

***Administration for Community Living  
Affordable Care Act Webinar  
Managed Long Term Services and Supports: Measuring Outcomes  
February 26, 2013  
3:00-4:30 pm Eastern***

Coordinator: And thank you for standing by. At this time all participants are in a listen-only mode.

During the question and answer session please press Star 1 on your touch-tone phone. Today's conference is being recorded. If you have any objections you may disconnect at this time.

Now I would like to turn the call over to speaker to Marisa Scala-Foley. You may begin.

Marisa Scala-Foley: Thank you so much Tonya. Good afternoon everyone. As Tonya mentioned my name is Marisa Scala-Foley. I work in the Office of Policy Analysis and Development of the Center for Disability and Aging Policy at the Administration for Community Living.

We thank you for joining us for this month's Webinar which is our latest in a series of Webinars focused on the Patient Protection and Affordable Care Act also known as the Affordable Care Act or the ACA and its impact on older adults, people with disabilities, and the aging and disability networks.

Our Webinar series is designed to provide aging and disability organizations with the tools that you need to participate in ACA related efforts in your state or community such as accountable care organizations, state integration for dual eligibles, managed long term services and supports, health homes and more.

Today we continue our multi-Webinar series on integrated care and manage long term services and supports.

As states move toward integrating their health and long term services and support systems and head towards managed long term services and supports for people with Medicaid measuring the quality of the long term services and supports that your clients receive becomes increasingly important both at the individual and systemic levels.

Today we'll explore this issue of measuring outcomes and long term services and supports. We'll provide background on this issue including potential tool and gaps, discuss the role of advocates in this process and how you can identify useful and valid measures and finally we'll look at action steps that you can take going forward.

So before I introduce our speakers we have a couple of housekeeping announcements. First if you have not yet done so please use the link that was included in your email confirmation to get on to WebEx so that you can not only follow along with the slides as we go through them but also ask your questions when you have them through the Chat function.

If you don't have access to the link we emailed you you can also go to [www.webex.com](http://www.webex.com) click on the Attend a Meeting button at the top of the page

and enter the meeting number which is 667837564 with a passcode of ACLWEBINAR and that's all one word in capital letters.

Again the meeting number is 667837564 passcode ACLWEBINAR in caps all one word. If you have any problems getting into WebEx please contact WebEx Technical Support at 1-866-569-3239. Again WebEx technical support can be reached at 1-866-569-3239.

As Tonya mentioned all participants are in listen-only mode however we do welcome your questions about the course of this Webinar.

There are two ways that you can ask your questions. First is as I mentioned earlier is through the Web using the Chat function in WebEx.

You can enter your questions there and we will sort through them and answer them as best we can when we take breaks for questions after some of our speakers present.

In addition after the presenters wrap-up we'll offer you a chance to answer questions through the audio line. When that time comes Tonya will give you instructions as to how to queue up to ask your questions.

If you think of any questions after the Webinar or have any questions you'd like us to follow-up on you can email them to us at [affordablecareact@oao.hhs.gov](mailto:affordablecareact@oao.hhs.gov). Again that email address [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov).

As Tonya also mentioned we are recording this Webinar. We will post the recording slides and a transcript of this Webinar on our Web site as soon as possible.

If you would like those slides - if you'd like to get the slides before we post them you can also email us at the email Affordable Care Act email address that I just mentioned earlier.

So without further ado let me introduce our terrific panel of speakers who have explored this topic of measuring outcomes in long term services and supports in-depth in their recently released guide Identifying and Selecting Long term Services and Supports Outcomes Measures.

And that guide was funded by the National Institute on Disability and Rehabilitation Research.

So our speakers, and I'm going to introduce them in alphabetical order then I will turn things over to them.

First we have Mary Lou Breslin. Mary Lou serves as the Senior Policy Advisor with the Disability Rights Education and Defense Fund, a national disability rights law and policy center.

For the past decade she has focused on advancing disability rights in federal and state health care policy.

Ms. Breslin has also written and published on various disability rights topics most recently on health care and disability.

Next I'd like to introduce Eric Carlson. Eric is a Directing Attorney at the National Senior Citizens Law Center. He has broad experience in many forms of long term services and support including home and community-based services, nursing facility care and assisted living facilities.

He counsels attorneys from across the country and co-counsels litigation on consumer's behalf. Mr. Carlson also serves as President of the National Assisted-Living Consumer Alliance.

And finally I would like to introduce Steve Kay. Steve Kay is a Professor at the Institute for Health and Aging and Department of Social and Behavioral Health Services at the University of California at San Francisco.

He is the director of the Center for Personal Assistance Services, a rehabilitation Research and Training Center funded by the National Institute on Disability and Rehabilitation Research.

His research focuses on community-based long term services and supports, employment of people with disabilities and use of information and assistive technology among people with disabilities of all ages.

So with that I will turn things over to Eric.

Eric Carlson: Thank you very much. I want to start with just noting why these months in particular this is particularly important and it's getting a lot of interest.

Managed long term service and supports are becoming more and more prevalent. You'll see that the numbers there there's been a pretty significant increase coming up to 2012 up to 16 states and then just not this year but next year we're going to expect that number to increase to 26 more or less.

And there are a couple of reasons for this. One is the dual eligible demonstrations that are currently being approved by CMS.

Approximately two dozen states as many of you are - certainly know have submitted applications to combine to integrate Medicare and Medicaid in the states for the dual eligible population.

And in most states that's being proposed to be done through a managed care option. And the pitch part of the pitch behind this integrated care is that the care's going to be better.

If all things go well you'll get a more integrated less siloed care delivery system. And if with that focus really demands that there also be a focus on whether it actually works

It's one thing to say that it works, another thing to prove it which is why quality measures are going to be incredibly important in evaluating those demonstrations.

Also independently to a certain extent of that there's a big move towards Medicaid managed care or managed long term services supports in general.

And you'll see that in some recent states within the last three to four months there have been approvals of applications submitted by New York, New Jersey, and just in the last couple of weeks Florida for programs that will provide in the future Medicaid LTSS through managed care systems.

And in the same way that this kind of evaluation is important in dual eligible programs is going to be incredibly important in managed Medicaid LTSS as well.

In defining quality there are a couple of different questions here at least. One is what is quality to begin with? It's a - it is not an obvious thing to measure

the same way you might measure what the temperature is outside. And so that's a little bit tricky.

And then beyond that even if you could decide what it is that defines quality there's the question of how that can be measured?

What is it that way can put a probably numerical value on that will characterize that what we're trying to get at in measuring the benefits of a particular LTSS system?

