

The Lewin Group
Disability-Competent Participant Engagement
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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 in the lower left hand side. Technical questions will be addressed as they come in, and content questions will be addressed at the end of the presentation. If you would like to download the slides from this presentation, click on the circle from the upper right side. Lastly, closed captioning is available at the bottom of the screen.

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. 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 efforts to deliver more integrated and coordinated care to Medicare and Medicaid enrollees. This series will consist of seven webinars running on Wednesday at this time through March 22nd. All the webinars are being recorded and will be available along with a PDF of the slides at the Resources for Integrated Care website referenced at the bottom of this slide.

In 2013, we published a comprehensive Disability-Competent Care Self-Assessment tool describing disability-competent care and gave 25 webinars on the topic along with numerous supporting tools and documents. These are also available on the RIC website. The DCC material has recently been revised to be more accessible to users and reflect the further development of the field. It is now structured into seven pillars of disability-competent care. In this series, we are introducing the seven pillars with a webinar dedicated to each. We will be allowing at least 15 minutes at the end of each presentation for discussion and questions. As you can see on this slide, today's presentation is on the second pillar: participant engagement. We would like to solicit your opinion on this series as well as past webinars and supplemental resources. Please take the time to complete our survey at end of this webinar and send us your ideas for future topics and content. Contact information is listed at the end of this presentation.

Today, we will encourage you to understand the participant experience. While each individual is unique, they have some common experiences. Most experience barriers to care, further access, communication, sensory or others. With understanding, we will be able to support them as they need. This is the means of establishing an essential relationship with each participant. The main body of this pillar is the assessment itself, the content, process, and outcome. This is where you get to know the participant from their perspective. Besides basic history, solicit their goals and priorities. In this assessment, disability-competent care providers, in partnership with the participant, can develop an initial care plan. The involvement of care partners is incorporated into the participant's care plan.

As I shared in the presentation last week, the relationship you are able to develop with the participant is the key to success. With a strong relationship, the participant and their team will be able to move forward in concert with open communication and a joint commitment to the identified goals and plans. Without this relationship, participants commonly become disengaged or feel their health and healthcare are in someone else's hands. The result can be withholding of key information and frustration on behalf of both the participant, their

interdisciplinary team, and their providers. Many of us have found ourselves in this position. Many of us have found ourselves in this position. If so, I encourage you to stop and put yourself in your participant's position. I have found this gives me insight in to why they are doing as they are and gives me a new way to approach them in the situation. Somehow you need to disengage from the conflict.

As stated earlier, establishing a relationship requires active listening to both their stories and experience as well as careful review of their complete profile and records. Ask them questions to engage them to talk about their history. Where were they born? Where did they grow up? Ask about their families. Ask them about what they would like to have different in their life in the next year. Try to get a sense of their social support system, family, friends, colleagues and others. Have they been active in church, an athletic league, or community activity? Ask them what they would like to do in their free time. This will all give you a sense of who they are and most importantly show that you care enough to get to know them as a person. Lastly, inquire into their health and health history. Getting to know them first as an individual helps to keep their health and disability in perspective. It is important to obtain their health history, but even more important to obtain their experience of health and how it affects their function.

Through this initial conversation, you will get to know the participant. You will certainly hear about barriers they have experienced. These health and other barriers commonly lead to frustration and health disparities. In a disability-competent care model, these barriers are considered attitudinal, access, communication and programmatic. As with other disenfranchised groups, they have a culture of their own created out of a common understanding and experience. Some may withdraw due to these barriers feeling isolated and frustrated. Some may become angry while others may find alternative ways to get their needs met. That said, the first step of disability-competent care is to simply listen to them, understand their experiences, frustrations, barriers and needs. The next pillar, and the next webinar in this webinar series, will focus solely on these barriers to care.

Research has repeatedly shown that persons living with disabilities experience a range of health disparities. Most all of them are related to the issues I reviewed in the last slide. They result in inadequate compare and poor outcomes. For example, a person with disabilities commonly experiences difficulties or delays in receiving necessary care and may fall short in targets and rates of important screening tests. Due to difficulty obtaining primary care services, their preventive care is often neglected. Many have not had dental care and don't routinely receive sexual health information. Even something as basic as hypertension is not identified at the same rate as with the broader population.

