January 31, 2018

Good afternoon, welcome to today's webinar, we will talk about using the national core indicators to develop contracting strategies. My name is Eric Anderson the Senior Director of the National Association of States United for Aging and Disabilities, otherwise known as NASUAD. This webinar is presented through the Business Acumen Center a part of the business acumen disability grant managed by NASUAD made possible by the Administration for Community Living. Shortly after today's session you will be able to find the PowerPoint and recording of this webinar along with the archives of all the webinars at HCBSBusinessAcumen.org/webinars. There will be time for questions and answers at the end of the presentation please ask your questions in the lower right-hand corner of your screen during the presentation. Todays speakers, Martha Roherty, Executive Director of NASUAD, Laura Vegas Director of Managed Care Business Acumen with the National Association of State Directors of Developmental Disabilities, April Young, NCI-AD Director with NASUAD, and Julie Bershadsky Director NCI-AD with the Human Services Research Institute, will discuss the National Core Indicators and how they can be used to develop contract strategies.

Throughout the presentation we will start with overview, and an introduction, and why CBO's should care about quality, will talk in detail about the national core indicators, followed by the aging and disabilities, and again how they can use this data, and thank you in a. With that I will hand the presentation over to Martha Roherty.

Think you, it is great to be with you and everyone today. One of the reasons we wanted to have this call, we want to turn the data that we have available on quality into actionable steps. Why do we measure for quality? Measurement is a tool, a quality improvement tool and not an end to itself. That is what we will be talking about today. The measurement can drive improvement, help to inform providers, and consumers and other stakeholders, and it can help influence the payment methodology, the you are receiving. As well as some of the -- that you are receiving.

We will talk about two tools that have been developed by the states and their partners at NASUAD, and April Young. The first tool is the national core indicator which was developed in partnership with the development disability directors, it has been used for over 15 years already. The national core indicators for aging and disability services has been used since 2015, and we are exciting to say -- excited to say that we have can hear my. The tools to measure satisfaction with the quality of their life it is given in person one-on-one. The national core indicator tool has several tools, they have a couple of surveys as well. As I said, it is a state driven tool that has been created by and for the use of the states, first by the DD network and then by the aging and disability network. Has been used very successfully to improve the services that individuals are receiving.

As I shared with you there are three main partners in the project. Including the states, there are four, the human services research

Institute, our own generally -- Doctor Julie Bershadsky , she will be talking to you about more of the data as we go forward. And then NASDDDS developed NCI with their leadership, and that tool has been instrumental in helping the state DD directors to drive rebalancing along with other improvements. More recently, the national associate for aging and disabilities, they help with the entire continuum of care, managed care, and the labor services for aging and disability.

Our additional part of that we have in the program is administration for community living which is supported -- has supported the project in the last for five years. Recognizing its value, currently ACL has a contract with HSRI for a couple of things, to refine and expand the use of the NCI a survey. It is specifically they are contracted to do three things, one is to publish the results, of the properties, peer-reviewed journals, the second is to revise existing measures for persons attendant planning, and the third is to select measures for the national quality endorsement.

The next slide will show you the states that are participating in both the national core indicators, and the NCI-AD. As you can see, we have such a wonderful array of states that are participating in both surveys across the nation. The next slide?

One of the things that I wanted to emphasize is how the community based organizations can utilize this data. It is a very proactive approach, meaning that the health plans can look at the data in order to approve their approach to services. In the national core indicators services for example, several states over sampled their consumers and therefore were able to compare how one states managed care organization was performing, versus another state. One of the things that a CBO could do, is to look at that and see if there's anything among the scores that we could do that would help address some of the differences between health plan performance. Secondly, you can go and attend some steak holder sessions to learn what the health plans in the state are doing or viewing them as important aspects, from that you might be able to look for services and support that you could do to help support the improvement of the plan overall or the health plan be delivered overall.

