

The Lewin Group
Preventive Care and Health Screenings for Persons with Disabilities
November 2, 2017
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Christopher Duff: Good afternoon, everyone. Thank you for joining today's presentation, *Preventive Care and Health Screenings for Persons with Disabilities*. First, I would like to review some technical components of this webinar. Please take a minute to orient yourselves to the platform. If you would like to ask a question, please use the Q&A feature located on the right of the screen. Technical questions will be addressed as they come in, and content questions will be addressed at the end of the presentation. Live, closed-captioning is available at the bottom of the screen.

On behalf of the Lewin Group, I would like to welcome you to the Disability Competent Care webinar. The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) has contracted with Lewin to develop technical assistance and actionable tools to support providers in their efforts to deliver more integrated and coordinated care to Medicare-Medicaid enrollees. To support health plan and healthcare providers in their efforts to deliver integrated coordinated care, MMCO has been developing technical assistance and actionable tools.

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My name is Christopher Duff, and I am a Disability Practice and Policy consultant who has been working with The Lewin Group to develop a Disability-Competent Care model and related webinars and materials. I will be joined today by Mary Lou Breslin and Dr. Judy Chamberlain.

Mary Lou Breslin has been a Disability Rights Law and Policy Advocate and Analyst for over 35 years. In 1979, she co-founded DREDF, a leading national civil rights law and policy center, and currently serves as a Senior Policy Advisor with DREDF focusing on the organization's healthcare initiatives.

I am afraid Dr. Chamberlain will not be able to join us today because she lives in Maine, and she is still without power and phone service. She gave me her narrative, and I will cover on her behalf as much as possible. Let me give you her background. She is a recently retired Senior Medical Director for Aetna Medicaid. She received her BA and M.D. degrees at Stanford University and Dartmouth Medical School respectively. She practiced family medicine in Maine for 30 years. At Aetna, her major area of focus was integrated care management programs working to develop clinical programs for Aetna's Medicaid members. She focused particularly on a biopsychosocial approach for each member and fully integrated physical and behavioral healthcare for their members.

We will also be joined by Gabriel Uribe, Independent Living and Diversity Services Manager at the Inland Empire Health Plan in California (IEHP). IEHP provides leadership nationally in the areas of member engagement and access.

Lastly, we will be joined by Lydia Orth who is a Presidential Management Fellow at MMCO. She will share some of the strategies and tools developed for the flu vaccination pilot project in California.

The objectives for this webinar will be evident as I read you the agenda from the next slide. We will start here with exploring the social determinants of health and their effects on the health and healthcare disparities experiences by persons with disabilities. We will look at primary and preventive care and then the barriers that both providers and participants face in delivering or obtaining this care. We will close with a variety of strategies you can use to improve preventive care for your participants. All of this will be followed by a Q&A.

As this slide shows, individuals with a disability are less likely to receive preventive care and health screenings despite being at a higher risk for many chronic illnesses and secondary conditions. Though this presentation will primarily focus on adults with functional impairments, the concepts are applicable to the larger community of persons with disabilities.

Persons with disabilities utilize a significant proportion of overall healthcare resources for their high medical and post-acute care needs. At the same time, they also represent the greatest opportunity to reduce avoidable episodes of care and thus costs. Health Care/System Redesign is focusing on participant outcomes, participant satisfaction and control, and quality indicators such as immunization rates and realizing financial incentives. Prevention, health screening, and immunizations are a crucial step to accomplishing these desired outcomes.

When compared to individuals without disabilities, persons with disabilities are less likely to receive recommended preventive health services and screenings. As a population, they are at greater risk for poor outcomes such as obesity, hypertension, falls, and mood disorders. Additionally, they are more likely to engage in unhealthy behaviors that put their health at risk.

At this point I will turn the presentation over to Mary Lou Breslin who will discuss health and healthcare disparities as they are experienced with persons with disabilities.

Mary Lou Breslin: Thanks very much, Chris. When we talk about health disparities we are referring to a particular type of health difference that is closely linked with social, economic, and environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on, for example, their racial or ethnic group, socio-economic status, gender, gender identity, age or other characteristics historically linked to discrimination or exclusion.

For a long time, people with disabilities were not considered a population that experienced disparities. It was assumed that poor health was a direct and inevitable consequence or outcome of impairment or disability. This perception began shifting as researchers and advocates delved into the reasons why people with disabilities experienced poor health. It soon became evident

that, in some situations, poor health status was the result of factors not directly related to disability.

