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Good afternoon, everyone. We are working to make sure that we can resolve the audio issues and I believe that we have. It would be great if somebody could just confirm in the Q&A or chat box that you can hear us. Fantastic. We are so sorry for the short delay. And again, we might just run a couple of minutes over. We are going to go ahead and start over but I will try to do my introduction a little bit more quickly. So again, I am Nanette with the NASUAD and I want to welcome you to the webinar. The slides and information will be posted to the website in the next couple of days and my colleague has put the web link up in the -- web link in the chat box. Just a couple of reminders, all participants are on mute to reduce background noise but we welcome your questions or comments through the Q&A function at any time and we will respond to those after the court -- presentation. Today, we are testing a new feature with our webinars. We are exploring the use of real-time captioning and want to thank Caption Colorado for providing us a demonstration of captioning on today's webinar. On your screen you should see a media viewer panel on the bottom right where the captioning will appear. You can minimize the panel or have it open., it will not interrupt the slide presentation. If you want to share any feedback on the use of captioning, we would love to hear that. For today's presentation, we are joined by my colleague, Damon Terzaghi, senior director at NASUAD, as part of a project for the state of Colorado, we conducted a national survey on data collection and outcome measurements for services for older adults and persons with disabilities. A topic that we know is of interest to many states. Damon is going to walk us through some of the key findings and later in the year, we are going to release a report that is going to explore these in even further detail. So because of our delayed start, I'm going to turn it right over to Damon.

Thanks so much, Nanette. And thank you for joining us this afternoon. Today, we are going to talk through the results of a survey that we administered to -- a national survey to all states. That was focusing on various components of their information technology system, as well as long-term services and supports, programmatic designs, and how those different components translate into outcomes measurement. And, for today's presentation, I really want to draw a distinction between data collection and program management, and what we are talking about here with outcomes measurement.

So, when we think about a lot of the reports and the monitoring that program administrators do around their long-term services and supports systems, often times, it really focuses on, you know, outputs and core metrics for service delivery. Things such as number of services delivered. Number of individuals served. Cost per unit, and overall cost of the program. While these are very important components of any program administration and monitoring, when we talk about outcomes measurement, we are thinking more about the impact of the services delivered to individuals. So, when we are talking about outcomes, some of the

examples of outcomes, measures we have seen from states, include things such as reduction in inpatient hospitalization utilization. Reduction in emergency room visits. Fewer people being served in facility based or institutional settings. As well as increased health status, increased functional status, and increased satisfaction from beneficiaries with the services that they received.

So as we move through this survey, I just want everybody to keep that distinction in the forefront of your mind because it is important when we think through the current status of where states are at with their data collection, programs measurement, versus where many states in the federal government are working to go in the not-too-distant future.

So, a brief background on this project. We worked with the state of Colorado, specifically, do do some more deep analysis and data collection on the current status of their health and human services information systems, and outcome measurement process, as well as this national survey to assess what other states around the country are doing with their program management, outcomes measurement, information technology systems, as well as programmatic design. Now, the key desired outputs of this project are looking at what our available data points that states currently collect, what are methods that they used to collect this information, what are the data systems that currently exist across the country, as well as the desired data systems that states would like to see in order to improve their program management and outcomes measurement, as well as identifying potential data points that could be used to measure outcomes and transition away from

an output measurement system, to an outcome measurement system. So, as I mentioned, there are two parts to the project, the Colorado specific analysis as well as the national data study. And, today's presentation is really going to focus on the second part of that project, the national data study.

So, one of the questions we have is why, at this juncture, are we putting more emphasis and more effort into studying data systems and looking at the outcome measurement process. And, it is really indicative of the challenges that we all face every day as we are trying to do our jobs and serve seniors and people with disabilities in the community, improve services, while grappling with limited and stagnant funding sources with a rapidly increasing population. So, because of all of these pressures, we are seeing a lot of emphasis from federal administrators, from state program managers, as well as from legislatures at the state and federal level around truly measuring the impact, the value, and the outcome of services provided.