Third, you could use your expertise, to help in managing any of the challenges that are being shown if you look at the data. And then you could approach the health plan, four strategies, improving the data results. Many of the states will begin or starting to begin to hold the plans accountable for the data that they are collecting. Using the national core indicators for aging and disability services. In addition, many of the states are using both the national core indicators, and the national core indicators for aging and disability services as a way to measure their improvements with the a CBS regulation -- HCBS regulation and setting role. You will be able to work with the state and demonstrate how your services could be able to help them as they were managing for that performance metric as well.

Now we will turn our attention to the national core indicators, I will turn this over to Laura Vegas he will talk to you more about that specific tool and its use. Thank you.

Thank you Martha, as Martha said my name is Laura Vegas, I work with the national Association of State Directors of developmental disability services. Affectionately known as NASDDDS. In addition to working on our business acumen project I also work with Mary Lou Horn who is our NCI project director on this project. This afternoon I want to give an overview of the national core indicators projects, a little more history about where the national core indicators began and came from. And then give some examples have -- of how we think community-based organizations might be able to use this data from the national data to look for opportunity to look at future partnerships with healthcare payers, and managed-care entities.

As Martha said, NCI is a voluntary effort by public developmental disability agencies to measure and track their own performance. In 1997, 15 state directors convened with NASDDDS to continue discussing the performance measurement framework. This was one that they could be shared across the states. They were interested in how to measure quality, how could they ensure that their services were meeting people's expectations of quality. So directors and staff in these 15 states work to identify the major domains of performance, the subdomains of each, indicators measures and data sources. Over the years, the NCI tool has been revised, to meet the changing model of service prevention -- in the nation, and to make the tool streamlined and user-friendly.

The purpose of NCI was initially to support the different agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time. Compare results across the states, and among the states, and to establish the national benchmark for quality. Staff from NASDDDS makeup the team, and they are responsible for overall project management. Currently as Martha showed in the map, there are 46 states, who are part of NCI, and including DC, and their and there are 22 substate entities who participate in the national core indicators project.

So we talk about indicators. And in Decatur is a measure that is used across states, to look at the outcomes of services provided to people and their families. With developmental difficulties. These indicate care areas of concern including things that are important to quality of life, such as employment, rights, service planning, community inclusion, choice, and health and safety.

The goals of NCI are as I mentioned to establish a national recognize that a performance and outcome indicators for DD service systems. And to make sure that there are valid and reliable data collection methods and tools for which states can use to compare amongst themselves and with each other. And we want to report state comparisons and national benchmarks of system-level performance.

As you can see, this slide demonstrates how national core indicators collect data. We use a variety of surveys to collect information about the DD service delivery system in the state. The first is the in person interview, formally known as the adult consumer survey, one of our primary tools that is used to collect important information about people receiving services. That was the original NCI tool developed by the state. In the in person surveys, it is a one-on-one person conversation with a sample of adults who receive services to collect information about their experiences.

The survey is key to very important person centered outcomes, that measures system level indicators, related to employment, choice, relationships, case management inclusion, health, etc. NCI also uses some other surveys, we call them the adult family, the child family, and family Guardian survey. Those are mailed surveys, they are sent in the mail, there also able to be accessed online. For a family to complete. We also have begun using surveys which look at the issues around direct support professionals including their benefits, wages, training, trying to get a picture of what is going on across the nation with our direct support professionals.

There are three adult and family surveys, one is called, what is for the family, living outside their family, one is for the adult living inside the family home, and one is for children living with their families. We also gather information from families about the support their son or daughter is receiving.

I think it is important to note that the accessibility survey currently there are 17 states that participates in the national reports, it is been edited and finalized, it should be released pretty soon so look for that on our NCI webpage.