The tide shifted at a federal policy level when agencies, such as the National Council on Disability, the Office of the Surgeon General, and the Institute of Medicine, issued comprehensive reports that recognized health and healthcare disparities among disabilities. The Affordable Care Act also recognized disability disparities in a variety of initiatives, and the HHS Committee on Minority Health further advanced the idea of healthcare disparities in a very important 2011 report which is a Statement of Principles and Recommendations. The report concludes that, by every measure, persons with disabilities disproportionately and inequitably experience morbidity and mortality associated with unmet healthcare needs in every sphere.

Minorities with disabilities are doubly burdened by the status. As this report suggests, the intersection of disability, race, ethnicity, gender, and so on reinforces the role of social determinants of health in health outcomes for these groups with overlapping identities.

What are some of the common health and healthcare disparities that people with disabilities often experience? They experience higher death rates from breast cancer and lung cancer and tend to miss benchmarks for mammograms, generally recommended every two years, and PAP tests, generally recommended every three years. Persons with severe mental illness (SMI) which would include schizophrenia, bipolar disorder and moderate to severe depression die 10-20 years earlier than the general population, which I think is a staggering statistic.

We know that roughly fifty percent of preventable deaths are attributed to non-medical indicators such as social circumstances, environmental factors and individual behaviors, while 95% of healthcare resources are devoted to direct medical services with only a small percentage being used to address these non-medical indicators. So once on the radar, it is important for us to better understand these non-medical indicators.

Public health experts and disability advocates turn to the idea of social determinants of health already being used as a way to understand disparities among groups of people who have systematically experienced greater obstacles to health. So what are social determinants of health, or SDOH?

SDOH are commonly thought of as conditions that have helped affect health risks and outcomes and that may pose significant barriers to preventive care. What role do they play in health and healthcare disparities in people with disabilities? Consider these inter-connected factors; income and economic factors, social and community context, neighborhood -- this may include limited transportation, lack of access to fresh food, lack of affordable housing, the built environment -- this could include exposure to toxic substances, education levels, health status, physical and service barriers such as lack of physical access or accessible medical equipment and even extended provider disability awareness.

Taking these factors into consideration, research has shown that those with disabilities are more likely to be unemployed, impoverished, have less than a high school education and have higher levels of risk factors such as obesity, smoking and being physically inactive.

One cross-cutting factor that stands out in a dramatic way is poverty. Only in the past few years has a powerful relationship between disability and poverty become part of the public discourse as it relates to health. This is an outgrowth of understanding that health disparities are not an inevitable consequence of impairment or disability alone. The SDOH model looks at the interaction of income poverty and disability. Disability is both a fundamental cause and a consequence of income poverty. Half of working-age adults who experience income poverty have a disability. This fact alone makes it possible to see the very powerful relationship between the two.

How does all of this affect health and healthcare, especially preventive services? Here is an example in the Medicare population. Medicare beneficiaries living with income poverty are less likely to receive preventive services across several quality metrics. This includes breast cancer screening, annual flu vaccines, adult BMI assessment and managing diabetes. So in crafting solutions, we have to devise strategies that recognize the role of these powerful social determinants and that target pathways that interrupt the damaging cycles they set up. We will be talking more about that a little later in the webinar today.

I want to turn the presentation back over to Christopher Duff who will be talking about primary care and prevention.

Christopher Duff: To remind everyone I am filling in for Dr. Chamberlain. I will be going over some notes she sent and also some previous conversations I had with her over the last year. Many people with disabilities see multiple providers. Care can get fragmented with no single specialty provider taking ownership for the health, education and preventive care of the individual. Everyone should have a primary care provider who is intricately connected with their specialty providers and takes responsibility for health education, preventive care, age-appropriate screening and care of common, acute and chronic conditions. In addition, the primary care practitioner should screen for abuse, neglect and substance abuse disorders and other health risks.

Persons with disabilities may not be appropriately screened because it is physically difficult to do so, for example, not being able to stand on a scale to be weighed. They are also often not screened for sexually transmitted diseases because of an incorrect assumption that the person is not sexually active. It is common for providers to assume they are not and, in addition, not to screen for current or past sexual abuse or to ask if a person is sexually active with men, women or both.