So, moving on, we will talk about the survey specifically. We drafted a survey in conjunction with our partners in the Colorado State Unit on Aging as well as an advisory committee that they had created to oversee the work of the project. We then developed the written copy of the survey and shared it with a handful of states that could

beta test it, provide feedback and recommended changes. Now, we administered the survey using a web-based tool to all 50 states, and ultimately we received 42 completed state responses. So, a roughly 90% return rate, which we viewed as pretty positive. So, moving on. One of the core findings of this survey was that 60% of the responding states did not have some sort of a report that looked at the outcomes measurement. And in fact, when you dig into the data a little bit deeper, and take a look at some of the examples that were provided from states that recorded having outcomes measurement in place, that number is actually smaller. Many of the outcomes measurements examples provided actually fell more into the previous example of output and program management as opposed to outcome analysis. And as I said, that program management process measures output analysis is very important, but is not quite what many of the policymakers and legislators are looking for when they are thinking through how do we measure the value of the services provided.

So, part of this survey was looking at how do we move forward and translate the current data system, current outcome analysis to, you know, what we are hoping to do with the more focus on outcomes and impacts to individuals. So you can see that when we asked individuals what suggestions for proper outcomes management, there is a lot of emphasis on consumer surveys. Whether it be kind of a generic consumer satisfaction survey, you also see reference to interviewing individuals, the national core indicators program which is something that we run out of NASUAD here, that is a consumer focused survey to gauge their quality of services provided, consumer satisfaction, as well as outcomes at the individual level. In addition to those, you do see other focus on health and well-being, whether looking at emergency room visits and hospitalizations, and discussing health outcomes, the pace -- the PACE model which is the all-inclusive care for the elderly does have some metrics built into it. That individuals suggested using that as a potential model for outcomes measurement as well as taking a look at assessment and data.

So when a functional or clinical test is done on individuals using that baseline information, and then comparing it to a follow along assessment, either 6 or 12 months later or several years after the initiation and provision that services. So, you can see two key themes. One is a focus on survey data and consumer reported quality and outcomes. The second is a focus on clinical data, looking at utilization reviews, looking at the assessment data as well as overall health and well-being of individuals. These are challenging metrics to collect in many cases, as information that is labor-intensive to collect, whether it be through administering the surveys to individuals, or collecting the information through things such as assessments. And it is also challenging because of the historic way that information systems are set up. As we know, individuals receiving long-term services and supports are often served by multiple programs. Medicare, Medicaid, older Americans act, and/or private insurance can all play a role in the health and long-term services and supports provided to these individuals. And if so, linking together those data systems is

a crucial part of really taking a look at what's happening to these individuals in their health and welfare, and how those services are supporting the needs of the individual as well as promoting positive outcomes.

So, the next stage of the survey started to look at some of these data systems that states have in place and the role that they play in state outcomes measurement. So the first question was really just getting a baseline of information about the types of information technology systems utilized at the state level. You can see that there is a large number come over half of the respondents, used a Mediware system, formally known as a Harmony system and it is the oldest system used in the Older Americans Act program administration. In fact, when you look at the answers of other on this chart, I think three out of the five states that selected other indicated that they previously used a different kind of information system, but were actually in the process of transitioning to using the Mediware system. Now, this creates some opportunities, because as you have a national vendor that is providing services in multiple states, some of the innovations and technological improvements that might be implemented in one state, there is more opportunity to disseminate those improvements across the country. However, it also creates some challenges because as we all know, programmatic entrenchment can become an issue when you have a certain way of doing business that has been done for a very long time. So, using that information, we then talked to the states and asked questions about, based on your current information system, what would you like to see changed in order to assist with your desired program measurement and outcomes analysis. So, when states were asked which features they would like to add, we saw some real core themes in the answers. The first is that integration of data.

As I discussed earlier, that is a very important component of truly taking a look at what's happening to an individual across their lifespan. The second is increasing the number of data elements that are collected and stored.

So many states do not have comprehensive information around assessment data, service authorizations, and then service delivery information, such as encounter data and claims. Some of the other functionality that states indicated they would like is a little bit more data analysis capability. The ability to, you know, slice and dice the data, run specific reports to drill down and look at geographic areas or targeted populations and other things like that. That is a real trend we are seeing in the healthcare world right now. You may have heard the terms around hot spotting and really looking at how does the geographic location play into the health outcomes and the healthcare services that are received by individuals.

