February 28, 2018: Stories from the Field: Lessons of sharing from the Disability Network Business Acumen Learning Collaborative

Good morning and good afternoon everyone, thank you for joining today's webinar, from the disability learning collaborative, I'm Samantha Gardner a policy and communications analyst at the National Association of States United for Aging and Disabilities, otherwise known as NASUAD. This grant is made possible by the administration for community living, shortly after today's session you will find the PowerPoint along with the archives for the disability acumen webinars HCBS business acumen , there will be time for the Q&A at the end of the presentation please enter the questions at the lower right-hand portion of the screen. Today's speakers are Kim Opsahl, Director of State Partnerships & Special Projects, American Network of Community Options and Resources (ANCOR; Wendy Witcig; Deputy Director, Community Operations, Division of Developmental Disabilities, Missouri; Sandy Hunt Bureau Chief, Bureau of Developmental Services, New Hampshire Department of Health and Human Services, New Hampshire; Maryellen Moeser Director, Housing and Community Living Unit, Division of Person Centered Supports, Office for People With Developmental Disabilities, New York; and Joyce Pohlman Health and Human Services Commission, Texas.

We will begin with an introduction of today's webinar, and then we will discussed breaking down silohs, then we will talk about managing change with the definite timeline, then we will announce our stories from the field from contest, and then have time for Q&A at the end of the webinar. Now I will turn it over to Kim to talk about the learning collaborative.

Good afternoon everyone. Before we get started with hearing from the state teams, we want to give people a perspective of the learning collaborative, the perspective is to bring together state teams to work together and among themselves to develop business strategies for specific challenges and healthcare services, really looking at issues around transitions as we brought together the teams within these purposes and overview, we have key themes that all of our teams are working around to identify this gaps to [Indiscernible], and to work closely with integrated health entities and the growing needs that they serve including those with significant medical or health needs. Another key thing is to provide organizations for success. Building an integrated system, a homegrown disability and MCO needs, and Schoening -- Insuring they can meet the needs of those with disabilities.

Our state teams. Are five teams I will introduce in a moment, each state team is comprised of at least one Medicaid agency and one operating agency that serves disability or community-based organization using this to serve those with disabilities. And other partners. Those other partners could include disability rights networks within that organization folks that are aging, things that can be run with gamma based on the things the focus of the team. I want to introduce you to the states of Maryland and Texas. Two of the five states. Marilyn in terms of why there state team is pushing through the learning collaborative. They want to see Maryland centers for independent lending -- Living, and the total cost of care model evaluate their

capacity in nature facilitate partners with entities, and develop draft business plans to establish formal relationships with them.

Texas has many that they are working with assisting in all partners, in enhancing skills that enable them to be successful working in a managed care environment. I am introducing them together. They are not only working with centers primarily, but creating awkward -- Non-awkward opportunities.

Those teams have identified a range of challenges, as well as on the horizon for them, they are all dilling with the conclusion of key federal meetings. For instance the money follows the person program, balance and incentive program, funding for key particular folks out of the settings and into the community, challenges in needing to continue the outreach and diversion, to focus on data driven outcomes. From an opportunity perspective they are both experiencing environmental changes creating opportunities, and a chance to build on the strengths of their community organizations. We see these teams educating their CBOs, looking at their own structures and understanding where their strengths and opportunities well lie, improving their communication skills -- Improving their strengths and opportunities and where those lay, improving their communication skills.

To create integrated system demonstrating improvement outcomes, increasing stakeholder satisfaction for building capacity for people with intellectual disabilities who are aging or living with co-occurring conditions.

New Hampshire to strengthen and prepare long-term support systems, including but not limited to CBOs, for the high quality of efficient services for individuals in need of support.

New York State team a providers in New York will be successful in building and implementing integrated care systems. Also known as Care Coordination organization, or Health Homes. For these three teams, they include changes on how things will be delivered, and we are focused on community-based [Indiscernible] in the community . And request for service dollars. Along with that increased complexity of those needing services, and a lack of workforce capacity. In terms of adequately addressing those. Other challenges for outdated systems, more effective Boehm -- Payment and billing measures.

These teams seen opportunity to use dollars for prioritized services, and action among medical, behavioral and whole person action.

