Welcome to the webinar, “What is ACL's Interest in HCBS Quality.” Please remember to mute your phones for the duration of the webinar. The link to for closed captioning is in the chat. >> I want to turn it over to Meredith Raymond.

Good Afternoon! Thank you for joining us for the kickoff of our Home and Community-Based quality webinar series, What is ACL’s Interest in HCBS Quality? This series will consist 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. To begin, today’s webinar will provide a broad overview of ACL’s HCBS quality initiatives: Due to a very full agenda, we will keep introductions short: Edwin Walker, Deputy Assistant Secretary for Aging will provide welcoming remarks, Susan Jenkins, Director, Office of Performance and Evaluation will discuss an overview of quality measurement, Eliza Bangit, Director of the Office of Policy Analysis and Development will discuss our work with the National Quality Forum, Shawn Terrell will discuss our contract work with the National Core Indicators and survey development, Amanda Reichard will present an overview of the Rehabilitation Research Training Center at University of MN and their studies on measure development, If time allows, we will have a Q&A period to answer the pre-selected question, How do you measure quality?” Now, I’d like to Introduce Edwin Walker, our Deputy Assistant Secretary for Aging to provide welcoming remarks.

Thank you very much. I would like to welcome everyone to the webinar. Here at the Administration for Community Living we are working with our partners and other federal agencies, states, consumers and advocates, providers, and stakeholders to create a sustainable LTSS system where older adults and people with disabilities have choice, control, and access to a full array of quality services that assure optimal outcomes including independence, good health, and quality of life. Advancing the identification, development, and implementation of measures of quality community living options that can be used by public and private entities is central to ACL’s vision: All people, regardless of age and disability, live with dignity, make their own choices, and participate fully in society. The concept of measurement forces us to ask ourselves – what is the basis for our claims and how are we fulfilling our mission through this work. The development and implementation of national standards for high quality long-term services and supports, and the systems that provide them, is needed to help track and measure the reach and effectiveness of national, state and community programs. ACL is working to support the development of standards and measures directly related to the well-being of older adults, persons with disabilities and their families, as well as the availability of and access to services and supports for all individuals. These standards are being developed and implemented through ongoing program performance, program evaluation, and other continual quality improvement strategies. HCBS are at the nexus of community living. More than 12 million Americans need long-term services and supports, a number that is expected to increase to 27 million by 2050. There have been efforts on the Federal level to examine performance measurement and quality improvement for home and community-based services

(HCBS). In 2005, the Agency for Health Research and Quality (AHRQ) contracted with Truven Health Analytics to conduct an environmental scan of HCBS quality measures for the Medicaid program. In 2014, the CMS Testing Experience and Functional Tools (TEFT) planning grants led to the development of an HCBS consumer experience-of-care survey used to construct performance measures related to beneficiaries' experience with Medicaid services, and an electronic long term services and supports service plan standard (eLTSS) that can enable electronic exchange of information relevant to the care of persons receiving HCBS.
There have also been efforts on the state level. There is growing use of surveys to assess HCBS quality, including the National Core Indicators (NCI), Money Follows the Person Quality of Life Survey, and Health Outcomes Survey used in the Program of All-Inclusive Care for the Elderly (PACE). Despite these efforts, the development, availability, and implementation of HCBS measures remain limited. Currently, there are many measures endorsed by the National Quality Forum (NQF), but very few are considered home and community based services-related. As we move towards value-based purchasing and increasingly integrate home and community based services with medical services, it becomes more critical to capture the experience of people who use HCBS and to work towards assuring that HCBS are of highest quality. ACL strongly supports any progress toward nationally validated outcome measures for long-term services and supports and has invested in a number of initiatives, which you will hear more about today and in future webinars that are working toward this goal:
The National Quality Forum group on measuring HCBS quality completed a two-year effort to develop a conceptual framework for measurement, review existing literature for measurement guidance, identify gaps in measures, and made recommendations on HCBS measurement last fall. We also have supported the development and implementation of the National Core Indicators for Aging and Disability. These two related instruments continue to inform the field on state system performance. NIDILRR is funding a Rehabilitation Research and Training Center on Home and Community-Based Services Outcomes. The result will be a set of recommended measures and procedures to ensure that they support quality-of-life outcomes for people with disabilities and older adults.