This slide speaks for itself. Despite negative and unscientific publicity, immunizations are safe and highly effective. Immunizations can be given at any visit, even during an episode of acute illness like a cold or ear infection. As discussed earlier, fragmented specialty care may mean that no one provider makes sure that a person with a disability is immunized appropriately. Children with disabilities may miss scheduled preschool immunizations because of other multiple appointments and procedures. Adolescents and adults with disabilities may not be made aware of critical immunizations or maybe assume that some are not needed such as the HPV vaccine prior to sexual activity.

Eighty-seven percent of individuals with disabilities reported experiencing a secondary medical condition. A critical part of primary care is anticipating and working with a patient to prevent secondary conditions, such as those listed on this slide. Specialty care may be focused on only one of these or on the acute treatment of a complication that has already occurred. It is far easier to prevent a complication than to treat it after it has occurred.

Both Mary Lou and I will be sharing the providers and participants' perspectives and challenges. On these next several slides I will start with the providers' perspectives.

There are challenges to serving people with disabilities in the primary care practice but most of these can be overcome with planning. It starts when the appointment is made. If the person is new to the practice, the scheduling staff should ask if there are any special accommodations he or she may need. For example, if the office has only one exam room with an adjustable table, it is critical that room be booked for that patient. If the participant has limited mobility, it may be helpful to have him or her come a half-hour early to get into the exam room and be comfortably ready for an exam. Being a truly accessible practice goes far beyond compliance with the ADA and is beyond the scope of this presentation. We recommend practices educate their staff and also develop a panel of patients who have disabilities to work with the practice leaders.

The next slide lists some of the common challenges, but just as anyone else, a person with a disability is a distinct individual, and the need of each distinct individual needs to be identified and compensated. Now, I will hand it back to Mary Lou to talk about the participant perspective.

Mary Lou Breslin: My organization has conducted a series of interviews with people with disabilities across the country about their healthcare experiences. We heard story after story about missed preventive tests and diagnostic screenings. Many of these stories center around the lack of accessible medical equipment. Others reveal that providers sometimes rely on misinformation or incorrect assumptions about disability, as we just heard in Chris' remarks. Still others describe barriers preparing for diagnostic tests such as colonoscopies especially if the individual needs extensive assistance to carry out the pre-test routine.

Here are just a couple of examples of the kind of remarks we heard in our interviews about people's experiences attempting to actually seek out preventive care. Mary, a Chicago resident and wheelchair user who had polio, had not had a PAP test for five years because she could no longer get on the high exam table at her primary care doctor's office. When she told her doctor she needed a table that lowered, her doctor said, "That is a really great idea. Go find one." This particular provider apparently wasn't aware or didn't think she played a role in trying to solve this problem. So, in fact, it took another 18 months before this person was able to identify a location where it would be possible for her to have the examination she needed.

We know that virtually every time we go for doctor visit, our weight is measured yet many people with physical disabilities are never weighed. In fact, most are never weighed. One of our interviewees, Michael, a New Jersey resident and wheelchair user who has multiple sclerosis, said in his interview, "I see quite a few doctors and not one of them has a way of weighing me. The last time I was weighed was 10 years ago when I was still on my own two feet." My own

personal experience with being weighed is similar to Michael's. The large medical facility where I receive care has an accessible weight scale but it is bolted to the wall in an alcove which blocks the access ramps. The staff who bring me into the office routinely say, "You don't want to be weighed do you?" The last time I said I did we tried to move the scale where the ramps would be accessible, which is where I learned it was permanently mounted on the wall even though it was intended to be portable.

Lack of insurance coverage or coverage of specific health benefits can also deter some people with disabilities living in income poverty from getting required screens or other prevention services. Other barriers frequently contribute from lack of access to a primary care doctor to transportation problems for people living in rural areas, a poor understanding of the reasons why the prevention services actually matter.

These examples of environmental barriers are common and stand in for other typical barriers to preventive care that people with disabilities often encounter. I am going to turn it back over to Chris now for the next segment of the presentation.

Christopher Duff: Thank you, Mary Lou; I appreciate your comments there. We are right on schedule, actually a few minutes early, so we are going to move on to the last main section of this presentation and that is to explore a variety of strategies to improve preventive care and screening.

First, I will ask Gabriel Uribe to talk about some work they have done at the Inland Empire Health Plan.