There are also a variety of social factors that impact health status and health outcomes. Many people with disabilities rely on Medicaid and/or Medicaid. These programs are being redesigned from fee-for-service to value-based purchasing. These pairs are beginning to focus on outcome measures such as cancer screenings, vaccinations, diabetes management, etc. The clinical interventions are straightforward, but the communications and service delivery stretch the disability competence of many providers. Of course, many of these are directly related to the issues that I discussed earlier. Adding to that, eligibility, transportation and other challenges, it is no wonder they experience poorer outcomes. For many providers and plans, it will have direct impact on revenue, and therefore it behooves them to also attend to related barriers. The goal, at this point in your relationship with the participant, is to establish a partnership in addressing their barriers and healthcare needs. Make the discussion participant-centered focusing on their life, their needs, and their goals. Be aware of barriers that exist in their living environment. It is good to remember that the barriers you perceive may be different than the ones they perceive. Be open to learning about their experience for they may have developed a functional

work around and share your observations. Perhaps the hardest to understand and appreciate are the attitudinal barriers many people with disabilities experience. These interaction can simply wear a person down and they stop trying. Again, the result is missed opportunity for quality outcomes. We will go through this in next week's webinar. Talking with a participant with their healthcare services will give you the opportunity to get their needs met and the level and nature of support they need. Ask if they have had avoidable ER visits or hospitalizations. It could have been prevented if the participant was able to obtain the care they needed and at the right time. Examples of this are UTI and respiratory infection. Is their home care stable or inconsistent and chaotic. Ask if they can they rely on having their needs met on a routine basis. Observe how actively the participant is able to participate in the assessment, or do they seem to have a limited understanding of their needs and functioning. Do they even have an active primary care relationship or are they relying on specialists for most of their care?

While specialists provide important services, they commonly do not focus on prevention and are not linked to the interests of their team or other physicians. Many people with disabilities, and I'm thinking of people with MS in particular, their primary physician tends to be neurologists for they are the ones they see most frequently about their disability. Neurologists, traditionally, do not address all the preventive services that everyone needs. Lastly, and very importantly, there are formal and informal support systems in place. More on that concept at the end of this presentation.

This slide provides a series of tips to help participants with their care. Many of them are simple tips to share with participants. Suggest they write down questions before the appointment or consider asking a friend or assistant to come along to take notes. Suggest they choose new providers based upon the recommendations of their friends. Personal experience from peers is often the best. Most importantly, coach the participant to actively identify any and all accommodations they require when setting the appointment with the provider, so they are prepared when the participant arrives.

Keep into account the participant's capacity to express and assert their needs. This slide outlines the dynamics that need to be assessed to incorporate the plan and level of assistance they will require. Some participants will be very clear about what they need and want while others may be unable, for whatever reason, to express these.

As this slide says, the main message is to listen to the participant. Don't be looking at your computer or watching and attending to texts. None of us like that, and people with disabilities do not either.

Now we are going to listen to Jim LeBrecht. We heard from him in the first webinar. He was born with Spina Bifida. He grew up outside of New York City. He went to college in southern California. He then moved to the East Bay of northern California to take a job at the Berkeley Repertory Theater as a sound engineer. He recently opened his own business serving the film industry. Before we start the clip, I want to remind people to turn on the sound on their computers, so they can hear Jim speak.

Jim LeBrecht (video): I have never come across a situation where I felt that people were really prepared to take the best care of me. I don't believe they knew what to do with me because I had a disability, and I think they were guessing what they might need to do based on how they've treated all these other people who don't have a chronic disability or active disability. I don't think anybody has a protocol for it, and I don't think anyone knows. It's my life and my care and the amount of pain I am going to have and the length of my recovery, you really should. This isn't about the ADA or having to follow the law; it's the right way to take care of people. Talk to me. I am your best resource to know what to do with me.

Christopher Duff: Jim is challenging all of us, again, to just listen. He wants to, and is more than capable of, actively participating in the design of his care plan. Our goal is to identify a plan and then simply step aside, so that he can make it happen and be available if he runs into any barrier along the way.

My experience is that a participant's ability to take charge of their healthcare has less to do with their disability and more to do with their level of activation. There is a great tool that was developed 15 years ago and validated by Dr. Judith of the University of Oregon. It uses a simple 13-point questionnaire to identify where the participant is on their journey of self-activation. We have placed a link into the chat function for a PowerPoint describing this tool. I have found it to be extremely useful, even if not actually applying it within a plan, to understand the concepts behind it are a good way to think about how we allocate staff and care coordination time in working with clients. The first two steps of the care planning process are assessment and identification of needs and priorities. The remainder of the process will be discussed in greater detail in webinar 5 introducing care coordination. It is important to remember that this process is ongoing and can be revised and updated as needed. In the DCC model, assessments are conducted by an interdisciplinary team composed of a nurse, primary care practitioner, social worker and behavioral health practitioner. While not all members may be present for the initial assessment at the same time, it is vital that they all conduct pieces of the assessment pertinent to their scope of responsibility. This information can be documented and shared in upcoming team meetings.