One of the last things we heard from multiple states was an increased ability to track the provision of unregistered services under the Older Americans Act. And I thought that bullet point might be specifically relevant to this group, because as we know, information referrals and

assistance are largely unregistered services, if they are provided under the Older Americans Act. Some of the other unregistered services we here I think are like basic transportation services, or senior center services, where states are asked to estimate the number of interventions or services provided, but there is not often a comprehensive way to track the actual provision of those services. And we did hear from a large number of states that they were hoping to do more around understanding exactly what was provided and, you know, when and where around these unregistered services.

So, moving from the state's desired state of being to the current state of being, we found that most states do not have a common database that includes information from multiple programs. There are a few states that do have an integrated database that pulls information from multiple programs, but in large part, we did not have states reporting that they had the stability and functionality. Now, other states that did report this, you can see the most common programs included in these integrated databases are older Americans act services, Medicaid funded long-term services and supports, and state-funded long-term services and supports. Out of the 42 states that responded, we had 11 states say that they collected some combination of those -- of information from those programs in a single database. I would note, however, that the 11 states that reported Older Americans Act program is being in the integrated database were not necessarily the same as the 11 states in reporting Medicaid funding and state-funded long-term services and supports. You can see that there are a few states where they really do have comprehensive integrated database management, states that have included things such as temporary assistance for needy families, child welfare services, social services, block grants, and other types of human services in addition to the Older Americans Act services and Medicaid funded long-term services and supports.

The types of data stored in these information technology systems also really vary from state to state. We did see a number of states indicated that they had information on the assessment of the individual services authorized and the services provided included in this single IT system, and a larger number of states reported that any single cross programmatic data system. So, you can see that in the integrated data systems that are operating, there is a real focus on this assessment service authorization, service provision data integration.

Slightly fewer states but still a reasonable number included information on payments, whether that be claim as payment for services, and or the rate of payment for specific services. So you can see again there is information on what services are authorized and provided,

as well as the actual delivery and payment information. Now, this next slide is similar to the last discussion but a little bit different because in states that do not have a single integrated database where you take information from different programs and populate a single database, there might still be opportunities to share information across programs by having, you know, linked databases or data sharing

across those multiple programs. Again, you see the slight majority of states do not have that type of information sharing across multiple programs. 13 states reported that they did, seven states that other and the responses really vary. Some of those states indicated that they had really limited data sharing across one or two programs. And other states said that they might have some information sharing but it was limited information about the individuals.

So for example, you might have multiple programs participating but really, all that was shared is that the same person is eligible for these different programs without getting into more detailed information about the individual's financial and eligibility situation, services provided, or any other information such as that. So looking at states that had these types of programs included in their data sharing agreements, versus integrated data you see the emphasis on some of the long-term services and supports, whether it be people in the Older Americans Act program, Medicaid long-term funded services and supports, state-funded long-term services and supports. And, pretty much all of these examples, fewer states had programs included in these data sharing agreements than states reporting programs included in integrated databases.

The types of information shared again really does vary across the states. But, unsurprisingly, the most common one is program eligibility. Really just sharing across programs when an individual might be accessing services and supports through multiple health and human services venues. You also have information about eligibility versus enrollment, which there is a bit of a distinction, as well as provider aims information. That is an important part of program management, to ensure that there is not duplicative billing practices, but again, fewer than 10 states are saying that they are actively sharing that type of information across programs. It is an area that we heard from states anecdotally, that they do have more interest in increasing these types of data sharing agreements.