And in general there's three basic ways of addressing this. One is the structure which might be provider qualifications or in some cases a physical plan, particularly if you're talking about an acute care model.

Secondly the processes that are followed, again it's to a certain extent easier talking about - there's more experience in dealing with these in a clinical setting, screening for diabetes, having folks get checkups at least once a year, maybe have an assessment for fall -- things like that.

If there's a particular process that is provided on a regular basis examining the percentage of occasions in which that process is made available to folks.

And then finally which might be in some cases considered the gold standard the outcomes, because you're looking there most likely specifically at the person, you know, what - not what was done, not what the system looks like but what kind of results you had for the individual person.

And so if you can get those measures there can be very important although it should be noted that, you know, you don't want to be in a position in - of saying necessarily that one is better than the other.

There all important and they need to be all considered. And ideally if you have on the table structure and process and outcomes you're going to have a more complete picture of the system.

It should be noted that today our focus is going to be heavily on outcomes because it is more person centered and gets more to the idea of what we're trying to accomplish in providing long term service and supports.

Just a quick bit of context here, looking at Florida I mentioned that the waiver application submitted by Florida to move managed to move Medicaid LTSS into managed care was approved in the last couple of weeks.

And the approval included some quality measures. and some of them for example were some could be categorized as structural.

The percentage of the new managed care organizations, the satisfied provider qualifications, talk about licensure and really a heavy focus on provider qualifications.

And then on the structural side in that waiver application as well there's a lot of focus on care planning, the percentage of services delivered in accordance with care plan percentage of care plans meeting assessed needs and risks, percentage of care plans distributed within ten days, percentage of care plan is reviewed and updated every three months, process measures.

And you can see the value of this. You can also see the limitations it's obviously easier to look at care plans because it's a piece of paper that can be evaluated retrospectively which makes measurement more easily but brings it further away from looking at the actual person.

Moving forward to the next slide I want to note that quality measures are not brand-new. It's not like this just started with increased focus on these issues given the dual eligibility integration demonstrations.

Dating back to at least 2004 CMS has had a quality framework for home and community-based services provided through the home and community based services 1915 C waivers.

This slide is the CMS description of the quality framework. You see in the left-hand column the areas of interest listed under focus, participant access, participant centered service plan delivery et cetera, et cetera, et cetera.

And then moving on to the right the particular components of what CMS calls the DRI -- Discovery, Remediation and Improvement.

The idea is that this data is developed, it's used for discovering problems on an individual level. It's then used so that those individual problems can be remedied. That's the remediation section.

And then finally the data is used for improvement. That is specifically systemic improvement to make the whole system work better.

And explained in the next slide the process is that CMS receives waiver applications from the states that sketch out their quality assurance systems. The waiver is approved presumably.

And then during the operation of the waiver the state submits data summaries plus a record of whatever the state has done to rectify problems.

And then at least one year before the expiration of the waiver CMS passes judgment on this data to a certain extent, communicates with the states that findings of CMS regarding the data in addition to any recommendations for corrective actions that CMS believes to be necessary.

That there has been little I would submit -- and if people have different experiences I'd really well commit during their comment section -- but I would submit there's been relatively little public awareness of this process.

One exception to that is this report that's cited here put up by the Office of Inspector General of HHS last year that looked at 25 states that got the data and that found that three of the states there is waivers approved even though the states did correct their problems.

Note here that actually the report consistent with this general lack of information didn't even identify the individual states.

I could tell - I talked subsequently to reporters submitted a freedom of information act question - request and determined that the three states were Colorado, Pennsylvania, and Wisconsin.

But it's, I think, telling that even the whistleblower report if that's the right way to describe it, still didn't reveal to the public what states the report was talking about.

The problems that were identified dealt with service planning, whether their providers were qualified and health and welfare.

Again the states weren't identified. As you'll note it here approximately 15% to 25% of the states fell short in each of these particular areas.

Again from this reporter submitted Freedom Act of Information Act request I can say that most of these states were repeaters that of these 25 states it's only seven that were that violated the were found to be deficient in one of these areas.

And just for the purposes of this discussion I can tell you that those seven were California, Colorado, Iowa, Nevada, Ohio, Pennsylvania and Wisconsin.

So I would encourage folks if they have experience in this area to let us know either during the Chat function at the end of this session or subsequently it's important that we really do this work on development but in doing the development in the new systems be very conscious of what's gone on before so we can learn from that.

So let me then turn the microphone over to Mary Lou who will start us on our discussion towards focusing on the outcome measures.

Mary Lou Breslin: Thanks Eric and hello everybody. In order to provide a sense of the landscape of managed long term services and supports outcome measures I'm going to be talking about some of the work that's been done to identify existing measures, work that's in progress, the develop and test measures and some potential tools that can be used immediately to evaluate LTSS outcomes.

I'll also be touching briefly on the role that all of us as state advocates can play in identifying outcome measures and introducing what we think are core MLTSS -- that's Managed Long Term Services and Supports -- outcome measurement principles that can guide the work that we're all doing to identify and select appropriate measures.

And I also want to just say that our intention here is that the information we're providing today is not intended to be sort of solely theoretical.

I realize this discussion of outcome measurements may seem a bit academic. But actually we're hoping that this information serves the practical purpose of assisting advocates and other stakeholders to really be an active - actively participate in the measures identification and selection process.

I'm going to just begin by summarizing some of the work that's been reported by the Measure Application Partnership by the Agency for Healthcare Research and Quality for this - from the Center for Personal Assistance Services at the University of California San Francisco. And Steve Kaye will be talking more about that work in his presentation.

I'll be presenting some information about one CMS quality management project that's under development and then summing up several of the standard LTSS HCDS quality measurement outcomes surveys that are currently in use now.

These are really intended to kind of give you a sense of the landscape but these are not - this is not a comprehensive overview of everything that's out there but it is intended to sort of set the stage for what some of the key issue areas are and what tools are currently available that can be pressed into service.

Okay let me just begin by talking a little bit about the Measure Application Partnership Report. This is referred to - this group is referred to as MAP.

Is authorized by the Affordable Care Act and it was convened by the National Quality Forum. It's developed a national measurement strategy for the dual eligible group.

This report was released in June 2012 but MAP also separately looked at quality measures in Medicaid, supported HCBS. And it identified these measures as a major development gap area.

This is not new news to those of you who are working in the quality measures area but this was an important acknowledgment in the course of implementation of the ACA.

And MAP also recommended specifically that HHS fund a National Quality Forum effort on quality measures and long term services and supports.

This is obviously going to be a long term effort. It is important and certainly much needed and this is a very important acknowledgement that this work needs to go forward.

