

The Lewin Group
Disability-Competent Care Coordination Care
March 8, 2017
2:00 p.m. EST

Christopher Duff: Good afternoon everyone, and thank you for joining today's presentation. Please take a minute to orient yourself to our platform. If you would like to ask a question, please use the chat feature on the left lower hand side. Technical questions will be addressed as they come in, and content questions will be addressed at the end of the presentation.

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My name is Chris Duff, and I am a Disability Practice and Policy Consultant who has been working with The Lewin Group to develop the Disability-Competent Care model and related webinars and materials. I will be joined today by Rachael Stacom, Senior Vice President for Care Management at Independence Care System (ICS) of New York City. ICS is a non-profit organization dedicated to supporting senior adults and adults with physical disabilities and chronic conditions to live at home and fully participate in community life.

ICS offers two distinct plans: ICS Community Managed Long-Term Care, a traditional Medicaid plan, and the ICS Community Care Plus for those eligible for both Medicaid and Medicare. In either plan, participants have a care coordinator and an interdisciplinary team.

Rachael has been with ICS since 2001. She created their multiple sclerosis program in 2007, which was recognized by the national MS Society as a Center for the Promotion of Excellence in long-term care.

On behalf of The Lewin Group, I would like to welcome you to our Disability Competent Care webinar series. The Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services has contracted with Lewin to develop technical assistance and actionable tools to support providers in their effort to deliver more integrated, coordinated care to Medicare and Medicaid enrollees. This is the fifth of seven webinars running on Wednesdays through March 22nd. All of the webinars are recorded and will be available along with a PDF of the slides at the Resources for Integrated Care website.

Christopher Duff: There is no definitive definition of care coordination, and many organizations prefer to use the term care management. In the DCC model, we have chosen care coordination because we have heard from participants that they do not like the connotation of being managed. In the DCC model, care coordination refers to a function or set of activities, which are performed by the members of the interdisciplinary team, individually or collectively, as compared to a specific role performed by a specific individual.

This lack of specificity is intentional because the professional background and skill set of the composition of the IDT needs enough flexibility to meet the unique needs of the participants they serve. Thus, the model describes functions of care coordination. Primary care may be delivered by physicians, nurse practitioners or physician assistants. Likewise, nursing functions can be performed by registered nurses, nurse

practitioners, or psychiatric nurses. Social service functions can be fulfilled by social workers, licensed social workers, licensed clinical social workers or by community health workers in some settings. The important thing is that together they bring these skills and the competencies to the functions of the team. Together they all perform care coordination.

Regardless of how your plan, provider system, or agency chooses to compose the interdisciplinary team, or whether all functions are provided by one single entity, it is vital to ensure seamless communication and collaboration as they work the individualized care plan.

First, I would like to provide context for the Disability-Competent care model and care coordination as a whole. Research has repeatedly shown that the population of people living with disabilities have significant health disparities. This is due to a variety of barriers, access in its many variations as was discussed in the third webinar of this series, as well as the availability of screening, services and supports. All this results in poor outcomes, secondary and chronic conditions.

A wide range of social factors also lead to poor outcomes. Many people with disabilities rely on Medicaid and/or Medicare for their health care. Medicaid, for example, is income and asset-assessed meaning the recipients are living on very limited income and are financially challenged. These programs are going through extensive redesign moving from fee-for-service to value-based purchasing. As the payers are increasingly focusing on outcome measures, such as cancer screening and diabetes management, the clinical interventions are straightforward but the communication and service delivery stretch the disability-competence of many providers.

Add to that the financial, eligibility, transportation, and other challenges, it is no wonder persons with disabilities experience poor outcomes, and thus plans and providers are learning they will achieve better outcomes if they attend to these challenges. At this point, I will hand the presentation over to Rachael.

Rachael Stacom: Thank you, Chris. My thanks to The Lewin Group for having me here today. I am going to start by talking about the team itself and how we use a team to provide care coordination. Over the years at ICS, we went through different models and came back to a team model because we realized a participant required different skill sets throughout the trajectory of their membership here. So, we found it beneficial for teams to come together, and our teams here are comprised of nurses and social workers that have various backgrounds and specialties. We also see a need for primary care to be integrated in those teams.