One of the other ways of looking at how our states leveraging information systems to truly provide cross agency and cross programmatic services is really looking at the provider directories, and whether individuals can use a provider directory

to locate a provider of services to find, you know, supports available through one or more program. So, we did find more states operating these types of comprehensive statewide provider directories, that number is likely to continue increasing as more states express an interest in doing this on a statewide basis. However, as a follow-up question to that, we have heard a couple of states tell us about how they have actually taken those provider directories and started using them as a tool for monitoring quality and allowing individuals to have some more information about the providers and about the, you know, the ratings that they have had in the past. So, we have seen Medicare do this through some of their nursing home compare websites and other similar programs for different service providers. We have heard a couple

of states, it was four states reported having some sort of information on quality of care and/or beneficiary satisfaction. Now, several states mentioned that it is almost like a Yelp-like feature where individuals can go in and provide feedback or ratings about services they received from a specific provider. Other states said that they had very basic information about, you know, provider sanctions, or other actions taken against that provider of care, whereas the majority of states said that the statewide database to find providers did not contain any such information. So, as we have been working with states, that is one of the recommendations that we have seen, to take a look at ways to allow individuals to receive some more information about the provider of care and what they might expect receiving services from that entity as they are looking at their provider directory development.

So, moving on to other ways that states are looking at data integration, we also asked states whether they were doing anything to integrate Medicare data into their outcomes analysis programs. So, we found that relatively few states, so only nine out of the 39 states that answered this particular question indicated that they did actually have access to Medicare and counter data. And then fewer states on this next slide are able to actually link that data with participants in their state run programs, whether that is Medicaid or Older Americans Act. So, eight of the states said that they are actually able to do that. Unsurprisingly, the majority of those states link the data with their Medicaid programs. There has been a big emphasis on Medicaid Medicare integration, whether it is through the models being advanced through the Center for Medicaid and Medicare innovation, and the federally coordinated healthcare office, or through state initiatives around dual eligible, special needs programs and Medicare and linking them to their Medicaid programs. There is a lot of emphasis around integrating information between

Medicaid and Medicare, but as you can see, it is still largely in its infancy and is still a challenging proposition for states to go about. What we did find interesting is two states mentioned that they were able to link their Medicare data with participants in the Older Americans Act program, which we found to be something we want to look at more as a potential promising practice, because we always talk about how state-funded long-term services and supports or Older Americans Act services can delay or potentially prevent an individual from entering into Medicaid funded services, either by providing a basic level of support so that the individual does not seek Medicaid funded long-term services and supports, or by preventing the spend down that would make an individual financially eligible for Medicaid funded long-term services and supports. So, the ability to link Medicare data with Older Americans Act services could be a promising practice in really taking a look at what are some of the value and outcomes of providing these Older Americans Act services who -- to individuals who are not yet on the Medicaid program.

Now, shifting gears a little bit, as we were doing this project, we recognize that one of the challenges we have heard from states across the board and from individuals at the local level as well is that when you are looking at outcomes measurement, you need to have the same

definitions of what the services actually provided are, as well as what the programs providing those services are. So, the first place we started for this particular part of inquiry was really looking at how do states describe the long-term services and support entry programs, and where are those programs, you know, located, and how do they actually facilitate an individual's entry point into the system. So, the first thing we looked at was really the single entry point, and No Wrong Door aging disability resource Center long-term services and support system development. So we have a lot of work that has been put in in the last decade and a half around the development of aging and disability resource centers, you know, kind of an evolution into this thinking around the No Wrong Door systems models, and then the Single Entry Point being , in some cases, integrated into that particular model of

long-term services and supports entry, but in some cases, being a standalone entity. So, you can see, the ADRC is the most common program developed across the country which makes sense because that is where much of the emphasis and funding has come from the federal government over the past decade and several years. But you also see a number of states moving toward the No Wrong Door and or Single Entry Point systems as well. Now, I want to point out that the numbers here add up to more than

the total number of respondents to the survey. And that was because many states indicated operating multiple entry point systems.

So, we wanted to better understand exactly how states were describing these long-term services and supports entry systems, so you can see 21 out of the 42 states show exactly half of the responding states said that they only had one model, whether that be ADRC, Single Entry Point or No Wrong Door. Now, the majority of those states with only one model for operating in ADRC. On the far left side, you see that seven states indicated operating all three models at once. In some instances, that was the same long-term services and supports entry point being branded three separate ways, but is saying that they operated all three models. In other instances, the states would have different functions. So, some states might operate a Single Entry Point but have the Single Entry Point only be for Medicaid funded long-term services and supports. And, you see on the far right side, three of the responding states said that they had none of those models. And so, when we asked, okay, you don't have any of these models , for not facilitating entry into long-term services and supports, how do people become eligible? How do they access the services that they are eligible for? And, you know, there are varying responses but largely, it is a historic model of county welfare offices and local health and human services agencies.