The purpose of this informational webinar series is to increase awareness of ACL's commitment to and development of HCBS measures and provide a platform among internal and external stakeholders to share developments and collaboration efforts in the HCBS quality field.
The first three webinars in the series will focus on ACL initiatives; however we welcome your suggestions for topics of future webinars.
We need you to help us continue this work and look to you for input, assistance and collaboration on all things HCBS quality!
Thank you and back to you Meredith. >>

Thank you Edwin. Now I would like to introduce Susan Jenkins to provide an overview of quality measurements.

Thank you Meredith. Thank you good afternoon everyone my name is Susan Jenkins and I have been working on gathering information about how our programs operate and whether they are providing quality services to individuals and communities for almost 25 years. I've seen firsthand

how programs use data to make decisions, to find out what initiatives to pursue and what policies to implement, how much better they do when they have that data and then programs that don't. I'm happy to share some of what I learned with you today. >> Why is quality measurement important? Program evaluation is a systematic method for collecting, analyzing and using information to answer questions about projects policies and programs. Particularly about the effectiveness and efficiency of those policies programs and projects. It's important to remember that when we think about measuring how our programs and policies are performing, we have to look at quality and quality measurements. Quality measurement is a type of evaluation. Institute of measurement defines healthcare quality in a degree to which health outcomes are consistent with current professional knowledge. With regard to home and community-based services and ACL's mission to maximize the independence, well-being and health of people with disabilities, older adults and their families to include supportive services and the degree to which those services provide the well-being of those we serve. When thinking about quality we commonly think about six dimensions. The first is effectiveness. That is related to providing services that achieve the desired outcome which in this case is helping people live independently with maximal health and well-being. Another is efficiency. Are we doing the most that we can with the resources that we have? We also have to be concerned with equity which is related to providing services of equal quality to those who may differ in the personal characteristics. We also look at [Indiscernible] which relates to meeting consumers' needs [Indiscernible] safety which is related to the actual potential bodily harm and finally timeliness which relates to obtaining the needed services and having access to the needed services as quickly as possible. And ACL examines these [Indiscernible] particular focus on what we call a three-legged stool approach which tells us make sure that we provide the best services possible and do not pool to from one direction at the expense of other program. These three legs that we used to balance our measure to assure the overall -- we ask ourselves, are we serving the right people? Those who are most needy and can most benefit from our services? Another is efficiency. Are we providing the services at a reasonable unit cost and the other is quality. Are the services [Indiscernible] quality. To bring these ideas to life, imagine a meals program that is designed to help people stay in the community and live independently. We could appear to be successful if we serve people at low risk for being institutionalized because few of those people would ultimately enter a care facility but because they are at low risk for [Indiscernible] it is unlikely that our meals are actually making a difference. In that case we are not really meeting our purpose of helping people at risk for entering a facility to remain independent in the community. We could also be very efficient and serve a lot of people if we serve very poor quality meals again not meeting our mission of the program because meals may not be nutritious or people may not eat them. Many look at quality of the meal thing -- nutritional quality. It is only by balancing these three things that we can truly make the mission of helping people live independently.

I want to offer a little bit of history. And make the point that the move to quality is not new even though if it has not always been talked about using the terms we talked about. Enacted in 1993 GPRA are a

modernization act was designed to improve [Indiscernible] the GPRA modernization act of 2010 aims to ensure -- established important -- requirements that move for a more useful -- the modernization act also served as a foundation for helping agencies to focus on their eyes priority and create a culture where data and empirical data played a more important role in [Indiscernible] in other words using data and service quality to make programmatic policy decisions that improve the program and the services that we offer.