It is strongly encouraged that assessments be conducted within the participant's living setting. This provides an opportunity to be aware in how the participant lives and assess the environment to some degree. While not all members of the team may be able to visit the participant's home, these observations can be shared with the remainder of the team. The involvement of family or care partners can be beneficial, but must be done only with expressed consent. I remember a couple participants were very self-conscious of someone coming to their house and doing an assessment. They didn't know who we were as a plan. They didn't know what a care coordinator was. So, the first two times we meet them, we met them at a coffee shop near their place slowly building their trust, and then they invited us into their home. So it may take some time and you may need to work with it, but I do think being in an individual's home will give you good insight into who they are and what they need.

The role of the IDT will vary greatly based on the ability and readiness of the participant to assume responsibility for their health and healthcare. The more they understand and are able to carry-through, the better they will be able to maintain or improve their health. It is suggested that the IDT expressly asked each participant how much support they want. This could be a shortened conversation at the end of the assessment and minimize expectations not being met. The number one feedback we had, in a program I ran, was that they didn't get enough contact from the care coordinator. This was our responsibility to explicitly agree on. We would ask our participants whether they wanted to be left to themselves and call us when they needed something or wanted us to initiate contact periodically. If they say periodically, we agree on a frequency and sometimes even a specific day. This was especially important for those with anxiety and stress concerns.

Having a strong and supportive relation will greatly enhance performance on quality measures. It will also provide a context to follow-up on regarding basic needs such as cancer screening, preventive inoculations, and identification of chronic or ongoing conditions. The Disability-Competent Care assessment is comprehensive and encompassing of all their needs as you can see on this slide. It is necessary to get a picture of the participant, their goals, prior history, and needs. Most integrated Medicaid and Medicare programs require this kind of level

of assessment such as the dual demonstrations or PACE programs. This assessment service serves as a foundation for the care plan and the oversight responsibilities of the team.

Besides the IDT members, the involvement of additional professionals may be beneficial. For example, persons with significant social limitation may benefit from assessment by both an occupational therapist and physical therapist. It is vital that each member of the team review the entire assessment even the parts they did not conduct for each discipline brings a different set of skills and perspectives. From this assessment, referral to additional specialists may be needed, such as a nutritionist, audiologist, rehab and mobility specialist, or others.

At this point, I want to tell you about someone I worked with many years ago. I will call him Tom. Tom experienced a traumatic brain injury in a motorcycle accident in adolescence. He also gained significant long-term functional and cognitive limitations. He would bounce back and forth between rehab and his mother's home. He never lasted long anywhere because he was a handful. He was angry and frustrated, and let it be known. He could be both charming and engaging as well as highly frustrating. When I first met him, his goal was to live with his mother, coordinate his own care, find a job and build relationships. His barriers to achieving his goals were physical limitations, limited access within the house, and impulsive and socially inappropriate behavior making relationships difficult. I will tell you more at the end of this presentation.

Having completed the assessment and having a good sense of the participant's needs and priorities, it is time to start developing a care plan with the participant. The plan is based on the participant's life goals, care goals, and specific action steps to meet the goals. The care plan is reviewed and revised over time based on changes in the participant's life and issues are identified. The individual care plan is a living tool developed to guide all those involved in a coherent and consistent course of action to achieve the participant's goals. While some components listed in this slide are relatively common, the resulting care plan will be unique to each individual and a priority for all. The individualized care plan also needs to have additional components needed to ensure health and safety. The plan needs to document any communication accommodations required which needs to be shared with all those working with the participant. This management plan will vary greatly based on the participant. For those with behavioral health issues, such as stress and anger management, strategies need to be developed, documented, and communicated to be able to provide support as needed. For an individual who is highly dependent on equipment or other's for personal assistance, emergency backup plans need to be specified and communicated. For example, a participant who requires help to get out of bed every day needs to have a plan in case assistance doesn't show up or isn't available. For a participant that requires power-equipment, such as a wheelchair or a ventilator, they need to have access to backup equipment or a generator. The disability-competent care model calls on the participant and their team to think through and develop a plan proactively.