Diving into these particular systems a little bit more, we were trying to figure out exactly how states are providing services and who they are working with in order to facilitate access into the system. So, this slide has a lot going on. Let me just take a moment to describe what we are looking at. So what we wanted to do is take a look at where are the different Single Entry Point No Wrong Door ADRC models being housed. You know, what partners are involved in administering these systems? So,

you see the bar charts, those represent just the number of states saying that the various models are housed in one of these agencies. So for example on the far left side, you can see that roughly 23 states, I believe, said that their ADRCs are housed as their state areas on aging. The line drawings show the distinction between the raw numbers versus the percentages, so that you could kind of get a sense of, yes, there are fewer Single Entry Point systems in operation across the country, but on a percentage basis, they tend to track fairly closely with the physical location, the other types of models.

For example, you can see on the right-hand side, there is the percentages that line up with the outline chart going up there so you can see with the AAA example, all three ADRC No Wrong Door Single Entry Point had similar percentages of them housed in the AAA, slightly higher number or percentage of ADRCs are housed in the AAAs, versus the Single Entry Point and No Wrong Door systems, yet, you know, it is in the same ballpark. It is relatively similar in terms of the percentages. One of the things that we found kind of striking was that for those programs that did exist, there is a little bit of a departure away from, you know, the county welfare eligibility office model. I think that that is kind of consistent with what we have seen more broadly with health and human services, where the Affordable Care Act has really pushed states to move their Medicare eligibility away from that county welfare office model and into, you know, statewide electronic entry points and other ways, such as that. But you know, a number of states do indicate that they still use those types of models whether it be the human services office or county welfare office. We are seeing a much higher number of states leveraging the community-based organizations to house these types of models.

We then look at what populations are served by these individuals. There is a push for allowing No Wrong Door truly to be a No Wrong Door that serves all individuals of all ages that have long-term services supports and needs. And so you see in this chart, there is definitely a trend to have full inclusion, yet, the historic ways that these models were developed is definitely reflect did in who they serve now. You know, seniors age 16 and up represent that, you know, the most commonly included population for all three models. Next most common being adults with physical disabilities, and then if you have the remainder of the population, there is high levels of inclusion, but still lower than those two core populations which were really the genesis of these types of ADRC models.

And then lastly, we have the programs that are able to be accessed by going into these long-term services and supports entry programs. And this is kind of where you get a sense of what our states calling a Single Entry Point system versus what our states calling a No Wrong Door system, and what programs are actually available. So the data point that really jumped out on me on this particular slide is if you look toward the middle, there is the Medicaid funded long-term services and supports. And we are talking about Single Entry Point, 100% of

Single Entry Points are providing access to Medicaid funded long-term services and supports, yet, that was the only program that had 100% inclusion in any of the types of models described here. So, what you are seeing is that states are calling things, you know, No Wrong Door system, ADRC system, but the actual services that an individual can access when entering through these doors does tend to vary, depending upon which state you are accessing services through. Now, these types of differentiated definitions can cause some challenges when you're thinking about measuring the performance and outcomes of individuals who access services through the ADRC, or whatever else, particularly on a national basis where there is state to state differentiation and what services an individual can actually access.

A similar issue comes when you're thinking about service issue and that comes to the taxonomy of service issues. We do have a push at the national level from CMS to push the taxonomy for Medicaid funded long-term services and supports in order to categorize what services are actually being provided under the different programs across the country, yet, even within states, a lot of the states reported that they do not have a shared taxonomy across their different programs. So, when you're talking about, for example, the provision of adult day health versus adult day care versus adult day social, there can be similarities and in some cases it can be the same service, but in many cases, there could be a pretty distinct differentiation in the actual service definition and what is provided to the individual. So, adult day services in some cases could be largely social in nature, but in other cases could be very clinical and have rehabilitative services, therapeutic interventions, and in many cases dental and other sorts of things are also included, yet, as I mentioned, another service with the same name could potentially be more focused on socialization, community integration, and medication management or things like that that may not be the same level of intensity of services. And so, one of the things that we have heard from states as well as the federal government is a desire to coalesce around some of these service definitions that allow for better comparison of services across programs, as well as from a federal program, across states.