In 2013 the memorandum shown on this slide offered -- continually improve program performance by applying listing evidence about what works generating new knowledge and using experimentation and innovation to test new approaches to program delivery. In HCBS, this means finding out which policies programs and -- communities do to make their own choices and to participate fully in society. >> In the recent 2018 budget blueprint the current Administration also discusses the evidence a measurement of program quality. They talk about using real hard data to identify poorly performing programs and organizations which we would say are of a lower quality in identifying those that have high quality and making decisions us extensively based on [Indiscernible].

The question becomes what we measure and there are many reasons some of which were stated in the previous slide but also if we do not examine our programs objectively we cannot really know if they are improving people's lives either directly through services or indirectly through improved efficiency. Measurement is important to improve lower preforming programs and help us give -- to help them choose what services and approaches are best for them. And ensure that we are getting our money's worth, and making sure we’re getting the level of quality we expect. It is important to remember though that the measurement of quality is an improvement tool not in and in itself. We should use quality -- as a way to serve in the people in the community and the best most effective way possible.

What to measure. We cannot measure everything and even though I am an evaluator and a focus on program manner, I do realize that we should not have measurement overcome the value of the program so there is a saying that we used sometimes in the evaluation field that if you can define it we can measure it. We need to remember that just because we can measure something or it's easier to measure something that does not mean that we should. Measurement should complement the program and gather the most important information needed for decision-making and service improvement.

If we try to think about what we would measure we would think about some common areas for measurement. There are several services that make most sense to measure because these are things that we can have control over as we try to improve our programs or maintain a quality these include quality of how care is structured. For example is it whole it listed multidisciplinary, how the process of -- community living outcome and what are the consumer outcomes in terms of health well-being and independence. We can also look at the level of resources using to compare the resources per positive outcome. For example we may want to measure the cost per day of remaining in the community, the cost per

person who reports living in the setting that they want to live in, or the cost per satisfactory [Indiscernible] developed.

We think about what to measure, we think about how to create those measures. The basis of evaluation and performance measurement is comparing actual performance of your program service or policy to intended objectives peers sometimes those objectives are clearly defined but many times they are not, and many times they are not measurable it is written. Once we have an idea of the service structure called the processes and cost as well as expected outcome for systems and consumers we can start to develop specific measures. The measures that explicitly define what will be collected. And ACL -- follows the SMART -- performance of quality. So there are the five areas and by specific we mean description of the objective is well written in any way anyone can define it -- two different programs to different providers have to be reporting comparable severable data. They have to understand the objective in the same way. That ensures that an object is specific to make sure it is described and that it is observable so specific meaning all those things. By measurable we mean the extent to which something can be evaluated -- quality measurement would be accuracy, format how well it fits within standard guidelines of service. Achievable, with the question can the program policy program or service make the [Indiscernible] different. We -- must contribute to our purpose and time oriented means we define -- so we have a goal for when we expect to have met the objective or milestone toward that objective.

Another way to think about specific is by looking at the numerator and denominator and defining them very clearly as shown on this slide. What I mean is we define a numerator which might be who or what system component showed the desired -- in this example the number of person centered plan of care which would be divided by the denominator which should be the number of individuals enrolled in a program. In the denominator we do not include people are service components that were not exposed to are eligible for the service spirit you want to look at the people who could have made the change that we are looking for divided by all of -- we want to look at the people who made the change the desired change that were looking for divided by all of the people that had the opportunity to make that change.

On the next slide, there is a funny way to highlight the importance of knowing our denominator we have to know the context in which we are operating to understand the quality of our program. In this case the little cat got three stars out of three stars and that's a much more positive outcome than what it really turns out to be which is three stars out of 1 million. So we take it back to an example on the previous page of we learned 10,000 consumers now have person centered plans. That’s great. It's great if we know that there were 10,500 people eligible to develop such plan. That'll be a rate of 95%. That would suggest that we have a quality program or approach for developing [Indiscernible] it is not so great a system included 50,000 consumers of which 10,000 which is only 20%. Thank you for all of your attention as I discussed quality measurements and thank you Meredith.