Let's get back to Tom now. He was still seeing a pediatrician in his twenties and was embarrassed and wanted a new doctor. His team talked with him about a couple of doctors in the area going over what they had heard from other participants and the level of accessibility in their offices. He had home assessments for both O.T. and P.T. who recommended some welcoming minor modifications such as the removal of bars and thresholds and he had some home-based therapy to work on his personal care, which was a real priority for him. Being a man in his late 20s, he really didn't want his mother to be doing his care. He participated in independent living skills training focusing on skills such as money management, meal preparation and arrangements and others. His personal care assistance was redesigned so that he could go to a local YMCA several times a week to work out. He is currently getting along much better with his mother and has re-established his relationship with his brother and friends from his high school years. So you can see how his life has turned around. Of course, there will

be more problems, but this gives you a sense of how the assessment leads to the plan and can result in nice outcomes.

As stated earlier, care plans are living documents discussed with the participant and their IDT. Once developed, the plan goes into action until a change is needed or requested. Throughout the development and revision of all care plans, participants need to be assured that they have right to request an alternative plan or appeal to a person within the plan or to pass to an ombudsman or an agency. Our experience is that conflict or significant disagreement seldom arise if there is open communication and a strong relationship and trust between the participant and their team.

We all need a circle of support either our immediate family or neighbors or colleagues or friends and those we've met in community activities. That is key to health and well being for all of us. In the DCC model, we refer to these as care partners not caregivers. Caregivers implies a one-way relationship. We view these as natural supports who choose to participate because they want to. It is important to clarify with the participant how they want to involve their care partners and what information they wish to have shared. Their lives have often been such an open book, and they just want to regain some privacy.

Mostly we suggest communication be left to the participant to share information as they see fit. Care partners also need to be helped in establishing and maintaining mutually supportive relationships. Sometimes the participant may need a break and the interdisciplinary team needs to tend to their needs so that they can be maintained into the future. They could consider an increase in personal care assistance or even a respite setting for a while. It is also important to consider that clear channels of communication and privacy be established between the care partners and interdisciplinary team and other providers. Most partners are not experienced in this role and can benefit from some information, coaching, or even basic support. I have seen tendency on behalf of care partners to overshare information with the interdisciplinary team. This can be disrespectful of the participant, and it is important that the interdisciplinary team not get pulled into such interaction.

As stated from the beginning of this webinar, the key to the health and well-being is the participant's relationship with their interdisciplinary team. The open and trusting communication will build a partnership that can achieve the goals of the participant. This trusting relationship is based on the team knowing the participant and how they have experienced the health and healthcare. The assessment is conducted through a discussion with the participant and repeated over time.

We would now like to open this presentation up to your questions. Please use the chat feature to ask any questions about the content of this presentation. I will be turning it over to Jesse Micholuk from The Lewin Group to bring us the first of the audience's questions.

Jessie Micholuk: Thank you, Chris, for that presentation. We had a couple of questions come in through the chat, and as Chris said please feel free to add your content questions to the chat feature on the lower left-hand side and we will get to them as we can during the last 15 minutes of this webinar.

The first question here: when working with a person with a disability, what is expected of us in terms of accommodations?

Christopher Duff: That is a question that ultimately your own organization needs to decide. But I think with that, you need to sit back and look at what is it they need. In their living setting, they may not be able to get

upstairs. Do they need an elevator? Elevators are expensive. Well, do they need an elevator? That may make it easier to get upstairs, but that might be expensive. That doesn't mean you need to accommodate that. There is a responsibility if there is a vital function upstairs, then you need to figure out how to get them upstairs. There are a variety of alternatives, but what we would do in that situation is call in a home modification expert who would come in and make recommendations and get some people to price out what those changes would be. So, there is no general rule. The ADA does not really define that. That's more about public accommodation. We are more talking about the mind-set of how your member's needs are being met, and that is something the team and the participant need to think through and partner in getting those met. I think that would also be good question for the presenter of next week's webinar by the name of June Kailes who has been dealing with this issue for 20 years in California.

Jessie Micholuk: Thank you, Chris. Another attendee said that they have a number of under 65 individuals in their PACE program and it has been difficult to keep up home care staffing not to mention back up choices for individuals. Do you have any advice for building resources for personal assistance?