Team members have to understand how to meet the needs of those with disabilities. That means understanding what their tailored needs are in regard to things such as mobility devices, what typical barriers they face, and the resources we can provide to address them.

In addition, we rely on other team members with other skill sets based on the member's needs. If we are working with someone that is no longer competent, we might have a guardian that is involved and is working with us to bring the care plan to life. So, it is important to look at the member and the population you serve to determine the need of the team members and their skill sets.

Whenever we talk about care coordination, this will be a trend throughout my presentation, it should be based on what the participant's goals and preferences are. If we are not keeping that at the center of what we

do in our work, the likelihood of us being successful is very low. However, if that is at the forefront and is taken into consideration in all of our decisions, we tend to be much more successful.

When we talk about the key elements of care coordination, at the forefront and from the beginning, what we are working to do is develop and maintain trust with that participant. It is hard to move forward if that is not present. We begin by understanding what is important for them. How much do they feel they are capable of participating in their health, and what is their willingness to do so? Often when we are assessing that, a lot of stories have come out about how the participant's past history is affecting their current decisions and beliefs themselves and in the health care team. So, asking about where they have been successful in managing their health or where they hit barriers is important and will help when you move forward.

Like any relationship, communication is key. Understanding who their support team is and including them if they want them to be included is critical. I think sometimes HIPAA has done us a disservice, where we restrict so much information, but if the participant wants us to include their family and loved one in the discussion, then we need to do it. If you include their support team, you will be more likely to be successful.

Often in health care when we talk about conversations, we are doing that without the participant and it becomes inefficient. In our teams, for instance, we will talk about what is going on with someone and try to problem solve and put together a plan. Then, we present it to the participant, and they say "no, that's not going to work for me." So, we need to change our method. I know that can be quite awkward and disruptive to our current processes, but if we can include the participant in those discussions as much as we can, it will save us a lot of time. Figuring that out, including the participant when we can, and making sure that we have those key arrangements set up so that they are receiving the services they need is really important.

For people who prefer a visual, this is a way to think about the care that we are providing. The member is always at the center. We start with the participant and build the support around them. This should be fluid and responsive; we should take the participant's capacity into consideration, and then build the support. If that participant is able to lead their own care, they might not need a social worker. So, it is important to look at where their skills and willingness are and bring the team around them.

Some guidelines for the IDT to consider is whether the providers have the training and the ability to provide quality care to people with physical disabilities. It is not a natural evolution, and as a healthcare provider, it certainly was not something I learned in school. We all start somewhere and have to build our expertise. I have learned so much from working with people with physical disabilities and asking them about what they need, and then understanding the barriers to their care, risk of their conditions, the risk of immobility, and how to reduce those risks or totally obliterate them.

When talking about a team, I always use the example of being on a sports team. I played soccer when I was in my youth, and we practiced before the season started. We practiced so we could get used to working together. Throughout the season, we would practice every day during the week and have about one game. That was really so that we could get to know each other's strengths, who is playing what position, when we should pass to someone. The same is true here in creating an interdisciplinary team. We need clear roles and responsibilities, we need to know who we are passing it to and what they will do with it. We also need someone to lead, so that there is someone taking over the responsibility for the care plan and making sure that we are on the road to success. That lead role may change as the person changes and goals are reached.

We might move on to something else if the person who is currently the lead does not have the right skill set to meet what the participant wants, so we have to ensure we have flexibility in that. Skill set is important, but the other thing is that the person has a relationship. We go back again to talking about trusting someone. There are certain times, particularly when people are vulnerable about having that relationship, that saying “Okay, this is good. Chris is here, and I know Chris will watch out for me,” can mean a lot.

We will move to IDT communication. We already talked about the “what” of the team and now we will move to the “how.” How do we work together? It begins and ends with communication.