MAP reported 24 potential examples or illustrations of person centered concepts that are important for further investigation.

And let me just say that these - this - I'm not going to recite all 24 of these but they do include some very important areas.

For example unmet activity of daily living needs, the degree to which people express satisfaction with relationships, the degree to which people with identified health problems obtain appropriate services and availability of self-direction options for example.

So these are just a few examples of the 24 potential areas that are suggested for further research and investigation in order to really help us clarify what outcomes we want to look at and how to make those outcome measures be useful in terms of a quality improvement.

The measures that require further investigation that MAP has have identified fall into 11 major what's called domains.

These include for example client functioning, and experience, program performance, choice of setting and provider and quality of life and quality of care. And these are really important areas, particularly the quality of life and quality of care areas are of major concern to all of us.

The next report I want to I want to just speak about briefly was released by the Agency for Healthcare Research and Quality, AHRQ in 2010.

The Deficit Reduction Act of 2005 directed AHRQ developed quality measures for the Medicare home and community-based services program in the domains of client functioning, client satisfaction and program performance.

And this was in order to assess the quality of Medicare HCBS programs nationwide.

In the course of its research AHRQ identified more than 200 measure sources. And this is sort of important because it goes to I think what Steve Kay will be talking about which is that while there is very little that's been done nationwide in terms of quality measures, validating quality measures, there's an awful lot of work that has been done in the area that on which a national effort can be built.

The 200 measure sources revealed some broad themes. And for example these include several consumer survey tools that have been developed and that assess the client experience with HCBS particularly in the area of services that people who with intellectual and developmental disabilities are receiving.

Also psychometric testing has been carried out on many of the surveys used by several state programs. And this is important because if measures are tested the - it isn't necessarily required that measures be tested but if they are they have more validity and are likely to be comparable one to the next.

There is AHRQ also noted that there's no single survey tool or measure set that addresses all of its constructs. They created 21, identified 21 constructs with a lot of stakeholder input and they identified that no single survey tool addresses all 21 of these.

AHRQ's eight constructs of client experience I've just listed these here so that everyone can have an opportunity just to look at them.

But the eight constructs of client experience listed below - can we go on to the - yes, great thanks -- are of particular interest because state specific surveys have used the same ones.

And these include for example respectful treatment by direct service providers, opportunities to make choices about services and so on. You can continue to read the list yourselves so I won't recite it for you but these are important constructs in terms of state specific surveys that are using the same ones.

Okay the next report I want to just mention briefly is the Long Term Quality Alliance Quality Measurement Workgroup Report. And this was issued in December 2011. LTQA identified measurement gaps for long term services and supports beneficiaries that suggested areas for measured development and also for research.

These include transitional care measures for persons and families centeredness. And specifically measures were identified that contribute to overall quality of individuals and their families for individuals and their families and broader - that are broader than clinical outcomes.

These again include the quality of life issue, autonomy, relationships, compassion, social supports and emotional well-being.

I want to just point out that in the next slide that important, very important new work has been done by the Center for Personal Assistance Services at the University of California San Francisco.

And Steve is going to be talking about that work in some detail. But I just wanted to mention that his inventory, the selected inventory of quality of life measures for long term services and supports participant experience surveys that he has produced begins to address the gap in methods to measure LTSS quality of life outcomes.

He's used the Wisconsin Personal Experience Outcomes Integrated Interview and Evaluation System. It's a mouthful.

The acronym is PEONIES. It's much easier to remember PEONIES than the longer name as a starting point and has searched among relevant existing

survey instruments to identify previously field tested questions that relate to the domains and the quality of life measures.

And I'll - won't say more about that as Steve will be getting into this piece of work specifically. But I want to urge everyone here to take a look at this piece of work as a very important starting point in thinking about how to develop quality measures in the absence of nationally validated measures. This is a really important contribution to the scheme of things.

Okay let me just turn out just quickly to an HCBS quality measurement project that's under development by CMS.

I think most of you probably are aware of this but CMS is supporting development of a new survey, the home and community-based service experience survey that's designed to align with the AHRQ Consumer Assessment of Healthcare Providers and Systems Project -- again another multifold.

But CAHPS -- and those of you working in the healthcare area will be familiar with the CAHPS acronym -- are tools that provide benchmarks for performance of healthcare providers using data obtained largely from patients. So this is an important patient centered set of tools.

The CMS is currently testing a new HCBS experience survey that can be added to the current group of CAHPS instruments.

And the goal of the survey is to provide standard performance metrics for HCBS programs that are applicable to all the populations served including people with physical disabilities, cognitive disabilities, intellectual impairments and disabilities due to mental illness.

The survey's intended to gather direct feedback from participants in the Medicaid HCBS programs about their experiences with services and supports.

And it's different from others in that it will provide comparable information on program participants across the spectrum of disability in federally funded services.

Survey responses will be compiled to develop quality measures at the program level. And data collection for the field test was scheduled to begin in the fall of 20 - this past fall 2012.

Okay let me just move on to quickly summarize some of the quality measurement outcomes surveys that are currently in use.

And these are going to be for - many of these are going to be I think familiar to a number of you on the call.

The first is that I'm going to be just touching on is the developmental disabilities national core indicators consumer survey. This is the NCI survey that is in use in 25 states.

And the indicators are standard measures that are used across states to assess the outcomes of services provided to people with disabilities and their families.

And they address key areas of concern including rights, service planning, choice, health and safety and so on.

The second survey that's in use is the participant experience survey. And I'm sure many of you are very familiar with this one for HCBS for elderly and disabled. And this was produced in 2003 by CMS and has been in service in - it has been in - being used since then.

The survey's administered in face to face interviews and it focuses on access to care, choice and control, respect and dignity, committee integration and inclusion.

The third survey that is in use is the P&E Survey which we just mentioned earlier. I'm not going to talk anymore about that because Steve is going to be going into it in a little bit more detail just a little later.

The fourth survey is the money follows the person, quality of life survey. This one was developed by CMS in 2007 and has been in use by a number of states to target population, groups that are transitioning from institutionalized care to a care setting in the community.

There's a number of states that produce reports on the process of that transition and the experience of that transition. And a number of those reports are publicly available.

Okay the last measure I want to just talk about quickly is the personal outcome measures that they were developed by the Council of Quality and Leadership.

And CQL as many of you know has been focused on developing outcome measures in long term services and supports and community integration for a long time.

They are focused primarily on community agencies and offer products to assist in developing quality measures to determine whether services ensure consumer choice participant direction and so on.

All right let me just move on now to the role that advocates and stakeholders can play in identifying managed LTSS outcome measures.

