National Quality Forum defined communities that are implementing one of the essential attributes.

And what NQF found is that the first essential attribute that a person's medical and nonmedical needs are being identified, evaluated and reevaluated, is most commonly being accomplished using the data, measurement tools and instruments, in innovative ways. Unfortunately, real life examples of communities implementing the other essential attributes, are far less common. And serve as a roadmap for delivery systems that aim to be person centric and for measure developers, as they create the next generation of quality measures for complex care patients.

So the bottom line here is we're at the beginning of a trap and I would really strongly encourage all of us to take a big step forward. Moving onto the next slide, in closing, while each one of the essential attributes is essential - oh, I'm sorry. Bear with me a second. The second essential attribute (unintelligible) that people want to be meaningful partners in the development of their care plans. For a delivery system to meet this essential attribute, it must support

the person and their caregivers, guide the care to the greatest extent possible. It has to empower each individual with tools and strategies to promote his or her strengths and the self-management of care within the care plan.

And finally, we need to use individual choices and priorities to help guide the most appropriate medical and social support strategy that is accessible and aligned with the person's values and their caregivers' needs. If we move onto essential attribute 3, the third essential attribute highlights that people want a delivery system that makes sense, where they can easily access supports that are needed and avoid services that they frankly don't need or want. So for a delivery system to meet this essential attribute, it must insure high quality, coordinated and integrated care, as well as accessible services that meet a person's full set of care needs, in the most appropriate setting.

It's got to provide timely information of benefits, cost, risks of care, as well as service options to insure that people and their families and their caregivers make decisions with all applicable information. and finally, it's got to provide culturally competent care and services that meet the needs of the individual, their family and caregivers, and really take into account the person's strength, health literacy, language proficiency and social and environmental circumstances.

In the fourth essential attribute, what we find is there needs to be a feedback loop. That feedback loop is where people receive services and support that can inform the way a delivery system is structured. For a delivery system to really meet this essential attribute it's got to solicit and be responsive to inputs from individuals, families and caregivers, provide avenues for feedback beyond the usual kinds of grievances and appeals stuff that we all tend to do. It's got to evolve based on the input received from a design, implementation and evaluation perspective that really engages people.

In summary, I think it's really important that we think about that - where this work needs to go. And from the foundation's perspective, you know, partnering with NQF, this idea that I mentioned at the beginning, that communities are how and where these essential attributes are going to be built, implemented and tested. And as I said, the first essential attribute is the one that kind of has the most meat on the bone at this point, but we have a long way to go with respect to not just that attribute, but the other three most particularly.

And as I was saying, you know, the real life examples just aren't there, particularly when it comes to those latter three attributes. So there is a lot of work to do. I think for us at the foundation, we're currently cofounding a project with the John A Hartford Foundation, which is being handled through the National Committee for Quality Assurance, our friends at NCQA, to develop tests and explore what a set of person driven outcome measures that reflect the essential attributes might look like. The exact essential attributes I just presented today. And we hope that those draft measures will be available in the fall, and we look forward to additional opportunities to support healthcare delivery systems as they incorporate what matters most to folks.

And I would say for those of you who are on the call who are from delivery systems, you know, these - we're going to be looking for - NCQA will be looking for organizations that want to pilot and try these. And, you know, the best way to understand how these measures might work and again, having run large delivery systems and worked in large delivery systems across my career, we all don't need one more thing to do. On the other hand, this is the future of where we're going and I think the opportunity to test these measures be part of evaluating how they work, how useful they are and to provide feedback about

how - you know, so future evaluation, accreditation and oversight activities is incredibly important.

So in closing, I just think it's important that while each of the essential attributes is essential, it's when we take all four of them together, when we see them knit together as part of the entire delivery system, that's when we actually address what matters most to the person - respecting and supporting their choices and their decisions. And it's our hope as a foundation, that these essential attributes can continue to elevate the person and what's really important to them.

So two last thoughts before I turn it back over to Meredith, and Kim and I are open to questions. The first is I just want to acknowledge as somebody who's spent most of my time in the operating world, it's all about balance. Right? I think one of the challenges we already know, there are probably too many measures out there. It feels too granular. And the reality is, we're probably going to need to prune back those measures - technical quality healthcare is really important. So as a physician I'm not saying we should walk away from those. But we've got to get quality of life and personal outcomes on the table.

I think that's incredibly important and the kind of the corollaries to kind of understand and acknowledge that not everything that's important in healthcare needs to be measured and not everything that we're measuring right now is frankly all that important to individuals. And trying to strike that balance of both technical quality measures but fundamental outcome measures as seen through the eyes of people and their caregivers is key. And we're at the beginning of that journey. Thank you.