What those three teams are focused on is building relationships within the integrated entities, focusing on integrated health services, they are also looking at how to structure and build community-based networks. How to support strategic building planning. Moving to performance-based or other payment processes, and changing to manage the culture around those changes. And building stronger systems that support these services with a particular focus on the utilization review process. With these five teams we have a wide variety of focus. When we look at it. In terms of the support in the areas of focus that are important to

them. It did come down to the various topics that you see here. As a learning collaborative we've been focused at understanding in the overall healthcare structure and working on how to articulate the value in this space focus on innovations and pricing, information technology and data analytics keypad to say, contract and negotiating. And then it moves to the value-based contracting. As our five teams come together over the past several months to talk, share, and collaborate. There has been opportunities to bring together specific teams because they have had an issue or an item in common. The Missouri and New Hampshire team. Wendy and Sandy, we brought those two teams together, because of the focus on how to break down silos across the system to better promote integrated care, we would like them to share with you what is the outcome of that discussion? Wendy and Sandy I will turn it over to you.

Hello this is Sandy had -- Hello this is Sandy Hunt.

Wendy if you are on the phone can you introduce yourself? What we did prior to this call we will work through these slides anything we have in questions for Missouri, I will ask Wendy to pipe in. I would like to go ahead and advance to the Next Slide. This slide basically describes each team's activities. In New Hampshire we are focused on four main activities which are listed here in the bullets. Specifically around implementing utilization practices and explore value-based contracting we want to strengthen linkages with healthcare organizations, that are here in the state and modernization of information technology. Those are New Hampshire's focus areas as part of this collaborative, the business acumen team. Wendy would you like to go through your business acumen team? >> It looks like the big give for the business acumen team, representing people with disabilities and people who are aging. I think what we will do is move to the next slide. The question about what brought New Hampshire and Missouri together was a good one, this was interesting. As part of New Hampshire's discussion on utilization review, basically working with the community based organization to identify ways to maximize the ways of resources that are about double -- That are available.

We discovered there are a lot of challenges within our system that comes from his system that has been built up in a way that has alienated different services from each other. We have services with disability, and health challenges. As we brought this information back to the national team. It was recommended that New Hampshire contact Missouri because they were working on similar projects. Moving on to the next slide. New Hampshire shared we have experienced changes of the state level. Changes and organizational restructuring. There was recently the development of a new division at New Hampshire called division of long-term support and services. Under that we had the Bureau of adult services as well as military programs. We have faced challenges because we are under corrective action plan under CMS to bring us to the requirements that went out in 2015 -- 2014. We shared that with Missouri and they expressed that they were using the business acumen learning collaborative to build bridges between statewide systems.

Can you hear me now?

Please add your comments.

I'm sorry I don't know what happened with my phone.

Missouri is coming from a different angle in terms of the structure and changing the new structure, we are working within our existing structure to use the business acumen team to create the bridges. Between the different departments. Representative agencies to build something unified and integrated. We are working more from anticipatory position and proactive position rather than reactive to something that is a result of some finding or audit. Trying to be proactive and move down that path with providers to prepare them for opportunities coming their way. Also if we were to take a different path in the future. It is not a new and unfamiliar process for them.

Thank you. What was shared some more information as we were moving through our conversation both Missouri and New Hampshire discovered our systems are similar in the way that they have dealt with typical issues coming up with the people that we support. Who have a need in various systems. For example. If someone from the developmental disability need services from different to him maybe mental health, a lot of these challenges within our system have been addressed by our system traditionally. So what we are trying to do is to identify resources that would be available to the public at large. And how this disorder is to tap into the community based systems as an alternative to rebuilding those services within our own system. That has been a challenge. With trying to identify certain rules and regulations. Historically in New Hampshire there was a question around people who have a developmental disability and people who are experiencing a dual diagnosis, and them having to case managers from each system. How that works into the system that we deliver. Traditionally our system have sideload themselves as a result of the needs that people are presenting. Missouri made a great point on the call around retirement for people with disabilities, if they reach 65 what do we do, or do we have services available to them through their community? Did you want to elaborate on that at all Wendy?

No. That is fine.

Great.

Next slide please.

New Hampshire currently has a demonstration waiver. This waiver is an opportunity for community-based organizations to come together around specific programs that they have identified as milestones. The goal is to have them work together to achieve certain goals. If they achieve those goals. Their payments will be based on the performance-based metrics.