Thank you, Susan. Now would like Eliza Bangit will discuss ACL's work with the National Quality Forum.

I will provide an overview today of the work of the National Quality Forum, or NQF on quality home and community-based to support community living. I am only providing a brief overview today so I invite all of you to tune in again on June 28 at the same time 2 PM. Our colleagues at the national quality forum will present a more in-depth. Moving on. Next slide please.

Section1890 of the Social Security Act requires the Secretary of Health and Human Services to provide a consensus-based entity. Under this authority the Secretary of HHS designated the national quality forum as the CBE. In 2012 HHS awarded a contract to NQF to synthesize evidence and convene key stakeholders to make recommendations to HHS on a national strategy and priorities for health care performance measurement in all settings.

Under that contract NQF was also tasked with convening a multistate holder committee to produce recommendations to HHS for performance measurement in home and community-based services that support community living policy.

This was a two-year project that involved the development of standard a HCBS definition, the creation of a conceptual framework for a HCBS measurements including domains and subdomains of development and characteristics of high quality HCBS which you will see later on in my slides. It also required NQF to produce an environmental scan of existing HCBS measures and instruments which then created an opportunity or platform for identifying gaps in a HCBS measurement as well as promising measures. The project also produced recommendations from the committee for prioritization in HCBS measurement.

How was this project done? One of the first things that NQF did was form a multi-stakeholder committee of national experts on HCBS quality. Something unique to this project was the active participation of the federal advisory group from HHS to help advise NQF throughout the project.

When the committee was formed, NQF held committee in-person and Web meetings which were open to the public; it facilitated workgroup calls, and conducted online surveys to solicit the Committee's input. Four reports were published under this project, three were interim reports and one final report, which was released last year in September. NQF took public comments on all this.

In the final report you will find the committee's definition of home and community-based services. The term home and community-based services refers to an array of services and supports delivered in the home or other integrated community settings that promote the independence, health and well-being, self-determination, and community inclusion of a person of any age who has significant long-term physical, cognitive, sensory and/or behavioral health needs. You will find this definition on page 9 of the final report. Stemming from the process of creating an operational definition of HCBS, the committee identified specific characteristics of a high-quality HCBS system. The committee felt that

this was necessary because the operational definition as you just saw previously is more functional than aspirational. The committee wanted to also communicate its vision for what HCBS should be. Through extensive discussion the committee established that high-quality HCBS should be delivered in a way that provides for a person driven system that optimizes individual choice and control, promotes social connectedness and inclusion , includes flexible range of services that are provided in a setting of the individuals choosing, integrates health care and social services to promote well-being, promotes privacy, dignity, respect and independence , freedom from abuse, neglect, exploitation, coercion and extract restraint and other human and legal rights. It also ensures balance of personal safety and dignity of risk and supplies and supports an appropriately skilled workforce that is stable and adequate to meet demand. >> It also supports family caregivers. It engages individuals who use HCBS in the design, implementation and evaluation of the system. It reduces disparities by offering services that are provided in a culturally sensitive and linguistically appropriate manner, coordinates and integrates resources to best meet the needs of the person.

It delivers accessible, affordable and cost-effective services. It supplies data to all stakeholders and finally fosters accountability through measurement and reporting of quality of care and outcomes.

One of the things the committee develops was an illustration as you see here of the conceptual framework to show how performance measurement should work and HCBS. Each circle in the framework represents a level at which measurement can be applied. At the consumer level, the level of the person receiving HCBS. There is the provider level which is at the level of service provision, and also at the system level. Measurement at each of these levels of analysis serves different purposes and responds to different information needs. You will see a list in the circle at the center of the diagram there are 11 domains and measurement that the committee compiled. This illustrates overlapping levels because measurement can be applied at multiple levels within many domains. The continuous arrows surrounding the four circles indicate the transfer of information that is necessary to operate a dynamic, learning system and the feedback loops between measurements and improvement efforts. >> As I mentioned in the previous slide the committee developed and defined 11 domains and 40 subdomains for quality measurement in HCBS. The goals of constructing the domains and subdomains are to stimulate evidence-based research in support of quality measure development, to guide quality improvement efforts, and highlight the important areas for measure development. >>