When we are talking about communicating with a participant, it starts by developing a trusting relationship and how you do that is by listening. I think we often rush particularly as health care providers. We have such a desire to help people and fix the problem, but we sometimes rush to do it before we truly understand what is going on. We need to understand what the participant needs from us, including if they are refusing something. If someone says I do not want that, or they are not showing up, or they are non-adherent, it is important to dive into that with them and ask them to tell us why they do not want to move forward with that. We should be asking what people value, understanding what people value, what they want for themselves, and moving from that model of what is the matter to what matters to *you*.

Also, we need to make sure that we know what they understand. Our healthcare system is complex, and sometimes people's conditions are complex. At ICS, our members have, on average, 11 diagnoses, are on 10 medications, and require 8 hours of care a day to remain in their community. That is a lot. So, what do they understand about what is going on with their health? Do they understand their disability, and what their functional capacity is? Are we maximizing it? Is there something we have to have a hard conversation about?

For instance, we have people with progressive neurologic illnesses such as multiple sclerosis and ALS. When you talk to them about what is most important to them, sometimes they will say, "I want to walk again." Unfortunately, today we do not have the ability to do that when someone's disease has progressed to a certain point. You might need to educate them, but before you do, it is often good to say, "May I tell you, from my view, what we can offer you?" Then have a discussion to explore what they want and be very specific about what we can offer and how we can help them. In that scenario, for instance, one of the conversations I often have is saying that, unfortunately, we cannot help them walk again, but where would they go if they could walk. Often, we can be successful there.

So within the IDT, again, communication is critical. I have a theme of telling people to set all of this stuff up before a crisis occurs because everyone is then panicking, and we do not know who to call or how to get them. When you are setting up the team, set up how you want to communicate. Sometimes people don't like the phone; they prefer secure texting or e-mail. Knowing that, setting it up, and sharing everyone's information is crucial because the other thing about an IDT is being responsive when it matters. If something is critical, I will get back within “x” amount of time. If it is standard, I will get back within a day or two or whatever that is, so that people can set realistic expectations of one another.

Again, setting a lead is important. Who is taking the role in this? The other thing to check is making sure you know who the member considers on their team. We might say this is who is going to be on the team for Chris, but sometimes Chris has an idea about who is on his team and has other health care providers that we

are not communicating with. The likelihood of something going wrong because we are all off on different tasks is high. It is like I said, when you are doing a medication reconciliation, you are asking people what medications they are on. You also want to hear about vitamins and anything else; this is the same thing. Ask them to tell you everyone they reach out to on their healthcare team when they have a problem. Make sure we know all these people, and we reach out to those people.

We are also talking about a team, as I said before, like practicing. A team needs to meet on a regular basis. I know everyone is incredibly busy, but we need to be sharing if there are any changes, how we are doing, are we meeting our goals for that participant, how is the participant feeling about this experience, and are we checking in on a regular basis? We meet every two weeks. When we first did a case presentation, it lasted 45 minutes because people were participating and taking a while to explain themselves. Now that they have been working together for years, the cases can be discussed within five minutes because they check-in with each other outside of team meetings too.

When we create this beautiful individualized care plan and are ready to implement it, this is when the rubber hits the road. So, it begins once it is completed. We developed it, and we want to see how it is going. We need to review it on a regular basis. When we set up the plan, we are often doing that assuming that what is currently in the participant's life is going to remain the same. For instance, their caregivers are going to be there to get them to appointments or make sure to remind them to take medications. Unfortunately, that does not always happen. So, we need to make a point of checking in, but also realize who these key people are, strategies that are going to need to happen, and checking in to see how they are doing. How is the caregiver or care partner doing? Are they able to fulfill their role? That is really important. We live in a highly technological world now, so setting alerts can help and using electronic medical records can certainly assist if everyone is working off the same one. Alerting people to changes is important, so everyone is on the same page and is up to date with what is going on.

I know that resources are hard and people are trying to utilize resources where they are needed. So, when we are allocating care management to meet the participant's needs, it is important to think about what is going on, what the participant needs, and who is the right person to do it.