A lot of the focus. In the waiver is around healthcare. And substance abuse disorder serving the whole person. The person's needs are getting

met from all of the community organizations that they qualify for. The people in the developmental disability system in New Hampshire are benefiting from that in a gentle way as long as they experience a challenge that has been identified through the project. The 1115 project. It has been an experiment in New Hampshire. We are working through these processes. The goal of this project is to have community-based organizations come together. Through this process we're uncovering challenges around roadblocks to services identifying policy changes that may occur as a result to make services easy and accessible. Neither New Hampshire or Missouri has managed care for the intellectual disability services in their state. In New Hampshire we do have it for behavioral services. We are also moving towards manage care for people who are aging and disabled. For the DD population it is currently not on the table -- For the IDD people population it is currently not on the table.

New Hampshire has commuted the waivers, and Missouri has eight the challenge is to look across all waivers to identify ways to leverage resources. Missouri also has 1950 C waivers, and other options that are serving populations, people with IDD, or have dual diagnosis, and Missouri is looking at the

PACE program, did you want to add anything?

No I think you are doing fine.

Both ways to break down silos is to identify commonalities, a great suggestion from Wendy. On where we begin to get this started, this service delivery system to communicate with each other, one example to identify a commonality. For example people who receive mental health services and people who receive developmental services may experience challenges around transportation. Leaders in each system have a conversation with each other, what are the challenges, can we solve these issues together? In New Hampshire, a huge challenge for people both with the Simental -- Disabilities, and the capacity to provide services to people.

Anytime I have a conversation about capacity development in the system, I consider how my Bureau of mental health services collaborates with us and partners with us on this. Ultimately we want to provide services to the community overall. Next slide.

Both the requesting team and the advisory team wore impacted by the information shared, we are experiencing similar challenges. Missouri indicated support for these are currently responsible for overseeing services and making sure that they are not duplicate, we do not want to duplicate. In New Hampshire they oversee these as well, we are working through each system and how each system looks similar, how can we apply this to the case management delivery system.

Recommendations that were made on the call, Missouri recommended that Missouri look at Pennsylvania, which has been recommended for being successful and the 1115 waiver, the exploration of the PACE program, New Hampshire does not have a PACE program, and it's something I want to look into. And other avenues to explore further. We are in the

process of communicating with each other and collaborating trying to identify options for each of our states. Wendy did you want to add anything?

I just want to share one of the most challenging things for me and even members on the team. How to start those conversations to get to the point where we identify commonalities and what things they may have in common. So they can lean on each other and we started off as a suggestion from Sandy. There beginning. Talking about the mission of each party. What is the vision and what do they hope to accomplish. As you are sitting down to start on a large project whatever it is. Especially when you have a system sideload. You are not starting with the same place. It is important to understand each party and where they're coming from and what they hope to accomplish so that you build those outcomes into the project at hand. Otherwise you will have a team that doesn't feel engaged or apart. It breaks down. I appreciated that guidance from Sandy, and how they got started with conversations. It proved to be especially helpful and important. We are a silos system, working across the different departments. We are not creating a different structure, but working within the structure to build bridges. The other critical thing we found. The timing has to be right for the people at the table to want that to happen. You can put people together. If the people don't want it to happen. They don't have an interest in partnering and how to share resources. It will not happen. We are very fortunate in Missouri to have a group of people that are very ready for a next step to figure out how we can do things better. That is very helpful.

Thank you Wendy.

Great points. We can move on to slide 23. Any surprises? Both states are surprised to see how similar the challenges are. Missouri and New Hampshire we mentioned capacity issues. And it's very easy to sit down and start on a new project to go adit from one perspective. It was really helpful to have the recommendations to contact a state similar to New Hampshire to start to have conversations on how they are struggling with very similar issues. And they didn't feel alone in the challenges they have in our state. It felt there was a little bit more support. It was a nice surprise. We move to the next slide.

Our audience today. A lot of community-based services and we get so busy. We have a big long to do list. We think it is important to remember if you pick up the phone to contact someone who is working on a project similar to yours. It would be very beneficial. We can't learn from each other if we can take the time to learn from each other. This is one recommendation. I have others on the next slide. Once you connect with your peers, we have just gone through that, follow-up with each other on things turn out , and what you can learn from each other. They are going through an action plan for the requirements for CMS. This has been a big topic in New Hampshire, a number of changes in our delivery system. A number states have undergone changes very similar to what we are experiencing in New Hampshire. Sharing and following up is important. When your agency experiences success.

Sharing this with your peers and making herself available for technical assistance.

Next slide. We want to reach out to an organization similar to ours. Making sure that we are speaking the same language. If possible inviting the agency to learn about your agency. If we were to explore an example we may want to reach out to Pennsylvania, come to New Hampshire to talk to us about their experience on that. Guest speakers are important and energizing. If I could have my wishes answered. This would be something I would explore to have people come to our state and share with us their failures and successes. We want to be open to new ideas and not get stuck in the new and the old idea of doing things.