Gabriel Uribe: As a health plan, we recognize many of the barriers that people with disabilities experience when accessing care. One of the areas that we decided to address a few years ago was our entire Urgent Care network. We have a great resource for individuals who need to be seen as many of our health plans have a resource for Urgent Care sites that need access to care urgently but not necessarily emergently. We realized fairly quickly that people trying to access our Urgent Care sites were experiencing disparities if they were deaf or used ASL as a primary mode of communication.

One of the things we did was strategize with local community-based organizations and talk about different solutions to this disparity. We discussed the utilization of VRI which is used in many hospital settings or emergent care settings, and we developed a project that would allow us to bring this technology into Urgent Care sites so that all of those Urgent Care sites had access to communication for ASL users.

What we did is we funded tablets for all of our Urgent Cares in our networks. We required that all Urgent Care have Wi-Fi coverage in their facility so the tablets could be utilized for that purpose and our results were great. Once we provided that equipment to the Urgent Care sites we had virtual access, 100% access, for our ASL users or members who are accessing our facilities there.

It took us around 12 months to get this project off the ground and going, but we were able to not only provide equipment, but also provide training on disability resources available to our members. We also talked about deaf culture and what to expect with individuals who are deaf and access their clinics. We learned that it was crucially important for us to work with local community organizations that are run by individuals who are deaf who can give us some perspective to the disparities and experience that they have when accessing care at Urgent Care sites. We also learned that the provider knowledge of the barriers that the deaf community faced was not good. We definitely provided some insight into that as we shared information.

We also developed easy to use training guides for staff. We trained providers and office staff in cultural competency and provided them with resources on how to use the devices expediently because we also recognized that many of these offices are in remote areas. We happen to be a health plan that is spread over a geographic region that is probably larger than the state of Rhode Island. In many points of our two counties, the population centers are not as dense as others. We recognize that individuals who are deaf may not be accessing those services regularly but we wanted to make sure all of the Urgent Care sites were ready to go and could easily pull out a guide to utilize the equipment when needed.

Another intervention that we are very proud of is our follow-up after a mental health hospitalization. Looking at mental health, we realized early on the disconnect between the continuity of care after hospitalization for mental health facilities and then the providing care thereafter. Our intervention was basically to follow-up with mental health hospitals after we received the authorization request for services.

Our goal was to work with the discharge planners prior to the individual's release from hospitalization to ensure we could schedule follow-up appointments expediently. One of the things we learned while working with individuals who are part of this community was that they have many barriers. We know a lot of our members who are Medicaid recipients have trouble sometimes accessing telephones, having a home phone or even an address. They experience homelessness so they are either couch surfing or maybe living out on the street. It is very important we connected with a discharge planner while the patient was inpatient to ensure we would have an appropriate follow-up.

The results were great. We saw around an eleven percent improvement from the previous year when we looked at our HEDIS measures for a follow-up within a week of the hospitalization.

Christopher Duff: I have several questions for you. I think your comments were great and really exemplify what IEHP is.

Preventive care strategies are the core of success in integrated care. The first step to prevention is to build this relationship. Educating participants about the importance and role of routine health prevention services and screenings. Most persons with disabilities see a variety of specialists and often don't understand the need for a primary care practitioner. That is certainly our experience in Minnesota.

Participants benefit from learning when and how to access their primary care practitioner and their care coordinator, both of whom can also provide training in self-care techniques. Some additional strategies include developing materials for the participant highlighting the importance of preventive care and screening. Many plans partner with local agencies, especially Centers for Independent Living, Area Agencies on Aging and Aging and Disability Resource Centers to help with this education and to develop materials. Every community varies. I think the best way to figure out who to partner with is to look at where your members go. Who do they look to for education and information?

Care managers and care navigators may be based in a health plan, a community organization or within a primary care clinic and are critical in helping participants identify needed services and accessing them accordingly. These individuals are in regular contact with the participant and can be trained to assist with accessing preventive care. Additionally, call upon those who are already with the participant in their home, be it home-based primary care practitioners or home-care staff. While most of these individuals focus on acute issues, they are in the home, they see what is going on, and they can be a great source of information both from and to the participant.

Another idea is to partner with local pharmacies to provide seasonal immunizations. Many persons with disabilities are in their local pharmacies frequently, and this could be a good strategy to providing access. Some health plans look at where their participants or members go on a regular basis and build upon these patterns. Look at where your members live or congregate and work with public health or home-care agencies to hold immunization clinics on site. Along those lines is to partner with your community-based providers such as adult day programs to promote and provide immunizations.