We know that there are no nationally tested and validated LTSS outcome measures yet. Nevertheless advocates and the stakeholders, all of this really have access to the significant work that's been previously discussed that sets up both import and quality domains and constructs and areas in which information should be collected.

A number of states are using some existing managed outcomes surveys. And these incorporate key concepts that we think are required to measure the effectiveness of managed LTSS.

Until there is some kind of a national outcome survey which is not going to be immediately we really need to take advantage and consider the quality measurement recommendations from the national research efforts that I just mentioned along with these existing surveys and related tools.

And again there's going to be further discussion about how this can work in on - a little bit more on the ground.

And I want to just wrap up this section with some suggested principles for identifying and selecting these measures.

These - this may be self-evident but I think it's helpful to have sort of a set of guideposts to use as we're thinking about selecting these measures state by state.

First the measurement process should be person centered. This is I think very obvious. Person centered means that all aspects of the LTSS's planning, implementation evaluation are directed by the individual with long term support needs the maximum extent as possible or by another person import in the life of an individual who has - he or she has freely chosen.

The second suggested principle is that measurement examines quality of life outcomes. This is related specifically to the individual's living situation, choice, and control, access to personal care, the experience of respect and dignity, the extent of community integration, participation and inclusion, overall life satisfaction, health status and achievement of person centered goals.

The quality of life outcome issues are really the most critical ones I think from a LTSS perspective other than the ones that are the most useful in terms of our focus and our energies.

And the third principle is the measurement outcomes that inform continuous quality improvement.

For those of you who have spent some time in business school it sounds like total quality management and I think it's a related cousin.

The idea of continuous quality improvement is an - intended to be an ongoing process that measures and improves outcomes and the provision of person centered long term services and supports.

CQI uses both qualitative and quantitative methods to identify needed improvements in process and outcomes.

And let me just say that the basic elements of CQI as Eric mentioned earlier in - that are illustrated in the chart that he showed are system design, discovery, remediation improvement.

The idea is that this data can't just sit in the drawer or be reported back to the state agencies and on to CMS. This data has to be - has to have a living purpose. And that is to really be fed back into the systems and processes that are providing services and to improve those services and improve the lives of individuals who are affected by the services.

So with that I'm going to turn this over to Steve Kay and ask him to make this - bring us down to the ground a little bit more.

Steve Kay: Thanks Mary Lou and hello everyone. Right now I'm just going to briefly talk about how to identify measures that are useful and valid and also data sources that can be used to obtain information on quality outcomes.

Marisa, if you can advance the slide. Thank you.

So there are some practical and technical issues, quite a few technical issues. There are number of practical issues involving how to identify measures to be used.

But first I wanted to mention some sort of more philosophical issues that I think are important to start with rather than launching into the sort of practical issues.

One thing I think is really important is clarifying your purpose in making these kinds of quality or outcome measurements.

And keep that in mind when considering measurements, when considering what measures you want to use.

You may be interested in making measurements about expenditures or the kinds of services people are using or as Mary Lou was talking about, outcome measures involving quality of life.

And it - these are very different kinds of measures. And I think it's important to focus on what you want to know rather than sticking with what's traditionally been measured or what other people are measuring.

And in addition to what you want to do I think it's important to seek input from stakeholders including consumers themselves as to what they think is important to incorporate those findings and to - into the (unintelligible) you seek.

I also want to point out that it's worthwhile to consider using existing measures. It's good to start out with a search of what - what's already being used whether in your state or other states and consider using those measures either as they are or as a starting points for further development. That'll make things a lot easier.

But on the other hand they shouldn't limit you. If you need to start from scratch and invent your own measures or have a mixture of existing and new measures you can do that too.

And I'll - later on I'm going to give you an example of an effort that did that sort of development.

On to the more practical and technical issues I find that protecting and developing measures is generally (unintelligible) among several issues.

First and perhaps most important is how relevant are the measures to the actual purpose? So you're keeping your purpose in mind and you want to evaluate each measure for how relevant it is to that purpose. So are you actually measuring something that you really care about?

Next is to what extent can the measurements you're be used for comparison?

There are lots of different types of comparisons you might want to make. And you need to consider that when you are selecting measures.

For example if you're worried about what's happening in the transition between a fee-for-service system and a managed long term care system you might want to have a before and after comparison.

Or you might want to make comparisons from one managed care organization to another to see who's the best of the worst or you might want to compare your state to other states or a certain type of population to another or a certain type of program to another.

So if you want to do those then you might want to worry about consistency between your measurement and other people's measurement or consistency across the system.

Another thing to consider is are the findings you're going to get from these measurements likely to actually influence policy?

For example will policymakers actually care about the measures you come up with about the, you know, the statistics you come up with or the statistics can be generated out of the measures you develop?

Maybe the policymakers are only going to care about how much it costs or how many people are using services or how much of the need is being met.

And it's also important to consider whether advocates are going to actually care about the measures.

Advocates for example probably don't care about how much it's going to cost but they do care about people's quality of life for example.

And another thing is with regard to influencing policy is suppose policy changes, will it actually influence the measured outcomes?

Sometimes people want to measure outcomes that are not directly related to the actual services that are provided. You can make an argument to do that but it has to be that you have to make an argument that's convincing enough so that somebody who's providing services is not going to say wait a minute, I can't actually influence this outcome that you're measuring so I'm not going to measure that.

Another practical item to consider is how difficult is it to obtain the needed data? It's very easy to go and say I want these five things measured. I want to know how much it costs, how many people are participating and what the cost per member is or per participant is.

If you're on the other hand proposing to conduct some large survey that's going to be a more difficult thing to obtain which is not at all to say it's not worth doing but you've got to think about that when you're considering the trade-offs.

And finally it's worth thinking about whether the measures you're considering have actually been tested for validity or how to go about testing such measures for validity.

Validity is a technical concept with a lot of different meanings. But basically what you want to know is so you're proposing a survey, is that survey actually going to work as a whole? Is it actually going to produce meaningful results?

A couple of things to consider is are you actually measuring what you think you're measuring? It's actually striking how often it is the case that people think they're measuring something and they thought it through - they think they thought it through very carefully but when you actually pick apart the word, the question or pick apart the actual items that are being measured it doesn't really correspond to exactly what they think - what they had in mind when they started.

And a relevant issue is so you have a survey question, are the people answering the survey actually be able to understand the question? Are they answering the question the way you think they're answering it?

So these are a couple of things among the many things that one needs to consider when addressing validity.