Meredith Raymond: Thank you so much Bruce, for that comprehensive overview. We're now going to move forward into the question and answer portion of our webinar.

Operator, would you please provide direction on how the audience can enter their questions in the queue?

Coordinator: Thank you. At this time, if you would like to ask a question, please press star and 1 on your touchtone telephone. You will be prompted to record your name in order to be introduced. Once again, please press star and 1 on your touchtone telephone. Please hold a few moments for any questions. I'm currently showing no questions coming into queue. And I'm still showing no questions.

Meredith Raymond: Okay. Thank you Operator. While we wait for questions to come in, we have a couple of questions here. Bruce and Kim, how can local and state level organizations be involved in HCBS quality framework development?

Dr. Bruce Chernof: Kim, do you want to start?

Kim Ibarra: Sure. So if you look at our committee roster and who is involved, we had a number of local and also state level participants. And I think looking out for opportunities where there are groups that are convening. Groups like NQA groups, like the SCAN Foundation that are convening committees or expert panels, I think that's a great way to get involved, I think at a more local level, looking at who is in your community and is doing work in this area. I think people recognize that no one stakeholder group can do this alone.

And what we found in our work is there is power in numbers and people are really willing to share what they're working on to talk about best practices, to identify challenges and barriers. And I think that local level, those local connections, with others doing similar work, is a really great way to get involved at the community level and at a state level.

Dr. Bruce Chernof: So building on that - I think Kim's observations are right on point. I do think a couple of things are true. One is sort of voicing up the food chain, looking for opportunities to shape the dialog as it happened. But I also think that there are things that one can do locally right now. So, you know, if I was in a delivery system, if I was in a community, I'd sort of start with basic questions about how well do my local providers even do the most basic things. Do we acknowledge who caregivers are; do our goal capture in people's charts; do we know anything about function; is the EHR that one has, see function as something that should be captured and measured so that you can actually understand what need is, or is it just sort of lost in the free text portion of how the medical record operates?

And I think, you know, beginning a local discussion of how do we capture voices of individuals and use that feedback beyond some of the sort of traditional things that one might do like your sort of (unintelligible) satisfaction surveys. You know, I also think that there are questions, you know, that are being developed and tested. And so looking at the case studies that NQF did, there may be some organizations there that are using some measures of quality that another organization might want to pick off and try.

Managed care organizations, not quite a dozen are actually piloting the first step of person reported outcomes and goal attainment measures with NCQA at this point. So they're really playing a role in saying what works, what doesn't, what are we experiencing, how hard is it to collect this data? I think, you know, if other organizations were to tap NCQA, there would be opportunities to pilot those questions in whole or in part. So I think it's both a mixture of a sort of - organization is doing today; how your organization puts the person first and hears from them in ways that actually drive quality and then look for opportunities to inform up the food chain, and to try to pull down a few questions and try. You know, be a part of the discussion.

Meredith Raymond: Thank you Bruce and Kim. That's really helpful and informative. Do we have any other questions in the queue Operator?

Coordinator: I'm still showing no questions on the audio.

Meredith Raymond: All right. We have one other question. In what ways are federal agencies collaborating and partnering in HCBS quality? And Eliza Bangit from ACL will answer this question.

Eliza Bangit: Good afternoon everyone and thank you for having me here today Meredith. And thank you Bruce and Kim on behalf of ACL, for providing a very comprehensive look of both the NQF HCBS report as well as the essential attributes from the SCAN Foundation's work. So thank you so much. And actually, before I go into the response about what the - what we're doing on the federal level to promote collaboration on HCBS quality, I also wanted to give a very brief - my answer to the first question, which is how can local and state level organizations be involved in HCBS quality framework development.

And this really is a firsthand experience for me, having worked with the staff, NQF and the organization in the two year project, in developing the HCBS quality conceptual framework and report, that was published last year. And one of the observations that really impressed me, was that the National Quality Forum insured that every draft of the report was made publicly available and provided time for the public to provide their comments.

So it wasn't really limited to just the committee or the federal advisory committee or federal partners, but it really was available for the public to provide their input. So I really encourage you all on this call, to perhaps put

an alert or sign up for NQF. And Bruce, I know that the SCAN Foundation also has a new quality Web page. And if there is sort of a similar type of alert for new things that are popping up in terms of quality and measurement for HCBS, I think that those are really a great start to kind of being involved and being aware of things that are happening on this front in this field. So again, I encourage you to peruse and look at the Web pages for these organizations.