Now I will turn it over to Lydia Orth from MMCO to talk about a special program pilot project they are implementing this fall in California.

Lydia Orth: Thank you, Chris. I am excited to join this panel of amazing speakers to share information and resources around education and outreach to promote flu vaccinations. As Chris mentioned, I work at the Centers for Medicare and Medicaid Services focused on serving beneficiaries who are enrolled in both Medicare and Medicaid. People who are dually enrolled in both Medicare and Medicaid have high rates of chronic illness and disability.

As you have heard from the speakers on this webinar, many people with disabilities face barriers to preventive health including information and access; flu vaccinations is one of these challenges. Research shows that individuals with disabilities are twenty-eight percent less likely to receive an annual flu vaccination than Medicare enrollees without a disability. Twenty-eight percent. That is startling.

In an effort to address the disparity of people with disabilities accessing annual flu vaccinations, we are partnering with federal, state of California and local stakeholders in an effort to improve access to annual flu vaccinations among low income Medicare beneficiaries. This is a pilot in California. It is a multifaceted effort to raise awareness, promote education and complement existing flu vaccination efforts.

We chose California because we wanted to leverage the Cal Medi-Connect demonstration. In the demonstration, participating health plans are responsible for providing both Medicare and Medicaid benefits for enrollees, and there are several years of work to build relationships and improve coordination among providers, plans, long-term services and supports and community organizations. The over-arching infrastructure gives us a unique opportunity to try to reach the populations that may not typically be reached by traditional public health campaigns; individuals with disabilities as well as non-English speakers.

Please visit CalDuals for more information. You will see the link there on the slide. It includes a list of free, electronic flu materials for your own efforts to promote flu vaccinations for a wide range of audiences. It also includes electronic copies of post cards that CMS mailed to 118,000 dually-eligible beneficiaries in 11 different languages. You can customize and brand many of the materials that we have available on the CalDuals website for your organization.

We want to hear from you. We want feedback on where or what we should be doing to reach beneficiaries and other providers as well as identify providers and other organizations in California that will partner with us to disseminate flu education materials to your clients and partners. Please consider completing a short survey that we have located on the CalDuals website that was listed on the previous slide. Also, on this slide we have a direct link to the survey to make it easier for you to access.

Finally, we are seeking as many providers and organizations as possible to join us on December 6th in storming social media, newsletters, blogs, etc. promoting flu vaccinations. We will give you content to use. We want to reach as many Californians as possible. Please let us know if you will join the campaign. We would love to hear from you. My contact information is on the CalDuals campaign website and we look forward to hearing from you.

With that, I will give it back to Chris for Q&A.

Christopher Duff: Lydia, thank you very much. I am going to follow-up with a question right back at you. First of all, I want to say that while this is a pilot program in California, this is an issue that is certainly pertinent across the country. Plans have been struggling with this for several years with this population so CMS decided to do a pilot with California counties and plans to develop some strategies and then they are going to be evaluating it to see which ones are effective and how effective are they.

Lydia, your question, is this pilot only in counties that have Cal MediConnect programs or all counties with Cal MediConnect beneficiaries?

Lydia Orth: Thanks, Chris; that is a great question. This particular campaign is really just focusing on California. However, these materials we pulled from CDC and other organizations focus on promoting flu vaccinations. So it is not necessarily just focused on California, but in relation to the demonstration we had in California, we thought it would be a good place to have a demonstration.

Christopher Duff: Thank you. I have a question for both Gabriel and Lydia. Are you okay with plans or providers in other states taking your concept and ideas and even some of the materials and adopting them for their use in their local community?

Gabriel Uribe: Absolutely yes. We would be willing to do that. For us, some of the big learning experiences came from working with different organizations who have been doing similar projects out in the community, not just in healthcare but also publicly. There are organizations that have done access in different areas whether it is telecommunications or, as Mary Lou was talking about, access to accessible exam equipment. We also did a large project where we provided about 95 exam tables to our primary care network after doing extensive reviews of facility sites. We made sure people could get into the door and get into the exam room if they were utilizing mobility devices. So, we would definitely be open to sharing that information.