Would you like to cover anything?

No I think you covered it.

Next Slide.

That completes the Missouri and New Hampshire. I would like to take the opportunity to thank everybody. We will continue working on these initiatives. We will be able to report back again hopefully. Thank you. Thank you so much Sandy and Wendy.

That was great information. Great to hear the positive benefits of the collaboration. We would like New York and Texas to share with us. They were brought together because they're working in very different spaces in terms of what their teams are trying to achieve from a service perspective. One thing they both have in common, they are working with an environment where there is a definite timeline to make these changes happen. To have critical need in terms of and particulars and stakeholders together to help them making those data changes, I would like to invite New York and Texas to share their experience of collaboration.

Good morning. This is Joyce Pullman from Texas. Maybe we can go to the first slide.

I will start if that is okay. Texas is in the process of several community-based organizations and an activity that was funded with general revenue funds. And in a form of a grant transitioning to a payment care system. This was done in a very short timeframe. When we first met with the business acumen we were in the process of working with this because of the general funding. Moving from the legislature. And maintaining the service. This service is very successful which has helped people move from institutions through the community. And have helped individuals transition since 2008. In this short timeframe we have had probably around February of last year. And then had to complete by August for the initial transition. We were successful in identifying the scope of work and the process we came up with the preliminary payment system and had the CBO's enter into the process. We are reviewing some of that progress and making improvements so that the system could function. To ensure everyone can manage in this

environment changing over to this which takes place on the first. Which is ongoing improvement. New York?

Good afternoon this is Maryellen Mosher, speaking on the person center supports, unfortunately she cannot be here today, to work with you all on this collaborative presentation. Basically the goal of New York and their learning collaboratives to grow their collective knowledge so that IDD provider organizations can be successful partners with managed-care plans and integrated care organizations in meeting the needs of people with developmental disabilities in the state. We have people supported in you nor -- New York State. The scope over 700 provider agencies, it is very broad. And we are focusing on launching care coordination organizations by July 1 by 2018. These Care Coordination organizations will be driven by the existing provider agencies designed as Health Homes, specialized on Care Management for people with IDD. We feel it will help with cross system care to move towards and integrate through a single care plan called the life plan. To integrate across systems the medical and behavioral health wellness community social services. The supports that New York provides throughout the 1950 waiver moving to 1115 demonstration during the same time period. We are moving the entire system first to the house home model. Then over the next five years our goal to move fully to an integrated managed-care system specialized for people with IDD. This Care Coordination is really the first step. We will be using these organizations to outline the path forward to get to a flexible and responsive system that we support, ultimately leaving this and leading into managed-care. We have limited experience for people with IDD, we were interested in the work that Texas has been doing. We do have a demonstration specific to people with IDD. We do have 26,000 with IDD, and mainstream Medicaid managed care plans. We don't really have a lot of experience with long-term services or rehabilitation services in a managed-care framework. Our first step again moving into this house home model. We feel this will help us by having the Care Management integrated experience to learn from. Being able to plan fully and thoughtfully moving our system forward. We were excited to talk to Texas about their experiences. We want to make sure our system and what we are designing, we learn from other states, to make sure that we cover our bases in our design as we move forward. Next slide please.

Great.

Texas initiated the phone call to New York. We heard New York when we first got together talking about their short timeframe, and a similar challenge helping them make to this managed-care system, and we were interested in how they were going to make the system changes and how they were communicating with families to ensure that they would be comfortable with the change in there would not be any concerns with losing services. How can we put in provisions to ensure no negative impacts. What was working for them in the process. Interestingly. Our business acumen is not focused on IDD. The state is a very mature manage system. We are in the process of looking at fee-for-service environments. In addition to some of the members that are very involved in the process. Going on to the next slide.

Do you want to go ahead?

Sure.