As for data sources you can - there are basically four different general sources of data beginning with program data, overall program data such as how much money was spent, expenditures on, for example on home and community based services for versus institutional services, on long term support and services versus acute care services that these kinds of things. And these things are traditionally reported to CMS in a fee for service program.

It's very important that these data which are used extensively by our center and by other people to evaluate things like the effect of rebalancing on expenditures -- that kind of thing.

It's very important that these data still be available in the transition to manage long term support and services.

One thing that's happened is for the states that have already transitioned all or part of their systems and to manage long term supports and services we often lose the ability to distinguish between expenditures say between institutional expenditures and non-institutional long term supports and services expenditures or between acute care expenditures and long term care expenditures.

So it's a very important that even under this transition that we still have this ability to get this kind of program data.

Our second area, a second source of data is data on utilization of services which can get you information such as hospitalization rates, receipt of specific services, cost per member.

And traditionally there's been some ability to get this kind of data from program records, for example from Medicaid program records.

And there is a danger again here that we might lose that ability as the fee for service records that have been available are lost and now utilization data is going to be the property of the managed care organizations.

So the state might not have access to that. So it's important to advocate for continued availability of utilization data.

A third data source is assessment data which is important particularly in finding out about how much services people need among the participants.

And assessment data is very useful especially in combination with these other kinds of data.

So if you're looking utilization data and you also have assessment data then you can say okay how much does the person need?

For example they have need for help with these activities and then you can looking utilization data and say well they got, you know, 36 hours a week of long term services and supports and see how that corresponds to the amount that they needed.

Use of assessment data is hampered by lack of uniform measures for assessment. This is relatively urgent need to sort of have some uniform measure that everybody's using so the comparisons can be made.

Finally I don't think there's any substitute for obtaining data from - directly from consumers through interaction with the consumers, for example through survey measures or other types of interviews.

I'm very interested in measuring quality of life and other types of outcomes and, you know, such as the extent to which consumers have control over their services, the extent to which they're satisfied with their services, how their services actually impact their lives. And these other sources of data don't provide that.

But of course doing a survey is considered to be a big deal. And, you know, this is something that requires maybe an additional advocacy effort to achieve.

And now I'll turn things back to Eric who's going to talk about reporting of these data.

Eric Carlson: Thanks Steve. Let me just first take a step back from the quality and talk about the procedures for approving these various waiver applications just to be a little more specific about where the pressure points are and what you might want to do.

We talk about, you know, making things happen but just to talk a little bit about the context that in most cases the program design is going to demand that there be an application submitted by the state to the federal government either in the case of one of these tool integration proposals or in the case of a straight Medicaid waiver.

And there are various places where the state or federal government is going to have to put something on paper that the initial waiver application to the federal government, the response by the federal government either in special terms and conditions or in Memorandum of Understanding.

And then subsequently right now we see a lot of instances where some of the details are being deferred to their contracts between the state and the managed

care organization and then to a certain extent between the managed care organization and their providers.

So all of those are opportunities to put a word in. And my experience has been that this - that there hasn't been enough focus on this and then we as advocates can really do ourselves a service by being able to present those at those points and make some strong recommendations as to what should happen. And we'll be discussing action steps regarding quality measures more specifically in just a couple of minutes.

Regarding the substance of what we as consumer advocates may be asking for we're going to want much more transparency certainly much more easy access to information than what you see right now generally in the home and community-based service waivers, reports dealing with for example some of these macro issues, ability of people to reach their goals and measure against cost of service and satisfaction.

Actually those are the ones that are focused more on that person on the individual person. The macro reports are more along the lines of the rebalancing issues, how are expenditures between home care in the community and institution-based care measured based on number of persons, the expenditures, length of stay in particular settings and in the transitions from one to the other, from community to institutional setting or in the other hand from an institution to a community setting.

Also we'll want a real record of what is seen in appeals. It's a good way oftentimes to get a sense of how the system works. If you see a lot of appeals granted there's some indication that there's some - it's a - you can look at it two ways.

The position of the state usually is while the system is working because we're eventually getting things right.

But the for the point of view of the consumer advocate oftentimes is there is - that there's smoke there, there's probably fire underneath it given that there's so many reversals we need to take a hard look at decisions that are being made previously so as to better protect those people who probably have a righteous cause but for whatever reason don't follow through it with the appeal processes.

And going beyond reporting there's also an necessity to demand changes in actual operations. It's not all about data. And the data is a tool to get where we want to go.

And either after the data has been analyzed or earlier on in the system for that matter we want to be advocating for improvements to the system that'll make the system more person centered.

It shouldn't just be a buzzword. And to make sure that happens there needs to be training throughout the system to make sure that this concept of person centered care permeates throughout the operation of the organization.

On the monitoring side we want there to be an off-site visits so that there's some sense by the managed care organization of exactly what's happening on the provider level and also some review of data as well.

So on-site review but also a paper review or data review looking at the outcomes and looking at the care plans to make sure that they're developed appropriately.

I want to highlight the ombudsman issue. There's been a great deal of advocacy focused on this issue over the last few months given the approval in recent months by CMS of some of the dual eligible demonstration proposals.

And there's been some for in the Massachusetts proposal for example there's a reasonable movement towards a decent ombudsman presence but it's still a work in progress.

I would say that the Florida, recent Florida approval on the straight Medicaid LTSS managed-care system is a step backwards because the - even though CMS in the revised waiver application specifically asked the state to comment on this program their response of the state was - there's a little opinion here but maybe not too much.

I think the opinion stands up to the facts that the state did a little more than just list some of their current options that are available in the state, the fact that there is currently a long term care ombudsman program but there are current age and disability resource centers but didn't do anything to indicate that there would be a separate ombudsman program dealing specifically with this new managed care component.

And it's a really important for people given that their care is going to be determined in large part by the operation of the system that they have some independent assistance in working through that system.

One of the resources is a white paper on the need for an ombuds programs that was put together by our organization and other national programs and submitted to CMS.

In January it's available on the Web site [dualdemoadvocacy.org](http://dualdemoadvocacy.org). And that site [dualdemoadvocacy.org](http://dualdemoadvocacy.org) is on one of the resource slides that will come up at the end of this session.

But if you pull up that page and look at the upper right there is a link to the ombuds discussion that raises the talks about the current models for the ombuds program and also explains why it's very important in a managed care setting.

And then one additional thing in talking about systemic changes it's important that there be reporting requirements in systems.

You're not going to be able to have reports if you don't have the underlying data that reports can look at. So the system should be required to do critical incident reporting which reports on incidents such as abuse and neglect and death.

You certainly want to have a system set up that also reports problems sooner rather than later so that problems can be addressed before you have horrifically bad outcomes.