The critical thing is to determine the member's ability to self-direct and lead their own care. When we first started this, we started a stratification model by diagnosis. For example, everyone who is a quadriplegic is at high-risk, so we should have high contact with those people with that condition. Then we learned that there are quadriplegics that are self-directive, very knowledgeable about their health and condition, and know what to do if anything goes awry; they do not actually need us. We need to see where the member/the participant is, and what they can offer. Then we can set out the critical points; this is when we need to touch base. Every time you are moving forward, you know you have set up that plan, the emergency plan, and also the check-in plan. You know when you are going to circle back to see if you are becoming successful, and you can set those alerts up so you remember.

That is at the individual level. The other thing to think about from the plan level and management's perspective, is the staff assigned and whether they have the ability. Here is what the member needs, but can the staff meet those needs. We are continuously checking in on the staff to see what is actually do-able, and if we can shift resources if needed because if it is not manageable, it is likely not to be successful.

So we have the individualized care plan, and we want it to meet the member's needs. We know that one plan does not fit an individual, so we have to tailor it. When we talk about tailoring it, often in plans, we are looking at what services we can provide. Those services need to be tailored to meet the individual's needs. Where are they in regard to their health, health goals, functional capacity, their risk, and how can we intervene and offer our support? We have found the more flexible we can be, the more likely we are to meet the member's needs. I know that can be challenging, especially for health care plans that have existing algorithms, to look at that and see if we can allow for individualization or customization from our benefit package.

When we look at those traditional defined benefits, our members receive on average eight hours of care a day; it is a required service, which includes personal care and a home health aide. We are providing that, but sometimes there are barriers to doing that. For instance, if someone has bed bugs, having an aide come into the home puts the aide at risk, so even though extermination is not in our covered package, can we arrange for that to come? Sometimes we have to pay for it in order to stabilize the person's services.

We need to look at those social determinates of health and well-being that are impacting our participants. I know consistency is important, but if the staff have an idea of meeting a member's or participant's needs that is not in our standard benefit package, we have a protocol for that. You reach out to your team leader, and the team leader knows where to go, so that protocol is set up to allow for it.

We talked about putting this altogether and where to keep it. Often, the individualized care plan is kept in the health record. Ideally that is where you have a comprehensive composition of the assessment, the care plan, what the member's medications are, the services they are receiving, their ongoing contacts with the IDT, and what is going on with them. I know it is not always possible, but if there is a centralized health record, that is where we want to go. The health record plays a role in care management so the IDT can see what is going on. What are we doing for that person? Are they calling? Why are they calling us? What is going on? If there is a change, those alerts are given out and sent to the IDT. We also know that when the care team meets, things change in between, so if that health record is there, it can tell the team members what is going on when they check-in.

I know there are participant portals available; we do not have this currently. We are hoping to do it. Right now, we are reviewing this at least monthly with the member when we call, outside of responding to any needs. We will tell them, "let's talk about and go over what you want to achieve in this care planning period." That is a way to go around and get back to the team members on your agreed method of communication to let them know how it is going.

Next we will talk about quality control within the electronic health record. That is a great tool to use; it will tell us are people using the ER and being admitted? Why are they being admitted? At ICS, about 60% of hospital admissions are potentially avoidable right now. It makes me a little sad, but also gives me hope that we can continue to impact it. They are going in for things like urinary sepsis or a wound that is deteriorating, so what are things we can do? The record is a great way to see what is going on with the individual, but also at the population level to identify trends and whether we need to develop additional protocols to meet them. We are always trying to reduce the health disparities and keep people as healthy as possible in living their lives.

So hospitalization, I think, is a great intro for talking about critical areas for care coordination. What do we want to address when we think about people with physical disabilities; care transition is certainly one of them. Transition is typically referred to when you move from one setting to another; it is usually a hospital or a nursing home. When you talk about people with disabilities, it can have a broader scope. For instance, at ICS, about 10% of our members have a history of homelessness because of various issues of inaccessibility or other reasons. We work with a shelter called Barrier Free Living that is an accessible shelter. We work with them to determine the level of change they will need when the member moves from the shelter back to the community and things we have to take into consideration.