I've Inc. -- today were get a Pope -- focus on the in person survey, it is divided into three domains, including individual outcomes, family outcomes, health, welfare, and system outcomes. In each domain there are individual outcomes. For each outcome, there are individual indicators that help define what is meant by the outcome. So for example, in our adult consumer survey, you may find under family outcomes domain, there is an outcome about choice and control. In the choice and control outcome, there are various indicators that we use, we ask the person we survey and interview the person, to discover if they have that indicator in their lives. So for choice and control, an example might be whether the person makes choices about their daily schedule, where they were, where they live, who they live with, how they spend their personal time etc. It is a high level outcome, domain, and that we have outcomes for each domain, and that we have indicators for each outcome the help us determine outcome.

There are key steps in collecting data, and how we actually perform the adult consumer survey. First of all, the state, identifies the sample. There is a variety of methods that have been used by states to identify the samples, some states use a random sampling method, some state sample by programs, some states sample by geographical location. Some state sample by state-funded versus waiver funded, it is up to each

state to determine how they want to pull -- pool their samples. Once the sample is determined, and people are chosen, the states are responsible for making sure that content is required. -- Consent is required. Every state has a different process for ensuring consent. In the state identifies the people who will be conducting the interviews, and those interviewers will be assigned to the sample. So if I am in the interviewer -- I am an interviewer, I will be assigned a list of people to interview using the NCI adult consumer survey, based on the sample of people pooled. Then there is a process of scheduling and completing the interviews, pre-survey information is key. Coordinating the interviews support the person, we work pretty closely with community-based organizations to schedule. Then we go out to begin the process of the gathering of information and data, and entering it into our data entry system. For the people who have been pooled on the sample. The first group of information that we capture is called our pre-survey information. This information is not actually entered into the database. This information is obtained before the interview, and it has tips about how to best support the person doing the interview, what times are good to interview the person, where they might be, any adaptability or accessibility issues that they may have, though surveys really are to help the interviewer be able to do the best interview that they can with the person.

Then there is a variety of background information, that is gathered, we get that information from the best source often times state has this information, in their service plan databases, or demographic databases. We try to get most of the background information before the actual face-to-face interview. Some of that information is captured during the interview, and sometimes after the interview in a follow-up method. That is demographic information such as your age, when was your last primary care doctor visit, those kind of information's. -- That kind of information.

Get to the actual in-person survey, that tool is divided into two sections, the first section we refer to as the NCI meeting, it is a list of questions or indicators for which only the person who receives the services can respond. So someone cannot answer on behalf of the person, four section 1 of the NCI -- for section 1 of the NCI. There are questions people do not want to answer, sometimes there are questions people cannot answer and that is okay. We only want answers from the person who receives services for section 1.

In section 2, of the survey or the NCI meeting, people who receive services can respond, or they can get assistance if needed. We call that allowing a proxy. This section of the survey is a person with -- who would like their only member to assist them in answering questions, or answer on their behalf, or direct support professionals where they are close to, if they would allow that person to participate in the survey and get the information from them.

Clearly, state DD agencies are the primary users of the national core indicators data. They administer national core indicators in different ways. In different states, it looks very differently. Every state DD agency, who is part of the national core indicators project has the

primary responsibility of providing coordination, for the project. The state is responsible for making decisions about policies and procedures on how the project is to be implement it. They are responsible for making decisions on how they are going to get consent. The procedures around the consent, and making sure those are followed, they are responsible for identifying the sample size, and the scope, and the state DD agency staff, they are the people who are responsible to the NCI national team, when it comes to project management.

Some states, may use external vendors. They may contract with external vendors, universities to assist with the national core indicators project. And through those contract states, they may have external vendors doing things such as hiring, training, managing the interviewers. They may have external contractors who do the data entry, they may have them acquiring consent, based on the methods that the state has prescribed for doing so. Sometimes the external vendors may do follow-up, as indicated. And they are also responsible for fidelity really -- to the protocol and reporting to the state agency.

Again, state DD agencies are the primary users of this data, states use the information of the data in a variety of ways. Some a very creative in the way they use the information and they really use it in a robust informative way. A lot of states use their NCI data to look at quality assurance, and opportunities to improve their services. States are very competitive, and they want to know how we are doing compared to her neighbors, how are we doing compared to our region, the other states in our region. Which date is way better than us and perhaps how can we learn from that state how to improve our services and support.