And also a record, you want data regarding complaints so that your system looking at appeals and grievances isn't all - solely about formal appeal the grievances but also all about lower level complaints that may be just as significant in indicating the pros and cons of a particular service delivery system.

And so with that let me pass the microphone back to Steve.

Steve Kay: All right, thank you Eric. We thought we would suggest some action steps for advocates. And we begin with the need to inspect and improve upon existing outcomes surveys.

We suggest that advocates ask the state for any surveys that are used to measure outcomes in long term supports and services in the waiver programs, in the home and community based services waiver programs to see whether there are outcome measures and what they are and to review those if they exist for appropriateness to the program goals in manage long term supports and services in looking at these existing measures take a look at them at that gaps and provide suggestions in how to fill those gaps.

Our second advocacy goal is to advocate for the state to conduct stakeholder forums to solicit input on quality and outcome measures getting input from consumers and from advocates on what measures are appropriate.

A third goal is to advocate for managed care organizations to be required to collect and report quality measures. This can be done through contract language between the state and the managed care organizations or through state level policies that require the managed care organizations to measure and report on quality.

And then finally to recommend - that we recommend that advocates do their homework and identify and recommend specific quality measures that managed care organizations can use in providing long term supports and services.

As many people have pointed out they're new to this game of long term supports and services and aren't likely to know what measures are most appropriate for that.

That is - we've come to the end of the main report and we thought that we could turn to a specific example of how in one particular - for one particular purpose we've been developing - we at our, Center for Personal Assistance Services have been developing a survey to be used for quality of life and long term supports and services.

And I say this is a very particular example. It's not meant to be a solution but is meant to be an illustration of how to approach developing a quality of life survey.

And I'm going to be referring to a report that I wrote, "Selected Inventory of Quality of Life Measures for Long Term Supports and Services Participant Experience Surveys" which is available at the URL shown on the screen.

And I did this particular survey that I'll eventually show you I've done for a very particular purpose which is the state of California Department of Rehabilitation spent some money on supporting independent living centers to transition people out of nursing homes.

And they basically would like to demonstrate that their money is being well spent. So they asked me to recommend some way of measuring that or assessing that.

And what I'm recommending is that they have the independent living centers collect data on how people are faring after they've been transitioned into the community and to be able to compare how they're doing in the community with how they were doing when they were still in the nursing home to see whether their quality of life has demonstrably improved.

So that may be a different purpose not particularly relevant to, you know, what you're interested in. But you can see that there is some - there is maybe some commonality between what I've been doing and what you might be interested in doing as advocates.

So my approach began with asking stakeholders what they thought was important. And in this case by stakeholders I meant the people who are actually doing the transition work. And these are basically advocates who are involved in running peer support transition efforts to get people out of nursing homes.

It would have been better if I had funding for a full-fledged (rehab) project together consumers and focus groups and ask them what they think are important, what they think the outcome should be measured, that should be measured in their transition.

I didn't have the funding to do that so as a fallback I asked stakeholders who themselves have direct contact with consumers.

And using that input I identified appropriate domains what I as an academic would call a conceptual framework for quality of life, in your case whatever it is you want to measure. It's important to think about what, you know, what areas you're interested in a measuring. And

Mary Lou went through a lot of different possibilities for what you what those domains may be.

And in this case, Marisa, if you could advance the slide -- as Mary Lou mentioned it was the P&E's measure from Wisconsin Personal Experience

Outcomes Integrated Interview and Evaluation system which most resonated with what I was hearing from the advocates.

It's a set of what they call personal experience outcomes what I would call quality of life domain that was developed for use in some of the home community based services programs in Wisconsin.

It's very steeped in an independent living philosophy which is I think why it resonated so well with these advocates who I spoke to.

It has - it very much has a consumer directed focus. I really appreciated that.

There some a misconception about this, the PEONIES. It's not a measurement tool but instead a set of areas for measurement.

And in Wisconsin it's used not as - not in the form of a survey but as a way of helping consumers identify individual goals which - and those goals within these domains can then be assessed. That is what I wanted to do the survey. I wanted specific questions so I didn't actually use the domains of such but I used them as guides to develop measures.

The 12, there are 12 domains that are in three areas. One of the areas is choice and there are three domains in that area -- choice in living arrangement, choice and services so consumer direction, and choice in how people spend their day.

Three domains involved health. One was health, one was safety and one was abuse and neglect. And the remaining six domains involved what they call personal experience.

You know, this is really closer to quality of life so the extent of the person's relationships, the importance of the activities that they are engaged in, their level of community involvement and their sense of community involvement, stability, how stable their life is, whether or not they are treated with respect and fairness and the extent to which their privacy is respected.

And so taking those 12 domains from the PEONIES and another set of domains developed by Rosalie Kane, I searched for measures corresponding to those domains.

So as I mentioned before, it's useful to start with measurement tools that already exist and see whether there is anything that exists that you could just take wholesale and just grab it and say let's use this.

And I went and inspected 24 different survey tools maybe they're full surveys or maybe they're a bank of questions that are part of a survey.

I looked at 24 of them. There are lots of others and I didn't find anything that even remotely came close to what I had in mind.

If I had I would have just used it because being able to use an existing survey tool adds a lot to the credibility of your effort.

As I said in this case there was no such tool. So then the next question is do the surveys contain individual questions that are relevant to the domains you have in mind and if so use them.

And in this case there were plenty of questions, you know, through these 24 surveys there were quite a few questions that corresponded to each of the domains.

That doesn't mean I have the answer there. There might not be the right questions but good to get you started.

And again as I said before don't be afraid to create your own measures. If there's nothing there be inventive and do it yourself.

And then I went ahead and organize questions that I found by the domain and then there was so many of them but I organize them by subdomain.

And let me show you an example of one of those 12 domains which is one of the choice domains and it's specifically the domain about making decisions about supports and services so it's the consumer direction domain.

And I divided the questions into subdomains one of them about hiring and firing of workers. So there are three questions that are more or less identical and they're basically do you help pick the people who are paid to help you?

One of it - one of those comes from the CMS participant experience survey. Another one comes from a Minnesota Consumer Experience Survey and another one from NCI.

And there was another one from the participant survey which was did you know that you can change the people who are paid to help you if you want to which is an interesting question.

In the subdomain of tasks for consumer direction thinking again about the people who are paid to help you do you tell them what you want them to help you with, do tell them what to help you with? Do the people paid to help you listen carefully to what you ask them to do?

A third subdomain on the next slide about services can you make changes to your budget or services if you need to?