During those periods of transition, whether from hospital to home or shelter to the community, people with physical disabilities are at an increased risk for poor health outcomes that we have to look for things and try to intervene whenever possible. For instance, someone who is a quadriplegic and goes into the hospital, their aide cannot come with them. It is considered duplication of services, so then the hospital is responsible for meeting their needs. They move from a one-on-one setting to now having to share with other people on the floor can be scary. If you are a quadriplegic you can't push the typical call bell, so making sure there are call bells that can be activated by touching your head or rolling from one side to the other is important.

Because of that and our desire to manage transitions, we set up a plan for people when this happens and protocols for when these critical points in time occur. We plan ahead whenever possible. How do we respond when someone goes in the hospital? Using those protocol check lists can be helpful, so people make sure they went through the critical areas or interventions and assessed what the member needs. Who is going to take the responsibility of following up? At ICS, we learned it can be incredibly disruptive to a care manager when all of a sudden they had planned on doing a set up and their member goes in the hospital. First question we ask is, what did they go in for and are they okay? Going in to help the participant can be challenging. At ICS, we set up a transition team that reaches out to the hospital when we know someone has been admitted to triage the situation, see what the level of care is, and go out if needed. We found that helpful, and the members responded positively to it as well.

We make sure the transition is being managed and followed. For instance, we use the Coleman Model to prevent a readmission and that someone understands their condition, the flags, as well as their medication reconciliation and that they have a follow-up appointment. We make sure those things are in place so the transition team will follow them upon discharge.

Medications is also something we need to look at. Many of our participants are on multiple medications. As I said, 10 medications is a lot to keep track of. Using a health record is important for when someone has multiple providers or prescribers involved. The other thing to remember is that we are taking that disability into consideration. For instance, if someone has problems with their fine motor movement, injecting might be hard, so are there other supports we can put in place so they receive the needed treatment? If someone is on a diuretic and they have an unsteady gait, they could be at high risk for falls or if someone has to transfer on a diuretic using a Hoyer to go to the bathroom, is that feasible? Maybe we need to come up with an alternative plan.

It is not often done, but I rely on pharmacists. They will help you come up with a plan and talk about the individual, what they need, and how we can come up with an alternative solution.

Advanced directives is another area to pay attention to. When someone has a disability, you might not approach it the same way you would approach someone that is able-bodied. You really need to think about what is currently going on with that person. We use the five wishes here at ICS; one of those discusses ventilations. We have people here on a ventilator already; how do you review that with someone on a regular basis and ask if there will be a time when maybe they would not want to be on the ventilator anymore? In order to do that, you have to have a trusting relationship with the person. In a crisis is not ideal because people feel pressured, and you want them to think about it and have time to consider it. Again, it has to be reviewed on a regular basis because things change. I might have wanted something 20 years ago that I no longer want now.

We are going to move to a case scenario to go through. Camille is a 35-year-old woman who describes herself as an artist, advocate and pet owner. Most of her family lives out of town, but she is able to stay in touch with them. She is on the autistic spectrum, has hearing and vision loss, thyroid disorder, recent weight gain problems, and difficulty ambulating due to swollen legs and pain. So, she went to a long hospitalization. When we were thinking about Camille, I automatically thought she will need rehab, and that is what the hospital recommended. Camille did not want any of it. Her identity is being a cat owner. She wants to be back with her cat. Her lifestyle is important, so she did not want to go into a facility. What does the team do?

The team, as any good IDT would, respected her choice and worked with her to develop an alternative plan. What did we want for her in the rehab facility and what can we bring into her home? They brought in home care services and increased the visits to her PCPs so they were seeing her more often. They worked with her personal assistants to make sure they knew how to exercise so she could keep the weight and swelling down. Camille began to learn the connection between her weight gain and her thyroid and taking her medications and her legs swelling; she became more empowered and was able to self-manage. She was also able to get out there. She is an artist, so she shared her talents and got connected with the paratransit system. If she needed more assistance, they could meet her functional needs, and so Camille is living her life.