A lot of states use the national data set to develop reports for stakeholders, to share with them their systems performance results, and a lot of states use it to assist with community transition, and they share with quality stakeholder councils, that look at quality for some states are very much involved in the use of the NCI data. Some states especially when it comes to this accessibility survey, the reports to the state legislatures, to inform them of the issues within their current system, of DD services.

Although the primary user for national core indicators at present our state agencies, there are ways that community-based organizations can use the national core indicators. They can look at their state specifically to identify service needs, and gaps. They may use the information to identify opportunities to help manage care entities increase quality and satisfaction. And as a side note, we are pulling together some states to begin looking at how to use the national core indicators in states that are currently using managed long-term supports and services. We will be looking at how we can use the data that we are already collecting, and the process that we already use and help apply it to those states who contract with health plans, health care entities, to help them look at quality and system improvement. Again, community-based organizations, you can look at this to compare performance across states, you may see the your state needs help in this area, versus the national average. Or another state. CBOs can look at the national data to explore ideas of improvement,

potentially needed within their own operating areas. So, if there is a statewide trend that has identified through the NCI, chances are as a community-based organization or supers -- service provider there are things you can do at your level as a provider organization within your individual system and operating area to help improve performance in that area.

Community-based organizations can also use the data as a benchmark for their own performance. They can see where they are able to contribute to states performance, and possibly the improvement of the states performance across time.

This afternoon I will walk through a few samples of how the data collected through NCI can be used in several different ways. I just want to say, that for the information that I will be talking about, the data that I'm talking about this afternoon, these things do not indicate a direct correlation. The information that I want to talk about will give CBOs a really good place to start, in terms of making assumptions about the system, and giving them a place to start to dig down a little bit more to determine where they can provide support or develop relationships with managed care entities.

If we look at the adult consumer survey data from 2016, we learn, and we are looking at employment, there are several indicators that look at employment for people. The data from 2016 shows us that as a valid response to the national core indicators adult survey, resulting -- regarding whether a person has a job in the community, 19.1% of the people do have a job in the community. However, 80.9% people who were part of the national core indicators do not have a job in the community. We wanted to know, what about those 80.9% of people? What is it about them? Do they not want a job? Do they want a job and they just don't have one? What is the missing information. So we continue to ask questions in the support sample, we asked of those 80% of people who do not have a job, would you like to have a job in the community? Of those folks, of those who did not have a job there were interested in becoming employed were 53% of the people. So of those people, we looked at those who do not have a job it would like to have a job, we look to see if there is an employment goal in their plan? 458.9% of people, there was no employment goal in the plan. So we are looking out of 365,000 responses, 2008 people want a job, but do not have a goal in their plan to have a job. So what are the assumptions they can be made from looking at this data? Some things, the CBO might be able to make with formulating a plan, to approach manage care entities for potential partnerships, 53.3% of people who would like a job do not have a job, perhaps there is a need for additional employment providers. Or benefits counselors, what is going on in the CBOs community, that would cause 53.3% of people who want a job to not be able to be employed.

Or, CBO may look and say, as the percentage of people who do not have an employment goal in their plan, but one a job, is 41.1% which is rather significant. They might assume there is a need to approach the managed care entity, to provide assistance in how to conduct real person planning. So the goals and outcomes that people end up working

toward in their service plan, reflect what is really important to them in their lives. Or, finally a CBA mail -- CBO may look at the people serving in their own operation and determined that they will change their assessment process to make sure that they are truly person centered, and that people's lands truly have the goals that are most important to them in their lives.