As states have looked at transitioning into these outcomes measurements, one of the focuses is on quality of services, which can sometimes be used as a different way of describing outcomes measurement. But in other cases, it does mean a little bit around what is the quality of care provided as opposed to the outcomes for individuals. Again as I mentioned, there is a large focus on consumer services from an outcome measurement perspective, you're also seeing these consumer surveys used to measure the quality of services from the perspective of the individual. We did see over half of the states indicating that they are participating in one of these types of quality initiatives, with the most common being the NCI, NCI-AD, which I described earlier, the TEFT program which is a federally run consumer survey out of the centers for Medicare and Medicaid services, or in many cases, also seeing state specific consumer surveys that have been developed and/or administered at the state level.

So, as you can see, there is a strong focus on participant satisfaction, participant surveys, with less of an emphasis on the qualitative analysis from administrative or claims data.

Of those states that have collected information, you can see it really varies in terms of the programs, whereas this information is collected. So, this chart breaks down collecting information on consumer satisfaction, quality of life data for the individuals and then quality of care for the individuals provided and much of this is of course self-reported. But, you can see things with home health and adult day tend to be areas where more of this types of quality and outcome measure is collected. But this is for Medicaid funded services. I want to be clear about that.

This next slide is a similar data point with the same services and is for non-Medicaid funded services. So looking at what type of information is collected around satisfaction and quality of life, quality of care information, for non-Medicaid LTSS. This would include things such as Older Americans Act funded services as well as state-funded long-term services and supports. I would note that one of the areas that we found a little bit surprising was that in some cases, there was more consumer satisfaction information collected on the Older Americans Act side, versus on the Medicaid site. And that, you know, particularly you see it around home delivered meals which are of course one of the core Older Americans Act services,

in this slide, you see 25 states collecting that information, whereas in the previous slide for Medicaid funded services, it was only 13. So, you do see a little bit more emphasis on that type of consumer satisfaction, collection, and analysis under the Older Americans Act. In contrast, you see less emphasis around quality of life and quality of care. So, you do see Medicaid focusing on those sorts of initiatives moving forward.

And then, another way that states are trying to get a sense of what is provided under these services and supports is really looking at the clinical utilization data. You know, I have referenced many times the focus on emergency room, utilization for measuring outcomes, and you can see the utilization data is collected a little bit more commonly for Medicaid funded long-term services and supports which makes sense because Medicaid B is such a large player and having such a large capital footprint in this space, they are going to need to collect that information to do their performance measurement and outcomes measurement. One of the areas that we did see a little bit more data collected was under the chronic disease management program. That is an area where we have seen the Older Americans Act play a large role across the country, so it does make sense that you do see non-Medicaid data being a little bit more common than Medicaid data just because it has been an area of emphasis under the Older Americans Act.

Other information that has been collected includes information around waiting lists and waiting times. You know, the average wait time between when you apply and when you are actually enrolled. And then ultimately, from when you are enrolled, from when you receive services. Because again, a core outcome of long-term services and supports, you have to receive the services before you can begin to assess their efficacy. So, having this type of information is a pretty important component of outcome measurement. Now lastly, we talked to states and pretty much every state was collecting information around licensing, citations and sanctions. That is a core function of, you know, having any long-term services and support system, is provider regulation function. And we had over half of the states that are actually using that information to try to monitor health outcomes, as well as quality of care. And we heard from a number of other states that we are looking at ways to better utilize that information to really drive performance improvement at the provider level, and then assess and track outcomes and hopefully improve outcomes at the consumer level.