In conclusion, I will just say that care coordination should be the glue that is bringing everything together. That glue should take the form of what that participant needs and it needs to be developed. Communication is critical as is developing a relationship with someone. It does not have to be a specific person but a function or role. What does that person need now and how will we respond to it? It is important that that is a fluid, ongoing discussion with the participant.

This is where I turn it back over to you, Chris.

Christopher Duff: I want to thank Rachel for her great presentation and call out a couple things she said that were really interesting and impressive. One, I quote from her, as professionals we are trained to fix, and she talked about learning to move from what is the matter to what matters to the person. I think that is a classic example of what the entire Disability-Competent Care model is all about. So I wanted to call that out.

The other thing that all of us have probably heard a lot is people saying that what they want is a girlfriend, or what they want is to walk even though they may have a spinal cord injury. We know that saying “no” or “that is not going to happen” does not work. I appreciated your suggestion that you go at it by a discussion

whether that includes education or saying, “Let’s revisit that when I talk to you next.” I thought it was quite interesting how you did not give the standard medical response or clinical response.

Couple questions have come in. First, questions are kind of related. What triggers care management to get involved? Secondly, who on the IDT talks most often to the members?

Rachael Stacom: Great questions. We are a managed long-term care plan and a FIDA plan, so care management is a service we provide all of our members. I know that is different in mainstream plans, but every single member receives a care manager here.

Typically upon enrollment we look at a couple different things, one being what is the member's condition? We have a multiple sclerosis program, a spinal cord injury team, and a dementia team, so if someone is coming in with one of those conditions, they more than likely will be on one of those teams. Then, the team reviews the intake. Nurses go out and create an assessment, and that is taken into consideration along with who they think will be the best care manager to begin working with the member.

If the member needs change, then we will. Just to add, on average, we are talking to our members at least once a month and as needed in addition to what is going on.

Christopher Duff: Thank you very much. Another question came in. Can you give a few more examples of the benefit flexibility? You mentioned one or two before, but sometimes when your teams have said, “it would be better for the member if we did this” or “we could improve outcome, quality, cost, etc.” Can you give some further examples to trigger the participant's thoughts?

Rachael Stacom: One thing we can do is be flexible with our home care hours. It does not always have to follow a 9:00 to 5:00 schedule. For instance, if someone wants to do something in the afternoon, they need their aide to be able to do it. They can have the aide come at 11:00 and work 11:00 until 9:00, so we can be flexible with hours. If there is a medical appointment, and we need to give an additional hour to the day so the aide can escort them home, then we can do that as well.

Recently, a physical therapist went out to see a member having a little dysarthria or slurred speech. The physical therapist went out and said, “I wonder if someone needed augmentive communication device, like a Dynabox.” These can be costly; sometimes we have paid around \$8000 for it. The physical therapist has a long history of working with people with disabilities and said, “I think we could actually try an iPad to help her speak, and it is much less costly, a couple 100-dollars. In addition, we could put music on for her as she gets dressed because she said music helps her relax.” So, it is a cost-savings and an increased quality of life.

Christopher Duff: Great examples. At a plan I was working with, a member came to us and said my automatic leg-bag opener quit, and I would like you to replace that. Obviously, leg-bag openers are not in any benefit set really, but when we sat down and talked with her, she said it was important for her to drink a lot of water. She heard that from her team and her family care doctor. She said in order to do that, she needed to manage her leg-bags more frequently and needed a personal care assistant sitting on her couch most of the day. That is not a fun thing for her and certainly is costly. For a matter of \$60, we replaced her leg-bag management device, and everyone was for the better. That is another example of giving the care coordinators and the people closest to the participant the ability to think outside the box; everyone involved

will benefit.

Another question came through. How do you prepare care coordinators for working with primary care physicians?

Rachael Stacom: You will notice a theme here, the same kind of conversation to have with your PCP. Before we start working, we have a group of physicians that we worked with along with care providers, nurse practitioners, PAs that have disability competency. So, when we wanted to have disability competency and help them get that, we went in and talked with them. We asked what they value in their role? Where do they get stuck? We looked at what we can offer to fill that.