This is another example of how you can use the national core indicators, if you are looking at is the level. The community-based organizations are looking at how the state performances, and try to determine how to assist the state with improving the performance. We used an example of Missouri and New York. We looked at the people who did not have a job, but wanted a job, and had employment as a goal in their service plans. So, you can see on this scale, on the left side, is the percentage of people who wanted a job, who did not have a job, but wanted a job, and had an employment goal in their service plan. Across the bottom is the percentage of people who had that in their service plan. You can see, the NCI average is 41%. You may look as a CBO in New York and say we are very far above the national average, we are 6% above the national average we are doing okay in terms of making sure the people who want jobs have that as part of their service plan. Or you could look and say, what are the seven states ahead of us doing, that could help us improve our performance in that area. The same with misery, looking at 34.8%, of the people who do not have a job but one a job and have that goal in their service plans, if you were a community-based organization of Missouri you might look at yourself, and say what can we do for the people that we support to ensure if they are interested in obtaining a job, that that is part of their service plan and part of something that that is work towards. In their list of services and support. -- Part of something that is worked towards in their list of services and support. You can see what kind of policies and procedures that they have in place, that calls greater success in this area. I want to point out that we used Missouri and New York as our example states because they happen to be two of the states that are in our business acumen learning collaborative. We decided to highlight those states, and talk about some of the things they can be learned using their specific information.

Using guardianship for example, if you look at the percentage of people who have guardianship, limited guardianship or full guardianship, or no guardianship. What my that tell you as a community-based organization? In terms of how you can approach a health plan, and say this is going on in our states, this is our performance in our states, here are the services that I can provide and that you can contract with me to provide to help improve performance in those areas. We looked at guardianship specifically as an example, there is so much work been done about supported decision-making, people having rights that are adjudicated back to them. It is so important for people with intellectual and developmental disabilities to understand their rights and have the ability to exercise those rights. We look at guardianship using the 2016 data, out of the national data set we found that 45% of people did not have guardianship in any form or fashion. However, 69% of the people had some limited guardianship. And 41% of people had full guardianship, and there was a small percentage of people that had a

guardian, but we were unable to ascertain the level, and 3% of the sample they did not really know whether they had guardians or not.

Based on this information, I community-based organization could see opportunities perhaps to provide supported decision-making support to people, who either have limited guardianship or full guardianship. Or provide advocacy training to people,. To peer mentoring, -- peer to peer mentoring, you could approach a health plan and say I see that 41% of the people we serve in our state have full guardianship, given the importance of people being able to understand and exercise the rights, we would like to approach you to begin providing advocacy training. That is another sample of how you might pool information from the data set, and use it as a community-based organization.

We have a website if you are interested in learning more about national core indicators, you can, the link is on the slide you can take a look at this . If your state is participating, the website we have the project overview, there are national and state report so you can pool your national reports. It has been written and is available for public viewing, there is a cool tool that is a chart generator where you can look at how different indicators or the performance for the different indicators for your states look specifically to your states, and then you can compare them to the national average if you are interested. There is also links to presentations that have been done around national core indicators, had to use the national core indicators doing proof quality, -- to improve quality, there are indications that are written by HSRI in cooperation with NASUAD about the results. Also at this website you can find more information about the NCI national team, including the contact information, and so, if you are interested in learning more about the national core indicators or having further discussions about how you as a community-based organization could use the national core indicators to develop a business proposal or approach managed-care entities, to develop new partnerships, we will certainly love to dialogue with you and engage in a conversation.

So that is the national core indicators overview and a couple of examples of how the information may be useful to you. Now we will talk about national core indicators, for aging and disabilities, I will turn the time over to April Young and Julie Bershadsky.

Thank you. A right thank you Laura, this is Tran -- April Young, I wanted to clarify that unfortunately Doctor Julie Bershadsky woke up not feeling well this morning, and take it from me she does not sound so great, so we would certainly hope that you start feeling better Julie, she's on the call to help answer questions, but I will cover the majority of the slides. We had a question come in the wanted to address before we jump in, the question from Marian, about what CBOs are and what we mean by that. Eric also feel free to jump in. In general community-based organizations are the organizations that are providing services to individuals, an example may be a center for independent living, or an area agency on aging, Erica would you like to join in and add anything else?