For example can you decide to buy something different? That's from national core indicators. And then the subdomain of unwanted health from the Minnesota survey in the past year did staff do things that you didn't want them to do?

And another question from the cash and counseling followed-up survey about how often have people who were paid to help you do something when you did not want help?

So that's an example of one of the 12 domains and the questions that I found in those 24 surveys that I looked at.

And on the next slide there are further steps in the approach. It's important when you're thinking about conducting a survey to think about some of the technical issues involved in the survey. And this kind of needs to inform your thinking throughout the process.

Administration means how is the survey going to be administered? So is a going to be a written questionnaire that you hand out to people? Is it going to be an interview over the phone, an interview in person?

Is it going to be a Web survey, you know, is it going to be something where you asked the person in the facility to, you know, or you ask their family caregiver for information?

So you need to think about that. You need to think about accessibility of the survey so that people can't see or can't hear or have difficulty with cognition, you know, how are you going to handle that.

And related specially difficulty with cognition is whether you're going to allow proxies to respond to the person or better yet to assist the person in responding.

So once you've come up with your preferred domain and your questions within those domains it's important to change stakeholder feedback.

In my case I went back to the same people who had - who I had spoken to about what the domains were. And I said but what do you think of these questions? Can you look through my very long list - I think there are I don't know, nine pages or something of questions in that inventory that I came up with.

And I said can you look through these and pick some questions that you like or if you don't like any of them make up your own?

And having done that I drafted a questionnaire and there's some things to think about when you're drafting a questionnaire.

You want to make it kind of streamlined and as consistent as possible. So you don't want to ask a yes, no question followed by a true, false question followed by an agree/disagree question followed by a true, false question -- that kind of thing.

You don't want to say have one question that says during the past six months and then the next one that's during the past two weeks and then the next one is have you ever so that's kind of one thing.

And it sort of helps to have somebody who's experienced in questionnaire design look over your survey and make some suggestions.

And another thing that person can do is go through the language and make sure it's appropriate for the audience you have in mind.

You can get trapped in your own - in the world that you inhabit and forget that other people don't understand the jargon that you do in the same way as you do.

Once I was working with a bunch of independent living centers on a survey and we all thought that the word accessibility would be very well understood by the people with disabilities who were being interviewed.

So we asked them a question about is your doctor's office accessible to you? And we thought we knew what we were asking. But in fact when they actually answered they would say things like oh yes it's right on the bus stop right near the bus stop.

So even that level of jargon is not - didn't work out so you've got to be careful about that.

And a related issue is people often don't understand kind of programmatic things like who exactly is providing their services, what the name of the program is.

Sometimes people don't know the difference between Medicaid and Medicare. They may not know the name of your program if you're program administrator so you've got to be careful about getting too specific there and confusing people.

So please don't run out and use this survey. I don't think you'd be tempted to do that. But this is a - one thing it's a draft and another is it's - it applies for the specific purpose that I had in mind.

But here with the feedback from the stakeholders is what we came up with. And the questions, there are two pages of questions. I think there are 14 of them and they pretty much span - they span most of domains from the PEONIES.

The first question, do you like where you live is from the domain about choice and living situation? And then a question from the domain about safety which is, in general, do you feel safe in your home?

And then a bunch of true/false statements, the first two are about choice about how the person spends their day. I have freedom and control over what I do and how I spend my time. This is an item that was similar to one that was used in another survey but one of the advocates made a good case for editing it.

I can get out of my house whenever I choose is another item from the same domain. And then the rest of these are the sort of part of the participant experience domains.

The next one is about extensive relationships being satisfied with how much contact I have with friends and family and then importance of activity domain.

I am satisfied with my level of social and community activity, I am satisfied with the way I am spending my life these days.

And then from the domain about being part of the community I feel that I am part of my community.

And on the next slide some questions about the services that people receive, questions about, two questions about consumer direction, do you help choose the people who are paid to help you, do the people paid to help you listen to what you ask them to do?

The original item for this was do the people paid to help you listen carefully to what you ask them to do? And one of the advocates said that's kind of condescending listen carefully, take out that word.

A question about neglect, in the past six months you feel that your care was ever neglected by the people who are paid to help?

And then finally a question about respect for privacy, do the people who are paid to help you respect your privacy?

And then well so included some questions about, overall questions on the quality of life, how often do you feel lonely and how would you rate your quality of life?

I don't know what - how people are going to respond to that but I think it's worth trying.

So some further steps which I as a researcher have to worry about, if you're an advocate you may not have to worry about these but you may encourage the

people who are actually going to use these measures to worry about these steps.

Cognitive testing is important. So you need to try the questions out on some consumers and see do they understand?

Ask them so they answer yes or no to a question or true or false or whatever and ask them what they meant by that, ask them what they were thinking about when they answer the question in that way?

And sometimes you'll find out that the - that you know, that you might find like I mentioned in the example about accessibility that they weren't really thinking about what you are thinking about. And then you go and revise the questionnaire according to the feedback you got from that.

A second round of testing is you try out the survey in a pilot test and then look at the data you get. And sometimes you'll see something very strange and you'll realize you'll think it through and you'll say oh right, they didn't understand that or that question got skipped and it shouldn't have so you may need to revise the survey.

You've got to think about who's going to analyze the data and how and when and how the findings are going to be disseminated, in other words how they're going to be reported in what form and who will have control and ownership of that. And then you need to be present to monitor whether the findings are actually used and how they're used.

So that's example of how one might go about developing an actual quality of life survey. As I say it's measured as an example and not as something one

should go and use but I think it's a proof of concept that at least it's not that difficult to do to do what we're proposing.

So now back to Marisa who's going to review some resources.

Marisa Scala-Foley: All right thank you Steve, Eric, and Mary Lou. But just really quickly because we did get some questions in through Chat and I also want to allow people to queue up through the audio line, as always we've included resources related not only to integrated care and managed long term services and supports that were either part of this Webinar or just additional resources that you may find helpful in the work that you're doing I just want to highlight a couple of them because a number of you asked about these and that they were referred to during the Webinar.

First is the guide that's was the basis for the bulk of this Webinar. And that's identifying and selecting long term services and supports outcome measures.

We've got a link to that and this is a great place to remind you because I'm sure people are trying to write this down that while you can't print the slides through WebEx we will be posting them on our Web site within probably the next week or so depending on if we have any technical issues.

But you can email us if you would like them sooner than that. You can email us at [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov).

The second one I wanted to highlight on this slide was the selected inventory of quality of life measures for long term services and support participant experience surveys that was part of the work that Steve was describing in his presentation.