Through its deliberations the committee identified gaps in measurement within all of the domains and subdomains and discussed the barriers and challenges in measuring quality. These barriers and challenges include the lack of standardized measures across the country, the lack of or limited access to timely data on HCBS programs, the variability across the numerous federal state local and privately funded programs with respect to reporting requirement and the added administrative burden of data collection management, reporting, and incorporation into quality improvement activities. Again if you would like to learn more about the committee work on this please look for the

final report that is on the national quality forum's website. Finally the committee also developed global recommendations that apply broadly to HCBS quality measurement. Its recommendations are: support quality measurement across all domains and subdomains. Build upon existing quality measurement efforts, develop and implement a standardized approach to data collection, storage, analysis and reporting, ensure that emerging technology standards, development and implementation are structured to facilitate quality measure minute. Triangulate assessment of a HCBS quality using an appropriate balance of measure types and units of analysis and develop a core set that of standard measures for use across the HCBS system along with a menu of measures that can be tailored to the population, setting, and program, finally the committee recommended that we convene a standing panel of HCBS experts to continue to evaluate and approve candidate measures.

Here's the slide with links to the reports and other materials produced by the National Quality Forum under this project. This concludes my portion of the presentation. Thank you Meredith and turning it back to you.

Thank you. We will now hear from Shawn Terrell who manages our contract work with National Core Indicators and survey development. This is Sean Terrell and you can advance the next slide. We have the contract with an organization, the Human Services Resource Institute to collaborate and we will go into a little bit to develop HCBS quality measurements from national core indicators for intellectual development disabilities, aging and physical disabilities. This is really our first attempt to try to build off of the work done and start to build a set of measures that are-- endorsed by NQF for use in variety of programs frankly and that -- the robust measures for NQF endorsement -- designed around paper performance kind of models. For that reason [Indiscernible] rigorous and wholly developed and pretty much on a sellable -- these are two sets of survey instruments that have their own history. For the National Core Indicators, they focus on adults with intellectual development disabilities who receive at least one service in addition to case management from state IDD systems. Most of the people are in some sort of home community -- this is in development and has been operational for a number of years started in 1997. There are three surveys in the suite of surveys that are offered . One is the adult consumer survey another is for family members and others staff stability. It's now operational in 46 states plus the District of Columbia. It is funded by state membership fees and ACL has supported expansion [Indiscernible] for a number of years.

NCI for aging and disability is for older adults and adults with physical disabilities and this is a much broader array of service programs cost skilled nursing facilities, Medicaid waivers, Medicaid state plan, state-funded programs, older Americans act programs [Indiscernible] PACE the program for [Indiscernible] for the elderly and programs of Medicaid Medicare combined programs and manage long-term service support. It is a full gamut of people. For that reason it is a little more complex -- they started this in 2012. They have one survey which is an adult in person only. On their website -- the management website there is a three state report published. They are getting ready

to publish a larger survey -- six states that should be out pretty soon. We're looking at about 20 states for 2017 and 2018 survey. It is growing rapidly. The states are interested in the surveys. Again 46 states and this is growing at a high rate. >> Here's the coverage for these two. The green is participating in both NCI in NCI-AD and the sort of blue is participating in NCI only. And light blue not participating in either.

You see the map turning green over the next couple of years.

Here's the indicators. There's a great deal of overlap with two sets of instruments. In NCI-AD was derived out of -- community participated in a think those of the self-determination, IDD versus [Indiscernible] aging disability . Self-determination was the old -- mostly people think of self-direction and there are a few extra additional indicators in aging disability around every day living in affordability and future planning and control. In general they are quite consistent with each other.