This is a clarifying piece, it is such a broad term. Because it is such a broad term, and the amount of confusion about their, the administration of community loving -- living helped us come up with an definition. It describes local organizations that living that provide -- the provide health well-being, independence and community participation with people with disabilities are older adults. Examples include organizations such as centers for individual -- independent living, developmental disability organizations, resource centers, areas of aging, it encompasses a number of different types of organizations.

Thank you Erica.

The way things will go on the NCA -- NCI-AD slide. We will go over what this is, and then we will jump into slides that show actual data from an example reports, and then how that data could be useful for CBOs. Thank you for joining us today, the project is co-managed by NASUAD and HSRI, I like to think of this as a tool that is by states for states, during the development of the NCI DD survey, we have a steering committee that was heavily involved with dropping -- drafting the questions, from soups to nuts. They were involved in the development of the NCI, that included state representation, all across the country, we had lots of states involved with the development.

The information comes directly from individuals receiving services, we also have a survey that is for the individuals proxy, but only as needed. We really stress and emphasize with surveyors to always try to interview the individual first. Our data is coming directly from individuals that have experiencing -- experiences in receiving these publicly funded services.

Just like the name says we are focused on older adults, and adults with mostly physical disabilities. Been served by state long-term services and support systems. And you can see that our table here, below, shows that there are many different programs funding programs that states can choose to survey. We are not limited to one environment, it is not just nursing facilities, it is not just people who are receiving Medicaid, home and community-based waivers, we are across different environments. It is totally up to the state what they would like their survey population to look like.

Our next slide, shows all of the different NCI 80 measures and domains that we cover, it is very wide-ranging. It is a survey that asks about everything from relationships, to medication, to work and employment, to care coordination. Our information comes directly from the individuals receiving services and our measures are focused on the consumer outcomes.

So the purpose of NCI , I like to say this slide is what this is all about. This is the why behind NCI-AD, so that feedback from individuals receiving services about the quality of life and their service satisfaction cans of Ward state agencies making quality improvement decisions for those programs. It is a cyclical impact, we start with the individual, providing responses to the survey questions, the survey data is used to improve programs, and that has eventually a

positive impact on the individuals experience of care. So we start with the individual and hopefully end up improving services for that individual.

So let's see what sets NCI-AD apart from other survey tools. The states own and have immediate access to their own data, we talked about how the survey can be administered across settings and programs with different funding sources. States can add their own specific questions to the survey tool, if they want, and Julie and I are here to help with that process as needed to assist with formulation of the questions, and also help determine where the question should fall within the survey. We act as the technical assistance gurus for the NCI -- for the NCI-AD project for each state. The survey results can be used to compare programs within the states, compare results state to state, results are risk adjusted where necessary to ensure the comparisons can be made. The NCI-AD survey also crosswalks to the NCI measures, the survey is not just about are you getting services in are you okay though services, goes a step further. It focuses on how the consumer experiences their services, and how the services impact their quality of life. States participating in and -- NCI-AD agreed to post the reports on the website, data is transparent, anyone can look it up, we have a slide that will show you what the website looks like, it is pretty easy to remember, www.NIC-AD.org the NCI-AD can also be used to compare results from year to year and identify trends in data with circ -- where certain target areas have improved or need more attention.

This is a slide about how states can use NCI-AD data and then we will get into how CBOs can use that data which is why we are here. States can use NCI-AD data, this is big picture stuff, to identify areas for service improvement, to communicate information to advocates and stakeholders, and we have found that there is a certain level of trust in this data, knowing that it comes straight from the consumer. The data can also be used to compare programs within the state, track changes over time, and if the sampling strategy allows we have talked about this a little bit, the state can compare managed-care entities. So those are some of the reasons why the data is important to the state, and also why it is important to managed-care entities. And why managed-care entities pay attention to that data and that is why CBOs might want to make them familiar -- themselves familiar with the information and be aware of what type of information is collected in the survey. Possibly they can use that data in the reproach -- approach with managed-care entities.