We've got several slides worth of resources on managed long term services and supports. We've also got a slide related to the Affordable Care act and some resources there.

We do welcome your comments, stories, or suggestions for future Webinar topics. And again that email addresses [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov).

Okay Tonya if you could let people know how to queue up for audio questions and then while we we're waiting for people to sort of get in the queue we will take some of the questions that we got through Chat.

Coordinator: Thank you. We'll now begin the question and answer session. If you'd like to ask a question please press Star then 1. Please un-mute your phone and record your name clearly when prompted. Your name is required to introduce your question.

To withdraw your question Star 2. Once again to ask a question please press Star then 1. One moment please for the first question.

Marisa Scala-Foley: Okay. So let's take a couple of the questions that came in through Chat. First was a question from Betsy, and I think this was for you Steve.

On one of your slides you had talked about potentially sort of creating your own measures.

And her question is does in creating your own measures take us further away from sort of the development of national tools or standards rather than closer?

Steve Kay: Well that's a good question. Well, somebody's got to create their own measures that address the things you really want to address.

And I think the best thing people can do - this is just my personal opinion but I think the best people the best thing people can do now is start developing examples of things that work, of things that get at the domains you are interested in and are actually fielded and work.

I mean we're have any problem for example with the National Quality Forum because there are measures out there but nobody's actually fielded them and used them on a bunch of consumers and demonstrated that they're actual useful.

So if people were to do that now I would approve that even if yes it's not that comparable and it may be a little bit less than perfectly organized.

Marisa Scala-Foley: Okay so that actually leads into another question that we got from Lisa who asks how far are we from validated HCBS and long term services and support measures being incorporated into things like CAHPS, HEDIS, and NCQA accreditation?

I think we had talked you had talked about the modified caps being field tested. She was curious about timeline.

Mary Lou Breslin: I - this is Mary Lou. I talked about the modified CAHPS. My understanding is that the test is - was carried out in the fall of 2012.

My guess is that and I'm - don't take this as necessarily the definitive answer but that it will be at least another year before there will be any file documents produced and probably more month after that before something is actually fully incorporated.

This is a process that takes quite a long time which I think is why Steve's answer to the first question was important to not be too derailed by the possibility of seeing some measures coming out over the next say two to four years.

Marisa Scala-Foley: Okay. So we got a question from Allan who asked who first of all said thank you for a thorough overview. He'd like to see - have your comments on where you see the intersection or overlay of Americans, of the Americans with Disabilities Act Title II and the Department of Justice's guidance on Olmstead segregation and integration in community living and day and employment supports in this context and in managed care contracts?

Eric Carlson: This is Eric. I'll take a stab at that. Is there - I think we mentioned some of this during the presentation if you're talking about community integration and rebalancing. You can look at some of the macro data as to where the money is going and how transitions are being done and not done.

You could also look at process questions about how assessments might be being done or not done about the person's interest in moving to the community and other processes that might be set up to make that happen.

And if you're talking about contracts there are certainly ways of evaluating the contracts as to the services that are part of the package of services that to the extent that those promote transition whether it be constantly, whether it be ability to pay housing costs, whether it be ability to pay transition costs in some way.

Other relevant questions in the contract would be the care planning principles and appeal processes that allow people legitimately to make decisions rather than having decisions made for them.

And also in contracts and in other waiver documents considerations of the amount of money they can be spent for HCBS as compared to nursing facilities.

You want ideally you'd want a system that could pay more than nursing facility costs when appropriate and not have that unduly restricted for that issue comes up in what in the New Jersey approvals.

There is some good features on that score but also some unnecessarily restrictive features. And there's plenty of opportunities to evaluate that through data and also through analysis of the waivers or the contracts that would be put in place to implement those waivers.

Marisa Scala-Foley: Okay Tonya. Have we gotten any questions through the audio line?

Coordinator: Yes. I do have a couple questions. Our first one is from Alice Dembner. Your line is open.

Alice Dembner: Hello there. Thank you very much for a great presentation. This is Alice Dembner from Community Catalyst and the principles and then the sources are very, very helpful.

And I have a question we work with a lot of state advocates who are certainly not going to have time to delve into this level of detail, you know, as they're working on these tools proposals in particular or on long term services and waiver.

So I wondered if you could sort of identify like the three to five top outcomes measures that they should be advocating for based on exist - what's available

now but they say, you know, to their states you should be using these. I don't see them in the proposal.

Eric Carlson: Steve, I think you have to jump in on this one.

Steve Kay: I don't know, I don't think you really want my opinion on this. I don't know.

I mean, you know, if - you could fall back to, you know, make sure that we know where the money is being spent and who's getting the services. And I mean whether they're getting the services they need along these sort of basic measures.

I would rather see something much more expensive than that but I guess if I had to just do a few that would be what it was.

Marisa Scala-Foley: Mary Lou or Eric, did you want to comment at all on that?

Eric Carlson: No nothing for me.

Mary Lou Breslin: While I don't have anything to add other than to suggest that two or three or four probably will not be enough to necessarily do the job that we would want to see these measures do.

And though it's tempting to try to streamline this process I think it's worth the time and effort to try to look at the measures that the most relevant to the circumstances of the particular locale or particular state.

The ones that we've pointed out here are at least a good shopping list from which to start but to try to tailor those and streamline those for the relevance of a situation that you dealing with rather than to try to rubberstamp three or

four that might - may or may not be the most relevant ones for a given location.

Eric Carlson: I'll just put in a slightly differing point of view based on my experience in California. Just to emphasize I do again based on that experience and speaking solely for myself I think there is a real benefit.

I think there is a benefit in focusing because the default in the California duals discussion was to just add more measures.

And so it's still under development by the folks in the state. But in my opinion the list of potential measures was just unwieldy because there was never any ability to never any real reason to say no to something that might have some benefit.

But my sense is that it's - it makes the whole process longer and maybe at the implementation stage will create some issues as well.

So I speaking again solely for myself I think there's a benefit in picking and choosing a bit. The question is is where is that balance between picking you're the best one or two measures and recommending the top 100 measures. And that's up to people's discretion.

Marisa Scala-Foley: All right. With that unfortunately we are out of time. If there are questions you would like us as I mentioned earlier if there are questions you'd like us to follow-up on please do feel free to email us at [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov).

I want to say thank you to our speakers for a terrific comprehensive presentation and thank you to all of you for your questions and for your attention today.

We do thank - we also welcome your suggestions for future Webinar topics.  
And again the email address is [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov).

We thank you all for joining us today and we look forward to having you with us on future Webinars.

Coordinator: Thank you. And thank you for joining today's conference. You may disconnect at this time.

END