We have a contract with human services Institute with National Association for State Directors, a developmental disabilities services in the national association first staging -- collaboration in these projects their goal is a number of things we are doing in this contract. First, refine and expand the use of NCI and NCI AD. Anytime we see results we want to know are these results valid and reliable. If I see a graph cannot rely on those results to be telling the truth meaning that the data is actually good and accurate and developed according to standards for these kind of surveys. Can I review the literature on that ? Cannot go somewhere and find the report itself that shows that the surveys were developed [Indiscernible] data are accurate? Again on standard protocol if you will. What we are asking to do is do what is necessary to do the [Indiscernible] testing of reliability -- states sample around 400 people in their respective tools. Interview protocols. Making sure that people doing these in person interviews are trained and are delivering the interview as intended and that they are implemented in consistency across all states and publish all of them. In peer-reviewed journal so everyone can see them and see that reading is done very well. This one area -- last area -- because we have a lot of questions that relate to persons -- person centered planning

-- person centered planning are the key to underlie the -- premised on each person having control [silence]

>> I think we are having technical difficulty. Amanda you could go ahead and speak regarding rehabilitation research training center at the University of Minnesota we would appreciate it.

Sure. If you will advance the slides. >> Hello I am Amanda Reichard with the National Institute on Disability Independent Living and Rehabilitation Research known as NIDILRR -- ACL. I'm going to talk about one project that has been mentioned a couple of times today the research and training center on outcomes measurement for home and community-based services. In 2015 NIDILRR held a grant competition for research in rehabilitation and training center on the quality of HCBS and I shortened that to our RTC because it's easier to say than rehabilitation and research training center. The University of Minnesota was awarded

the grant for $875,000 per year for five years and is a mentioned this is [Indiscernible] the University of Minnesota staff are using this grant to develop HCBS qualities and measures and these measures will be applicable across a wide range of disability subgroups in the aging populations that receive HCBS. The grant team at Minnesota includes partners in organizations that have relevant expertise that is specific to these disability sub groups in aging population that are covered by the measures.

These partners include several universities, the National Council on Aging and relevant policy and research organizations. >> The work of the University of Minnesota is in response to the NIDILRR and ACL -- ACL priorities are one identifier develop measures and test the reliability and validity in usability of those measures in assessing the person centered outcomes of individuals with disabilities who receive a HCBS. Another priority is to work closely with NIDILRR ACL in the National Quality Forum project on HCBS quality. Develop procedures and mechanisms for applying HCBS outcome measures in policy and service delivery settings to in an effort to maximize the quality and appropriateness of HCBS from the end-user perspective.

Collaborate with stakeholder groups in developing evaluating or implementing strategies that increase the utilization of these new HCBS outcome measures. And finally serve as a national resource center related to person center measurement for HCBS outcomes. >> As a starting point the University of Minnesota founded their work on the NQF framework that allows the described earlier. These 11 domains and framework focus on consumer leadership in system development, system performance and accountability, equity, service delivery and effectiveness, person centered service planning and coordination, caregiver support, workforce, holistic health and functioning, community inclusion, human and legal rights, and choice and control.

The grant at the University of Minnesota includes six main studies. The first study uses a participants or a planning and decision-making process for people with disabilities their family members and providers and program administrators and this is across five disability groups including people with IDD or intellectual and developmental disability, physical disabilities, traumatic brain injury, mental illness in aging population. The second study involves a gap analysis between what is included in the HCBS domains and subdomains and existing measures. In this study will attempt to identify measurement gaps through an analysis of what is currently available -- what instruments are currently available to focus on outcomes of HCBS and the NQF outcome -- ACL in -- one into is almost complete. Study three will identify -- will include identifying high-quality fidelity implementation pride is add code measurement program study for will refine and develop the HCBS measures. These will be -- this refinement will be based on the results from studies one through three to fill in those gaps and measurements that were identified.

Study five will reliability validity and sensitivity to the measures that were changed by using a large-scale of testing of the most critical measurement [Indiscernible]. Finally, study six will involve identifying and testing risk adjusters to validity of the measurement instrument.

Similar to allies that, this is another project that will be presenting in a future webinar so we hope you will be able to tune in for much greater detail for these projects in the result of their findings later this year.

Thank you Meredith.