Christopher Duff: Gabriel you hit on another question we received. I would trust that you have a lot more than 95 primary care sites in your service area. Did you have a criteria you used to decide where you would be willing to invest in some equipment?

Gabriel Uribe: Part of the set-up of that project was to look at our entire region and geographically place or provide grants to primary care physicians and also specialists in different areas based on some of the data that we collected from our encounter information and from our claims and utilization data. We also looked at time and distance factors to make sure those 95 tables covered a large coverage area, and we had providers responding to certain questions. So we did a preliminary review of provider sites by asking basic access questions. We also looked at our PARS data, which is data that in California we collect for accessibility measures out in each provider site or large provider site or network provider site. We leveraged all of that information to do our preliminary selection of finalists. Subsequently, we followed-up with an actual review of the site to make sure it was accessible in collaboration with a consultant and also members of our team to ensure those would be appropriate sites.

After the project, we learned we needed to let other providers know this was available. We want to make sure they know about this information early on or through the network so they can refer members if they don't have the equipment in their office. We want them to know that they are also able to leverage other providers that are close by without having to go through so much red tape, as well as far as referral process or anything like that.

As you know, those preventive exams are part of primary care, and the health plan ensured that people could access those without a prior auth or referral, and that there is collaboration even if the two providers are in different independent physician networks as well as long as they are contracted with us.

Christopher Duff: Gabriel, what I really appreciate in IEHP is how strategically you guys go about things and how you keep your information open to the general public. We will be hearing from Gabriel about some of their other strategies in a future webinar around access, which we will be hosting sometime in the first quarter of next year. Another thing that IEHP does is provide training and education for the staff there on how to use the equipment and why they need to use it. So it is well implemented. It is pretty impressive what IEHP has done.

Lydia, I am going to go back to you if it is okay. For the California pilot program, could California HHS reimburse in-home flu shots?

Lydia Orth: That is a great question, Chris. Medicare actually pays for flu shots.

Christopher Duff: They pay for flu shots, but they won't necessarily pay for a home visit for that. I believe that would be part of role of the care coordinator to get the member into a flu clinic or a setting where they can receive the shot versus sending a home care agency out to that person's home?

Lydia Orth: Exactly. They will work with their care coordinator.

Christopher Duff: Great. Then, a question for Mary Lou. You mentioned intersectionality. Could you talk more about that? Do you remember where and how you used it?

Mary Lou Breslin: I think I do. I think the important message about intersections in relation to healthcare is that many of us belong to many different demographic groups. Our gender may be male or female or other. We may belong to different racial or ethnic groups. We are obviously of different ages. Many of us have a variety of disabilities, and we all sort of overlap and intersect in the same body. There has been an important evolution of our understanding of the intersection of these various demographic characteristics in terms of contributing to health and healthcare disparities, and disability is obviously one of those demographic characteristics, but not the only one. Variants of the characteristics bring about or experience certain problems in terms of accessing healthcare that are unique to that particular demographic group, but when you overlay or intersect that characteristic with many others, then the picture is much more complicated and the need for awareness of what the barriers are for each of the specific groups that has to come into play.

Many healthcare practitioners, public health professionals, researchers are taking a look at the role of intersectionality and trying to understand it and devise methods to improve healthcare services for these groups that experience different memberships in many different demographic categories.

Christopher Duff: Thank you very much. Another question for you, Gabriel. How are you able to get behavioral health hospital providers, and their discharge planners in particular, to buy-in and partner with your care management team? This person said they have had huge barriers when getting responses from hospital staff and that certainly was our experience in Minnesota.

Gabriel Uribe: That is a great question. It starts with our efforts to develop strong community relationships and have a group of team members who have these conversations, very candid conversations. In California, a lot of our mental health providers are managed locally by our county health departments. We work closely with our county health departments and have liaisons that are familiar with the process of both the health plan and the county system. We have regular joint operations meetings to discuss some of the goals that have in common and work together and strategize those goals every quarter; this makes a great impact.

It also gives you somebody to call if you have a need for a specific member on both sides. I think that is definitely breaking the ice with public health departments; strategizing what the goals are and having open conversations usually leads to strong collaboration over the years.

Christopher Duff: Thank you very much. A question for Lydia. Is the pilot program for the flu vaccines in California only in California? Would you want other community health partners to participate in your study?

Lydia Orth: That is a great question, Chris. We would love for other community health centers to join into the campaign and share materials with us. My email address is on the CalDuals website, so if you go ahead and email me, I would love to find a time to set up a call and talk with you.