Christopher Duff: That is often challenging. Depending on the model, whether it's going through an agency or through a PACE program, you are probably hiring them yourself. What I would do is see if you can find an organization who would partner with you. Whether it is another home care agency or it is a social service agency in your community or some other organization who can help you promote that there is people that need services. Then, I think the issue is the trouble of finding people or keeping people, my experience is then, and the issue becomes one of frustration. That is really directly related to training and supervision of the caregivers. Often these individuals are really frustrated with their life, and they let that be known. A lot of younger men, especially, may have other interests and relationships with their kids other than just personal care, and that can be difficult to deal with in a professional relationship. I would start looking towards their circle of support and think of some natural support in the community who they could possibly partner with whether some PACE program or health plan to help identify some individuals. I think your role in this would be to support and train them to work with your participants. I wish I had a more direct answer other than to assure you that you are not alone.

Jessie Micholuk: Thank you, Chris. The next question here is about the interdisciplinary team. How does the hand-off happen between all the members of the team? In practice, many of them work in different locations and settings of care, so timing communications are challenging.

Christopher Duff: That's true. We had several questions regarding that last week. I think we will also get several questions on that during our primary care presentation which will be in two weeks because often that's where linkage falls down; the connection between healthcare and social services or healthcare and community-based care. Where does the care coordinator sit? That is a classic role of care coordinators, but then where do they sit? Do they sit in primary care or in health plans? Do they sit in community-based organizations? There are a variety of different models that are in use, and I don't know that there is a right or wrong model in that. So what I'm aware of as the most functional is all assessments are entered into an electronic health system. Then you have the issue of operability of electronic health record.

Let's make up a situation. The primary care portions of the assessment are done in a doctor's office. The chance of a doctor going out to a home regularly are not good. We would also have the care coordinator go to their home and do those portions first, and then join the participant, with their permission, at the first or one of the

primary care visits to share the information. Then gather the information from primary care and make sure it is entered in the system and built into their plan of care. So, the issue is how do you do this? I'm aware in Minnesota that we had a large county that located a bunch of staff in. We had access to their healthcare record. I know of another place where the health plans partnered closely with the primary care clinic, and they gave me access to their physician portals so they could enter information and take notes and communicate that way.

We all know the least effect active way is faxing papers because that does not happen. I know there is another plan that has been working on this. I think we are in process of writing something up about this where back within the plan people are being taught and coached on going to an appointment with the primary care physician to serve as that communication link two-way and making sure that the physician knows everything else that is going on with that person. It takes a pretty strong care coordinator to do that because physicians can be moving pretty fast, but if you establish a good relationship with that primary care physician or practice, they will pretty quickly come to see the value that the care coordinator can bring to them. Even as simple as health plan having access to all medications that have been filled as recently as yesterday. If you could get that information to the primary care doctor prior to all appointments, that is incredibly thrilling because he or she never knows that. That will be a way for them to see pretty quickly the value that that can bring. There is no easy answer. It's what works in your own setting and looking at where your greatest opportunities are and establishing unique linkages that will accomplish the goals that you believe ongoing.

Jessie Micholuk: Thank you, Chris. Next question here is looking at money side of the issue. It says, I would love to be able to have a full team work with each of our members with a disability but we simply cannot afford that level of intensity of touch. I do believe the DCC model would provide excellent care, but how do I make it work financially?

Christopher Duff: That's ultimately the issue. I understand that in some of the primary programs that the DCC model was based on, there were severely disabled adults. Therefore the capitations those plans received were high. So, they were able to do a level of touch that plans with broader and larger base cannot do. At the same time, all these people who are in these programs exist in these plans. The key to it is figuring out who are they and how do you allocate your staff time to those individuals as needed? Because it's not going to be kind of a one-time thing. I know that I have heard of a plan that basically has four levels of care coordination they provide. One level that had, I believe, about 50% of their members had low touch. Basically, you run behind them, and you wait for their calls.

They were placed in that group based on the assessment and as much care as they can handle themselves. Therefore, you are taking 50% off the base right there. Then you are dealing with 40%. Of that 40%, you probably have 10% that are in crisis at any one time. They may be in the hospital, they may have lost their housing or whatever it might be. They need intensive help quickly, but they may not need that. They might be able to go back to that 60% group quickly once they are through their episodes of crisis. That plan had a crisis team that would deal with the person and stabilize them and get them back to good setting. Then they work on handing them back over to their team that assesses them.