Thank you. We have Sean back on and he would like to say a couple more statements.

Thanks. So to finish up and I apologize I was cut off.
They are going to revise and develop some questions about [Indiscernible] planning insert into the existing surveys or they might create a new survey depending on how many questions we feel we need to have and we are currently working to some focus groups [Indiscernible] and others to help develop those questions. There's one more. This fits in with what Amanda is talking about. The work here that we want to have measures that are endorsed by NQF to put home community-based service measurements into the same arena as those that are more medically oriented. There are over 600 measures that are endorsed by NQF around the medical field and they get regularly inserted into a variety of [Indiscernible] programs for instance, managed care programs, programs that integrate medical and long-term service support. Those are out there they are used and they have a track record. In fact the challenge now is aligning those because they are 600 and some are similar in their doing a lot of work on that. On the other hand on HCBS you don't have many measures and yet we are running into a situation where we have home community-based services and a full array of medical dedicated services for instance offered by the same plan but the only thing that has the value-based purchasing measures are the medical side. We want to have a HCBS measures to be as prominent as those other measures are for the purposes of HCBS so we don't lose people so we don't lose the concept and more integrated world that we are entering into. That's the purpose. Want to get tread -- 20 measures minimally out of the NCI and NCI a decent and we think [Indiscernible] place to start because the states Aarti have the infrastructure. There are 246 states that have state commitments and ongoing work to administer the surveys and so the measures -- the numerator and denominator is an easier fit as they are Aarti doing -- asking these questions. We think this is a good place to start for us. In coordination with everyone else what they are doing particularly the work that Amanda it was just talking about in Minnesota so we do not have the overlap in these competing measures of the same thing that we see now in the medical field. The last thing that they continue to do is technical assistance on how to do all this work and how to do the surveys etc. That's it for me. Thank you for coming back to this slide. I think it was relatively important. One more thing. This is a precursor so once the [Indiscernible] will be doing their own webinar in the not so distant future with more detailed look at what they are doing stating for that.

Thank you to all of our speakers. We greatly value your work at ACL. We will move into the Q&A portion of our webinar. Because the time

limitations the opportunity to submit questions was provided to those who registered previously. The question, "How do you measure quality was selected from the submissions. Ultimately the goal for measuring quality is to help guide decision-making and drive improvement over time. Unless we measure, it is difficult to know exactly what we need to improve and whether we have in fact achieved improvement.

In order to begin to measure quality we need to know what data we should be measuring and we need to ensure that that data is reliable. This is a fundamental component that supports and advances quality driven efforts. We can measure quality in different ways. At HHS there are many efforts that support quality measurement including what you heard today of the three initiatives that ACL is spearheading. The Substance Abuse and Mental Health Services Administration (or SAMHSA) has a Behavioral Health Quality Framework and had identified several NQF endorsed measures under three of the goals: Person Centered Care, Healthy Living for Communities, and Reduce Costs of Behavioral Healthcare. The Centers for Medicare and Medicaid Services (or CMS) requires NQF endorsed measures in many of its funding authorities including managed care waivers, 1115 Demonstrations, and Dual Eligible programs. For HCBS Waiver programs, States are expected to develop a quality improvement plan and measure six assurances, which are administrative oversight, level of care, qualified providers, service plan, health and welfare, and financial accountability. Lastly, the Testing Experience and Functional Tools (TEFT) program recently received endorsement for 19 HCBS measures related to experience of care in HCBS programs. We hope this webinar was helpful and informative. Thank you for participating. The slides will be e-mailed to all who RSVP'd. The slides and transcript will also be posted to ACL.gov. As Edwin mentioned, we need you to help us continue this work and look to you for input, assistance and collaboration on all things HCBS quality! Our next webinar will be on June 28 and will expand on Eliza's overview of quality framework development. Representatives from the National Quality Forum and the SCAN Foundation will discuss the progress made in quality framework development. An announcement will be sent out in early June with registration instructions. Thank you!

Thank you this concludes today's conference. You may disconnect at this time. >> [event concluded]