Christopher Duff: Thank you. Mary Lou, I am going to go back to you. A question that has come in is, do you hear of much fear from participants or persons with disabilities of receiving immunizations, particularly flu and pneumonia vaccines? If so, how would you characterize these fears, and how do you address them?"

Mary Lou Breslin: I haven't had experience with people that are afraid of having vaccinations. I usually hear of the logistics problems rather than actually getting the shot itself. These logistics problems go back to some of the comments that Gabriel was making about the circumstances of people with disabilities. They might be homeless. They might have difficulty acquiring the right kind of transportation, or they might not actually be able to leave their home, which is the example that just came up a few minutes ago where they really have to have the shot brought to them. There may also be some cost barriers that prevent a provider from being able to accomplish that even with care coordination.

My response is I think there is less fear of them and more concern about just how to go about getting them in a way that is actually practical, feasible and achievable.

Christopher Duff: That certainly makes sense from what we have heard, and I know other plans have tried to develop all sorts of strategies and most of them are exactly about that; around how do you get the person and the vaccination connected. So what you are saying absolutely makes sense.

Another question for Gabriel. Do you in particular have a teaching tool for helping people decide when to contact their primary care provider versus going to the ER?

Gabriel Uribe: That is a great question, Chris. I know we have a series of videos that we pushed out through our website that address that. We also have robust promotions of our nurse advice line with highway billboards. Also, through our newsletters we talk about the appropriateness of that. A few years ago, we made one of our big programs in home visits for families who had increased utilization in ER visits and also increased utilization in a primary care and durable medical equipment which can many times be associated with disability. We saw there was a need for education for navigating through a health plan and getting resources from a health plan.

We developed a navigator program within the program that taught families in one of the units on the different times they can access different levels of care; whether it is primary care, urgent care or emergent care. That was pretty successful. It curved the utilization away from the inappropriate encounters some of our members were having to more appropriate encounters with the appropriate level of care.

Christopher Duff: Thank you, Gabriel.

The last question for you, Gabriel. How did you reach the homeless and your participants with no phone numbers after hospitalizations and increase your compliance through the year?

Gabriel Uribe: When we are outreaching to the homeless population, we make sure we make contact whenever somebody in our network is having a face-to-face contact. We have trained our providers. We made information available through our Provider Services Unit who are dedicated to providing resources directly to our provider network, and let them know we can assist our members with connecting them to community resources. Some of the cell phone programs that are out there. We train them on those programs. If they need further assistance with that, they can also communicate with the health plan or refer the member to the health plan. They themselves or the provider can connect with us. We have a resource team that will fill in other gaps if needed as well.

We have found that whenever we have an encounter, whether it is at a provider office or urgent care, we have the ability to do that and then subsequently meet that person where they are at in some location. There are also programs that are designed to, once the member makes contact outside of a clinical setting, follow-up with care out in the community as well if needed.

Christopher Duff: Great. I have heard from other plans that what they do for these people is they put a trigger on their plan's system. So if that the person shows up at a pharmacy for some medications, someone who can reach out to that provider and let them know they are trying hard to get ahold of this participant. Can they follow-up in that way? That is another direction to go at it from. I think you partially mentioned that in your comments, Gabriel.

Our time is coming to a close today. Our next Disability-Competent Care webinar will be reviewing the recently released update to the Disability Competent Care Self-Assessment Tool (DCCAT). We will have a health plan from Wisconsin and some folks from the state of Colorado talk about their experience using the tool. The webinar will be on December 13 at 2:00 p.m. ET.

We are also in the final stages of preparing the 2018 Disability-Competent Care webinar series to provide users a more advanced look at some of the key Disability-Competent Care subjects such as hospice care, working with persons with autism and so on. CEUs will be available for those webinars. Check your inbox in the next few weeks or visit the RIC website for further information.

Lastly, please take a moment to complete the brief evaluation of this webinar. A survey will pop up following the webcast. Help us to diversify our Disability-Competent Care webinars and to address your current training needs. Your input is essential. We are especially interested from hearing from providers and plans at all levels of the healthcare delivery system.

Again, I would like to thank the Medicare-Medicaid Coordination Office for sponsoring this webinar and the entirety of the Disability-Competent Care work. We thank all the attendees on today's webinar. Goodbye.