The remainder were in medium and high coordination. The high is someone who may be on a ventilator and has high history of ER usage. They may have some serious mental health or chemical health issues. Therefore, they need a lot of ongoing care coordination, and then the lower ones may be those who can't self-correct. They need a monthly call. Sometimes that monthly call may be from an office-based person just checking in and seeing how they are doing. These half hour calls, at most, may be all that person needs. So I am giving you an example

of what one plan did, but the message behind this is that in the initial assessment and subsequent interactions, the goal is to figure out what they need and then provide them with it. You are right, you can't do the intensity laid out in model for every one of your members. That's not financially viable. So the issue is you have to work on allocation of resources.

Jessie Micholuk: Thank you, Chris. We have time for one or two more questions here. The next question here: do you see all members in some level of care coordination within, I assume, the DCC model? Isn't care coordination voluntary? Many do not want to engage in care coordination despite our effort to engage them.

Christopher Duff: That's a good question. Absolutely some people refuse it. They may refuse it because they do not trust. Most care coordination is based on health plans, and many people with disabilities do not trust health plans. So, you're right. Some may refuse it. We found that many do not understand what a care coordinator is. They tend to see it as a social worker comes in and tell me what to do or that a doctor is going to treat me medically with a diagnosis. No, I do not think every member needs that. I think what's important then for those people if there is consensus between the member and the team whether they need coordination or not, then that's fine to go off to the side. Likely, the plan would require that you do an annual assessment or something for some frequency of connection. But then, I think the issue is that there is a difference between what the member sees or wants and what the care coordinator team thinks he would benefit from. All you can do is keep going at it suddenly and slowly. You may also need to wait until you are aware that they were in the ER last week. Then, you can call them up and say "I understand that you were sick last week. What happened?" You may need to wait until there's some episode of care that you can help them see how the care coordinator could have helped them with that. If they do not want to be assessed, then you can just document that.

The other thing we did in Minnesota is work with providers who they had high levels of trust with. In one place it was an achievement center and another place, it was with a doctor they had been seeing for quite a while. If a doctor recommended something or the MS achievement center, that was a done deal. Okay, I will follow-up. Having the provider who they trust put their arm around you as a care coordinator to get your foot in the door to figure out what's going on and how you can help them get what they need.

Jessie Micholuk: Thank you, Chris. I think we have time for one more question. So the next question that came in here: what do I do if I have concerns about the relationship between a participant and one of their care partners?

Christopher Duff: This is pretty common, and the concerns that we see are financial; some of them are sexual; some of them are kind of more abusive in terms of bullying and that kind of thing. Ultimately, the organizations have to have their own policies of how to handle this. I would always suggest that you start by engaging with the participant in order to bring that concern fourth. Ultimately, there may need to be reporting to an authority if you think there is an abuse that you are not able to address. There is not an easy answer in that sense, but it does always start with a conversation. When it comes to their vulnerability issue, the person may feel, "if I assert myself with him, he may hit me." Maybe you look to see if there is another caregiver you can get in there or would you like me to talk with him how he scared you. That's one thing. Let's say they are sexual. We don't know what sexual concerns or initiations are coming from. Are they coming from a caregiver or coming from the participant? I have seen it both ways.

So, again, it is the mind-set of the participant first. Start with talking with the individual about concerns we have

seen and go from there. Ultimately, there are laws in every state about reporting of vulnerable adults. Many states have narrow definitions of what vulnerable adult are. Some situations you have no choice, but to report to the authorities. The intervention, I would encourage, to do it at the individual and the team level if at all possible.

Jessie Micholuk: Thank you, Chris. I think that's all the time we have for questions today. Anyone who we were not able to get to your question, e-mail us at RIC@lewin.com. I will turn it back to you, Chris, to finish off these last few slides.

Christopher Duff: Thank you for your questions today. I appreciate your attention very much. We are going to wrap it up. Please send your feedback to the link on this slide. For the post-event survey, we would like to have your feedback and close that loop within the next hour if you could. Again, I would like to call your attention to the resources that we have online at the Resources for Integrated care website such as the disability-competent care self-assessment tool. Next week at this time, we will have our third webinar, Disability Competent Access. That will be followed by Disability- Competent Primary Care and then we will go into Disability-Competent Care Coordination. Those came up through my presentation and were certainly present in our conversations and questions from the audience. Next week, we will have an expert presenter who I think will bring a great deal to these discussions. Again, I would like to thank you, and the Medicare and Medicaid Coordination Office for sponsoring this webinar and the entirety of this work. Thanks for attending.