For our care managers, we shared that and set up protocols. For instance, we used SBAR. The provider came back and said we do not have a lot of time, so if someone wants to share information, how can they make it as concise as possible? We taught our care coordinators how to use the SBAR tool, what's the situation, the background, assessment and recommendation. We sent it the day before we were going on the visit, so the provider could read it, and have time to come in and have a very direct conversation with the participant.

In addition, follow-up was important. If you want any relationship, and you say you are going to do something, then do it right. We developed tools to track if someone was coming out of an appointment with a list of things they need to do. It let us integrate into our care plan here and follow-up and make sure we are actually delivering on what we said we would.

Christopher Duff: That's great. I know you struggled with that model at first, and it seems you have come into some training and pattern that seems to be working better.

Rachael Stacom: Yeah, and it is a work in progress. It does not happen overnight.

Christopher Duff: That is what I was hoping you would say exactly. How do you facilitate ongoing communication and facilitation with the primary care physician and the remainder of the team, if the physician is not in the same site?

Rachael Stacom: You should be engaging with that person before a crisis occurs including what their preferred way of communicating is, how they would like to be updated, the information they need to know. I practice one day a week, and I get these reports sometimes from a certified home health agency on one of my patients. There is so much information in there, and I do not know what they need from me. I think it is important to figure that out and have that ongoing check-in. What do we need to change with the provider? I reached out, shared this with you, do you want to know that? Or is that appropriate? Again, it takes time, and they have their preferences. Making sure participant's needs are being met is critical. It is ongoing.

Christopher Duff: The last question is from Dr. Saunders, and it is a great question. This goes back to the issue of healthcare directives and advanced healthcare directives. When should that discussion take place and who should be on the team that makes those decisions? Does every member need to have advance directives? And if not, why not?

Rachael Stacom: We are required to talk about it at enrollment and every care planning period, which happens at least every six months. It is really important that people understand what the purpose of an advanced directive is. At our first visit, it is a lot. We introduce it if they do not know what it is; we provide information, and then the care manager goes back and facilitates that discussion. If they do not know what they want, it is then brought back to the primary care provider or their preferred provider. Some of our people in the MS community trust their neurologist and want to talk through some scenarios, so it depends on who they choose or identify as that person. That discussion is led by the care manager but the member is making those decisions. In order to make an informed decision, sometimes they need to talk to their provider about a scenario. We can sometimes talk through a typical scenario for someone and what they would want in the event they were not able to communicate for themselves, but a lot of times we bring the provider in too. Then, if not at the beginning, but in the discussion, he or she knows what the member has decided. That is reviewed every six months, at least.

Christopher Duff: Great. Is that a conversation that is best had with the primary care doctor or with the nurse, social worker, or specialist?

Rachael Stacom: We have all of the above. It depends on what is going on with the participant and who they want that discussion with. Who do they have that relationship with? I have seen social workers work with a member so their wishes are out there and are very clear. I have seen our nurses do it as well, and primary care providers, and neurologists.

Christopher Duff: Great, I was guessing that. This question goes quickly to what you were talking about. In your experience who on the team talks the most with their participants? Is it the nurse? Social worker? Someone in the office?

Rachael Stacom: We do not have physicians on staff. Everyone is assigned a care manager here, and the care manager can be a nurse or a social worker. That is who they are having the most contact with, but it depends; that is our plan here.

Christopher Duff: Yes, okay. Great. With that, I think we have to wrap it up. I would like to thank everyone for participating in today's webinar.

Please send any feedback you have to the address on this slide (RIC@Lewin.com), and answer the survey that will appear on your screen at the end of the webcast. Again, I would like to call your attention to the resources we have outlined at the Resources for Integrated Care website.

Please join us one week from today for our sixth webinar. The presenters are Dr. Andrew Jorgenson, Assistant Medical Director at Outer Cape Health Services and Dikke Hansen, Director of Behavioral Health.

I would like to again thank the Centers for Medicare and Medicaid for sponsoring this webinar. Thank you for attending.