What we shared with Texas, of the advising team. We shared why we were moving forward with Care Coordination organizations. Particularly how we were ensuring our services were not negatively impacted as we move forward with the huge transition. How we are building the future system on the expertise Medicaid service coordinators, which are part of the state plan targeted services. And this service coordination will be terminated effective July 1. And we are able to bring existing MSC's into performing a lead care coordinator in the organizations, this is one way to ensure continuity of services as we are moving forward, we shared that and we share some tools that we are using as we built this Care Coordination system. Including comprehensive assessment tool called chaos. And a person centered tool called IM tool. We shared those with Texas as well as our coordinated assessment validation study. All of these tools are really setting the foundation for how Care Management will be provided in the new Care Coordination organization, as we move into the managed-care infrastructures. We talked to Texas about a new service we were conceptualize housing navigation. We did a lot of work with our stakeholders in New York to develop a scope of service for this housing service that would help people. Who would want to live independently move from group homes to their own apartments and homes in the community. New York has relied on our group home model for housing. Being able to build our capacity and our system to deliver services to people who don't live in licensed housing is one of our future goals. We were really interested in Texas experience with the relocation service.

Next slide please.

Texas has a lot of experience with managed-care. A large part of this focused on the experience and the different services that we have folded into managed-care and how that has gone, this is really interesting to learn the process in making that transition we have intended to do this over a shorter timeframe. We were especially interested in how they are doing their managed-care services for developmental disabilities and how they are communicating with family members to make sure that they were comfortable with that service.

In this area of business acumen focus. Texas is focusing on community-based organizations that provide relocation.

We have our business acumen participants on the phone to describe what services they provide under relocation and how that function works and housing navigation roles. Also we were able to get a lot of information from them about how they price their housing functions. And how we are looking into changing the system for pricing relocations for Texas. Next please. >> The slide for Texas. As I said we have a lot of participants on the phone and we had information about the relocation and the functions as well as the managed-care and how this has worked in some of these challenges in making these transitions to a managed care model. We were interested that New York focuses on holistic care

coordination and not exclusively on saving money. You also have this goal in Texas, but stated in a way that was very inspiring. There person centered approach, taking the time to make that transition was new information for us and we were not aware they were looking at implementing a coordinated function. It was helpful for us to learn about how they take that function and break it down into part's. Determining what the cost of that is to provide the services.

Next slide.

So New York is going to be taking a closer look at Texas and their experiences. We want to incorporate the experience with managed-care. To prevent any adverse experiences as we move into managed-care.

The more we can move from Texas and other states of their experiences in this area. The better we are able to be and anticipate any challenges that could arise to cover these basis. We are interested in what Texas talk about ensuring sufficiency of services for the various folks that needed to be served and making sure that we have a solid system for determining how to have sufficient levels of service. And in defining medical necessities in the healthcare system. This is something that New York is interested in learning about. One of our biggest take altar fears I think as we move into a fully integrated managed-care systems. People with IDD, our system would become medical model. We would lose that person centered focus on habilitative supports InterCall to the work that we do here. Anything that we can learn along those lines to cover our bases in those areas. We are trying to build a deliver it person centered foundation as we move into our Care Coordination's using quality leadership and personal outcome, methodology, and that IM tool we share with Texas.

Really focusing on the preference of people as a part of the assessment.

A coordinated assessment tool is focused on the capacity. As a true functional assessment, the IM tool developed and piloted in this demonstration is truly getting to the heart of an assessment tool on a person's preferences and their goals. What they want from their lives. Making sure that it is closely connected on the life plan developed with that person.

These are some things we want to learn more from Texas to avoid any potential pitfalls moving forward. The relocation system, appeals as a director of community living. Designing what sort of supports will be available to people moving out of group home settings is one of the focuses at this agency and working with people on a continuum of housing options. Not just the group model. Which is very challenging in the state, parents and stakeholders that rely on this future of their loved ones.

Next slide please.

The information that we obtain from New York is definitely being utilized. The models that they put forward. And the goals they are

pursuing into a managed care provider element, we are passing that information on to the members. And to the state as an example of what we might do. The learning collaborative. This will value, as a concrete example. How can this be broken down. One example of pricing in a service.

Going to the next.

Go ahead New York.

Real quick.

One of the surprises for us. How many people have you been able to transition through the relocation service?

For us it was very interesting to hear you were going to hear savings transferred back into the service which is a great model. Also referred to Minnesota on the housing function. You should never be surprised it was very exciting that our members were involved and engaged in the call.

Next slide.

What is the most valuable in the process?

New York do you want to go ahead and talk about that?

Sure.

From my perspective hearing about the relocation function is extremely valuable, and having a new contact to reach out to, I'm very happy to know you Joyce and touch base with you.

I already have followed up on a new topic yesterday learning about another aspect of your program which is roommate matching. This is an ongoing resource for sharing information. We are very interested in the stakeholder education process which has been done very well.