I want to explain, and discuss an example slides about the way that this is set up. We will go through three data slides and then we will show how that information can be useful for CBOs. The data is from the Texas NCI-AD reports the tranny -- 2015 and 2016 report posted on the website. It is real data, but the suggestions for applicability is hypothetical. Those are just suggestions way to help CBOs into that mindset. Of how they can be helpful for NCOs. To contract with.

Our first slide is on service coordination. It shows the proportion of people who services meet all of their needs and goals. You will notice

here that Molina came in the highest at 60%, and's America group came out the lowest at 39%.

The next light is care coordination, the slide shows a proportion of people who reported someone followed up with them, after discharge of the hospital or rehabilitation facility. Here we see CIGNA, and United healthcare had the same percentage at 82%, superior came in at 69%.

And picking up the highest and the lowest as we go through these. The next slide in this kind of data sets, is on community inclusion, and it shows the proportion of people who are able to do things that they enjoy outside of their home, when and where they want to. Here we can see that superior came in at 76%, and the range went down to United healthcare which came in at 52% bigger

--. >> I was looking at a question they came in, the surveys are administered face-to-face, we currently do not do over the phone interviews or surveys. It is all done in person, with the person receiving services or their proxy.

Of those data slides that we just reviewed how good I can be applicable for CBOs? -- How could that be applicable for CBOs? The service indicator indicates -- for those that meet their goals, we can infer that they may want to focus on some of the service coordination activities, such as development of service plans, reviewing needs and goals with their members, so that is an opportunity for CBOs to approach America group with ways you can assist America group in that endeavor. Maybe her CBOs specialized in information and referrals, which could lead to members obtaining services that help them meet their needs and goals.

That is one example. The second slide discussed after the hospitalization, as a CBO you could use that data to approach CBOs with follow-up data once you know someone who has been in the hospital. If your CBO is sharing that information with the NCO, that helps them to know that they might need are are in service court Nader to follow up with that person because the CBO told us that they have been in the hospital, and that could increase their percentage for that indicator. Approaching the NCO and coming from a place a partnership goes a long way. We know it is hard to know when an individual goes into the hospital, and the health plans do not always find out and tell it has already occurred and they are back out to the community for quite some time.

Finally, the third slide, CBOs can take notice that United healthcare had a lower percentage of respondents saying that they could do things outside the home, when and with whom they wanted, an approach that MCO with services and programs to help members get out to the community. So basically think about it as if you were the NCO, how the CBO offering to support your work would be attractive to you. Especially in areas where they might need extra help. You might have a good idea of where those areas are, because the data is posted on our website and is available for everyone to see.

Our next side of slides -- set of slides sure proportion of people who have concerns about falling or being unstable. CIGNA came in at 82%, superior came in at 66%. Our next light is related, the proportion of people with whom someone is talk to or worked with to reduce risk of falling or being unstable. Superior at 30%, and United healthcare at 77%. And then our last slide for this set is on healthcare, it shows the proportion of people who have had a routine dental visit in the past year. United healthcare respondents came in at 46%, and superior came in at 28%.

How can this be applicable to CBOs? Inflecting on the slides with the same mindset, the data shows us that people have concerns about falling, but the proportion of people who worked with someone to reduce the risk of falling if they had those concerns, was as low as 30%. So there is another opportunity here for CBOs to proactively reach out to health plans, and discuss your risk fall of monitoring activities. We have some prompting questions on the slide here, to help get in that mindset, how do you let health plans know of fall has occurred to an appropriate follow-up could be made? What kind of tools you have a disposal to monitor false? That sort of thing. The last data slide was on dental visits, and we noted that superior had room for improvement, so the CBO could approach that, with examples of how they are helping educate or refer members for routine dental visits. Quickly we will look over these last few slides. This one is on self-direction, and shows the proportion of people who can choose or change what kind of services they get and determine how often and when they get them. Superior came in at 60%, and United healthcare came in at 45%.