So to answer the question, on the federal level, what are we doing to promote collaboration on HCBS quality? So agencies within the Department of Health and Human Services really work together in a variety of ways and I'm just going to highlight a number of observations from our end here at Administration for Community Living. So we participate in advisory committees that help guide the work. For example, Kim mentioned in her presentation that there's a federal advisory committee.

So officials from here at ACL from the Centers for Medicare and Medicaid Services, Assistant Secretary for Planning and Evaluation as well as Substance Abuse and Mental Health Services Administration or SAMHSA, served as - you will see in the slide deck that you will get after this call or this presentation, that we served in the capacity of federal advisory group to the National Quality Forum.

So for two years we met regularly to discuss the status of the HCBS quality project. We provided guidance to staff at the National Quality Forum and really became - we were almost attached at the hip. We talked regularly and exchanged emails to really sort of help provide some recommendations or suggestions in terms of the work. We also hold regular meetings on the federal side. We talk to each other. We update each other on quality projects and activities within our agencies. This is a really great way for us to hear firsthand from our colleagues, about the work that we all are doing. It gives

us a great opportunity to provide immediate feedback and share our thoughts about a particular matter or topic.

And we are also able to seamlessly reach out to our colleagues across the department if an issue or a question arises or we hear from our networks about a particular issue that maybe coming up the pike. So this occurs quite often. And at times we even participate in each other's staff meetings and give updates on our agency's projects. And we've actually recently just done this in the last couple of weeks. We went to CMS and provided an overview of ACL in general, as well as some of the efforts that we're implementing here in our agency.

But in addition, federal staff also participate in working groups facilitated by our nonfederal partners. So for example, officials here at ACL, Centers for Medicare and Medicaid Services and Substance Abuse and Mental Health Services Administration, participated as ex officio members and contributed to the development of essential attributes that Bruce presented on today and he did mention that in one of his slides. So there are many more of these examples going on across the department. What I just highlighted are just some of the most common practices in which we engage with our partners internally and externally.

And if you - you have our email address and you will see that later on today, if not we will include it in a follow up email. Please engage with us. Send us your questions. Send us your comments. Any bright ideas, thoughts, please share it with us. Really sort of a very broad, you know, solicitation here. So it doesn't have to be just, you know, on the framework that we discussed here today.

We also welcome - we always welcome your thoughts and we look forward to working with you moving forward. And before we end Meredith will talk a little bit more about what's coming up here at ACL and what, in the future of the quality - HCBS Quality Webinar Series. Thank you.

Dr. Bruce Chernof: Meredith, there are a couple of questions on the screen and I'd like to hit one of them quickly, that people have typed in. Somebody asked about what do you think of the measures, the days at home over the year? You know, and I really appreciate that question. I just want to start by saying any measures that start to move us in the right direction are good measures. And I think one of the things I challenge the measurement folks is it is very much a yes, but world.

Yes that could be a useful measure, but there are all of these concerns and so we never seem to get started. And I actually think, you know, days at home is always a little bit challenging, because days at home alone in social isolation, we would not view as good or (unintelligible) would not be good. But ultimately, days at home really begs the question, you know, are healthcare delivery systems starting with the premise that people want to be, you know, at home and in control, or not. And I think the only way to know how well a measure like that works, is to get going and implement it and hold people accountable for it.

And I do think that taking any one measure in isolation always feels a little funny because no one measure is sort of ideal in painting a picture of what people's experiences are like. But I think it's a very important place to start and I think we need to talk less about what the future quality measures look like, and start to do and pilot more. So I'm a fan and I would push the quality measurement people to sort of move beyond the well, you know, it's in

isolation, we need more. It's like that's great. Let's implement it and let's get more. So a really good question. I appreciate it.

Meredith Raymond: Thank you very much Bruce and Eliza and Kim for your comprehensive and informative answers. As it's 3:01 I'm just going to go ahead and close out the Q&A session. Thank you again everyone, for participating. As we close I wanted to talk about the upcoming third webinar in our series. It will occur on August 16th at 2:00 pm EST. Representatives from the Human Services Research Institute and The University of Minnesota Rehabilitation Research and Training Center will discuss the importance of and progress made in survey development as a part of HCBS quality measurement. An announcement will be sent out in late July with registration instructions.

We hope this webinar was helpful and informative to you. Thank you so much for participating. The slides will be emailed out to all who RSVP'd and the slides and transcript will also be posted to ACL.gov. Any questions or feedback may be emailed to HCBS-Quality@ACL.HHS.gov. Thank you so much.

Coordinator: Thank you. That does conclude today's conference call. Thank you for participating. And you may disconnect your lines at this time.

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