Next slide. My recommendation in these calls you can see we called with one intention and ended up with numerous outcomes. Do not limit your call to just one object to. To allow yourself to go beyond, you can learn more and more things that you didn't even know about. Things that are working and what is not so that you can learn from one another.

If you would like to add to that.

Sure.

Use the call for the first steps in sharing resources and branching out from there.

As the advising team. We saw very positive things about her experiences, to step back and reflect just a bit. It is always great to share learnings across service systems and states.

That is it for me.

Great.

I think we have one more slide.

Yes.

This is pretty much the same ideas that we have been talking about really helpful in talking with other states and learning how we can do things different, I love that they are able to get together on common issues and challenges, I really appreciate that we were able to do this so thank you.

Fantastic thank you both for sharing that experience. It is a great segue into the last bit of our presentation we would like to talk to you about. Today we will be launching our contest, hopefully what you have heard in terms of New Hampshire and Missouri. And New York in Texas. Really hearing examples talking with other folks. And having a view on the perspective maybe someone has gone ahead a you on some issues. This is vitally important. We are launching these stories as a way to hear from all of you. To hear from you stories on how organizations have been able to use different strategies. Share stories relevant to other disability communiqués -- Communities.

And the positive impact on the people you serve. Demonstrating those experiences, and a positive impact for the delivery of your services. As well as improving the delivery and the accessibility of your services to a diverse range and people.

In particular we are looking for community-based organizations to share with the successful business Park disses they have had with Merck -- Working with private health systems.

Other community-based health systems, universities. And any other organizations that have helped you improve the performance of your business. Next slide please. Within these contests, for the following categories. For those of you participating in prior calls, we are in the process of watching the [Indiscernible], if you have stories or experiences you would like to share. Things you you did in success in preparing this movement.

Process your SWOT analysis. And joining you in the pathway. How do use the information you gather through that preparation to steer your organization. And perhaps maybe it is in ways you have executed. What are the ways that you sustain the relationships with partners? Maybe some successes you have.

Finally. Monitoring and evaluating in these partnerships. Steps I have taken, with contract expectations and modifying approaches. Next slide please.

We are really open to hearing for this in community-based organizations, on a wide topic.

Some of the experiences you have had moving into working with management and integrated healthcare. In terms of guidelines for the contest, it is open, we asked submissions are written clearly and received by March 23 of 2018. The submission form can be found at the acumen website at HCBS business acumen.OIRG. -- DAT -- >>
Business acumen.org.

We will be looking for stories that are relevant and reckless bull -- And a wreck gullible --

-- We will be looking for stories that are relevant and [Indiscernible], for these deliveries , for the services that you provide, and demonstrate to improve the successful diverse range of inquiries.

For the contest there are three awards that folks will be competing for. First place winner will receive complimentary lodging for the 2018 CBS conference held in August of this year at the Baltimore Marriott water for waterfront.

Third place winner will receive complimentary ticket for one to the conference. We will all participate in the appeal. Sharing award-winning experience, you will have your story distributed on the acumen website, and also participate in an interview that will be published.

Without further ado please submit your story today, you see the link for the contest itself. We will be sharing information through the list serve and other distribution channels, please keep an eye out on that and share your story. No story is too big or too small. We are looking at ways to connect with one another so that you have the same experience you had today, opportunities to connect with your peers whether here are across the country, where you can share your experiences and collaborate together on solutions.

Next slide. With that we are actually a few moments over. I'm sure our panelists would be happy to stick around if folks have questions. Sam do we have any questions coming in through the Q&A box?

Yes there is one question . What are the states doing to advance their Care Coordination capabilities through the use of modern health technology? Such as EHRs, health and information exchange, and analytic data at the provider level.

Would any of the panelists like to answer the question?

I can speak for New Hampshire. We are recently deciding to put our individual service did something that CBO's are filling out on an

annual basis. The service agreement template is right there in the agreement. That is not necessarily an application for case management, but it is an application that allows us to enter data and run reports if we need to. We have been looking at different options for electronic visit verification, moving forward for case managers who do home visits. This is not something that we have implemented in New Hampshire as of yet. Part of our initiative around the business acumen , is to modernize our IT systems within BDS and be DAS, there are a number of applications that we are moving. We are moving in that direction.

Thank you Sandy. There are no further questions. With that thank you to all of our panelists for sharing your time and expertise with us today. Thank you to all of the participants for joining us. We hope you can join us again for next month webinar Wednesday, March 28. Thank you again, have a good day. >>

[Event Concluded]