The last two are unemployment this one shows the proportion of people who would like a job, if they are not currently employed, America group we see is that 33%, and United healthcare that 60%. And then of those people who reported that they did want a job, this shows the proportion of people who reported that someone had talk to them about job options. We have superior 9%, and United healthcare at 29%.

Our last applicability side, take the time to learn about the NCOs in your area and what are their goals. Does the staff go through person centered training, it seems that most people do these days, could there be a tie in their. Since -- in there. Could we help change the type of services they get, the argument could be made if the staff is trained in person centeredness, they could help better. Finally those last couple of slides in employment were shown that the proportion of people who would like a job were substantial, up to 32%, and there were shown the proportion of people were someone talk to them about a job if they wanted one, and the average is at 50%. So there's definitely -- 15%. There simply room for that number to increase. They have a philosophy that people want to work, and they should be able to work as an option, does your CBO also have an employment first policy in place, could they communicate to the NCO about the CBO philosophy of employment, and opportunities to help address the low percentages in those slides.

So those are hypothetical examples of how NCI-AD data can be applicable for CBOs when you are thinking about contracting with NCOs or in the

process of contracting. I last slide, shows the website. As I mentioned we have our state, and national report posted, also we have other webinars and presentations, that Julie and I have done. I will give an overview of the project. With that I will turn this over to Erica I believe.

All right thank you April. And Laura as well. Just to recap, we have a slide here where we are talking about how you can utilize that data, really be proactive, identify areas and organizations that you can help support. Go ahead and go to the next slide, we only have five minutes and we actually have a number of questions in the queue. So I want to go straight to them. First off either April or Laura you can answer this are the session standardized and use in every state and do they align with quality measure in Medicaid?

The questions are standardized, and they are the same questions asked in every state. With the qualifier that some states have their own state specific questions if they want. Every survey is the same from state to state.

Very good. Do you have examples of supplementary questions that they may add to the survey?

We do, Julie actually created and has been keeping track of all the different questions that have been asked, I think that is something that we can follow up directly with individuals.

And for NCI, HSRI has also kept up with the supplemental questions.

Are there any questions in either the surveys about how transportation may affect outcome?

This is April, for the NCI -- the NCI-AD survey we have a section on community, and it does ask questions about transportation and if the individual can get to medical appointments, when they need to, and also questions about if they can do things outside of their home. More things for fun, or entertainment rather than just medical, asking if the person is active in the community as they would like to be, and one of my data slide was about that as well. We do ask about some transportation.

We did the same thing at NCI, we look at is the person of the transportation that they need, to go out of their home as much as they want to, and do the kind of things that they're interested in. On the frequency that they are interested in. We look at transportation in that arena. >> I think this is a clarification, I think the both of you spoke about this, the surveys administered face-to-face, by paper, electronically? Do all states administer the same way?

So this is April, the NCI-AD survey depends on if there is a vendor during the survey, and whether or not they have devices that can be connected to the Internet, and the survey can be done through that. It is still a face-to-face conversation, but the responses can be entered into a computer as the surveyor goes through the survey tool. Or you

can always use a paper version of the survey. We do try to help surveyors be really familiar with the tool, how to be a conversation, and establish the rapport with the individual. So that makes that information possible.

This is Laura, for NCI, the adult consumer survey, the actual section 1 and section 2 are conducted in person, it is a conversation as April said, with a person who is selected to be part of the sample. Then we have the family survey, and the accessibility surveys, which are either mailed out, or available online, if there are on paper there melts back to the state, or some states give families the option of going online and completing the survey. The accessibility survey is the survey that is said to states and they distribute that to the provider organizations. And it is a paper survey that they submit back to the states.

Very good. Unfortunately it is already 2:00. We have a number of questions we were not able to get to, we will work with Laura and April and Julie to provide a written response that we will post to the hcbsbusinessacumen.org website. The Q&A portion as well as the audio and webinar will be available. We look forward to talking to you soon. Goodbye. >>

[Event Concluded]