So, with all of that information, we distilled it down to some key takeaways based upon the survey responses as well as interviews and conversations that we had with

the federal government, the state government, respondents, and other participants in this program. The first is that outcomes measurement is an area on increased measurement and we are hearing from a number of entities at both the state and federal level that they are actively seeking to improve the way that they collect data and translate it into outcomes measurement. The second key takeaways that we saw was that the current data collection efforts are really driven by the mandates that they are given. You saw a lot of states really focusing on the core reporting elements that the federal government requires from us in order to continue our funding stream. Also on the previous sign, discussed things around licensing and citations, and other sorts of provider monitoring information as a way for states to drive program improvement. Again, that is tough that they are already collecting, that they have to collect for program administration. So that is really what is driving these sorts of data collection. Three, we talked a lot about the integrated systems being a core component on how to actually track the participant experience as they enter these programs, and yet, as you saw from these data, there is really not a whole lot of integration going on across the country. Where it's happening is some examples of the value that it can provide, but, it is not a commonly occurring IT way of doing business is in the health and human services IT world. We are seeing more and more effort to move that direction but it is still a work in progress.

The definitions of systems and services as I mentioned, there is a lot of variation both in terms of the way services are defined and described, as well as what the systems of delivering long-term services and supports are called. So, it does create some challenges when you are trying to compare information and truly assess the efficacy of different services. So again, that is an area to look at moving forward.

Another key take away is that moving toward this outcomes measurement instead of process and program management measurements is really going to require more emphasis, more information needs to be collected, more challenging information is required. So, it definitely is going to be labor-intensive to do so. This is not to say that we should not measure the process, it is because it is important to understand what those measures are. But, we still do need a lot of effort in order to move beyond just measuring process and outputs. And then, one of the key takeaways is that the data collection and the information technology is going to need more funding and more investment in order to truly transform the systems and moved to where we want to be in terms of demonstrating the value of these services and continuing to serve individuals in the most effective way possible. So, with that, I will close the prepared part of the presentation and I know we are a little bit over, due to our technical difficulties at the beginning but hopefully we can stay online for just a little bit and answer some of the questions that have come in.

Thank you so much, Damon. I also want to appreciate Caption Colorado for joining us and for being willing to stay on a couple of extra minutes to capture the last part of our presentation. And we got some wonderful feedback from some of our viewers around the captioning so we really do appreciate that.

As always, we get a number of questions about the availability and slides and audio. Those will be posted to our website shortly and the link is available a couple of times in the chat box for you. So Linda, let me turn it over to you if there were a couple of questions. More for the group at large. I know that we had a number of individual questions for Damon.

So, we did have one question that came in. I was talking about states having an interest and a desire to do more information collection around unregistered services. And unregistered services is really a definition that is used under the Older Americans Act for certain types of services. So, the Older Americans Act has registered services and they tend to be some of the more commonly thought of OAA services such as home delivered meals, or personal care, home and community-based services, types of provision. Unregistered services under the Older Americans Act, examples such as, you know, transportation services, senior center services, information assistance and referral services, where the state is not collecting detailed information on how many units of services are provided, you know, when, where, to whom. So as I mentioned earlier, we are hearing from a number of states that they would like to have a little bit more ability to track what is actually occurring in those unregistered services arenas.

Great. We also had a participant wonder about whether those states that do have data sharing, if any of those data sharing agreement templates might be available for other states to look at.

That is not an area where we collected. We did not collect examples of those data sharing templates, however I would say that, you know, as an

association, we really do believe in and promote estate to state information sharing and state to state technical assistance, so if that is an area that individuals on the call are interested in exploring further, you should feel free to reach out to myself or to Nanette, and we would be happy to facilitate some of that information transfer.

And just to note her on the last slide, Damon's contact information is there. While he has presented a lot of data in the aggregate, we are able to go back into data and she sort of individual services. So we may also be able to reach out to some states and see whether we would be able to share some of the models that we developed in a little bit more detail. So again, please feel free to reach out to us. Ende, were there any other questions in the Q&A section?

I think we are good.

Wonderful. Again, I want to thank all of our participants for your patience as we had audio difficulty at the start. I want to thank Damon for a great presentation and again, we will be releasing a more detailed report later this year, so look for that as well. And I wish everyone a very good and to the day. Thank you again, and again, thank you to our captioner very much.

[ Event concluded ]