

"Disability-Competent" Care – What Is It And Why Is It Important?

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Operator: Ladies and gentlemen, thank you for standing by and welcome to the DCC webinar conference call. At this time all participants are in a listen-only mode. Later we will conduct a question-and-answer session. Should you require assistance on today's call or if you would like to ask a question, please press star then zero.

I would now like to turn the conference over to our host, Laura Dummit. Please go ahead.

Laura Dummit: Good afternoon. Thank you call for attending this webinar on delivering disability-competent care. My name is Laura Dummit and I'm with The Lewin Group.

Before we get started I would like to introduce two features of our technology. You will notice at the bottom of your screen two circle icons. The icon that is third from the right will allow you to download the slides as a PDF, if that's more useful to you. The icon that is the third from the left is our question-and-answer icon; if at any time during this webinar you have questions, you can type them in. If these are questions about the actual technology in the webinar, for example, if you're having trouble hearing or viewing the slides, that question will be magically answered in real time. Other questions on the content of the webinar we will compile and we will return to all of those questions towards the end.

Now I'd like to give you a bit of an overview. You are listening in on the first of three webinars to introduce to you the overall concepts of disability-competent care. This is a general introduction that will include all of the major concepts under disability-competent care. The second in the series will present more information on understanding the lived experience of disability. The third in this series will be on patient-centered care management. We have a slide at the end of this deck that provides information on the timing of those other two webinars. I'd also like to point out that each of these webinars has been designed to be self-contained, that is, you don't have to listen to all three webinars to be able to understand the content.

I will also point out one last thing on the current slide. At the bottom you will see our website, Resources for Integrated Care. You will be able to access this webinar and the other two webinars as well as additional content through that website and I really encourage you to go visit and see what else we have available.

This webinar is part of a larger effort that is funded by the Medicare-Medicaid Coordination Office to support providers as they improve their practices to coordinate and integrate care, particularly for individuals who are eligible for Medicare and Medicaid. Under this larger effort we have developed a gap assessment tool designed to help health plans and providers improve their ability to support individuals with physical disabilities. That gap assessment tool is more fully explored on our website and you will have more information about that tool as we go through this webinar. The gap assessment tool would take an organization through a series of questions that you can use to understand your ability to provide disability-competent care and to also improve your ability to perform these functions and give you ideas on where to start.

The final thing I would like to address now is that at the end of this webinar we will have a very short survey. We would really appreciate your feedback. We would like information about future webinars, how to target specific groups of healthcare professionals, and feedback on other topics you'd like us to address.

And now I'm going to turn this over to Christopher Duff, who's the Executive Director of the Disability Practice Institute. Chris has been instrumental in helping us develop the disability-competent care gap assessment tool as well as these webinars. He's been a pleasure to work with and I'm sure you will enjoy hearing from him now.

Christopher Duff: Thank you, Laura. I appreciate the introduction.

This has been a long process, as Laura mentioned. We started with the development of the gap assessment tool. Lynne Morishita, June Isaacson Kailes and I worked closely with Lewin and the Institute for Healthcare Integration -- Innovation, excuse me -- to develop that tool, and this webinar series will further explain and provide more information that will inform your understanding of that tool.

Lynne, June and I are very excited to be presenting this webinar series over the next couple of months. We will also be inviting content experts to join us for most sessions. June and I will be presenting this introductory webinar today and Lynne will be joining us in the near future.

Today we will provide a definition of disability and its impairments and explore the demographic, utilization and cost patterns of persons with disabilities on Medicare and Medicaid. We will proceed to describe the challenges of meeting the needs of the population within the existing healthcare delivery system and briefly describe the experiences of a few disability care practice pilots. This will lead to a basic introduction of the disability-competent care model.

Today as with all the webinars we will reserve the last 15 minutes for questions and answers. As well as stated in the introduction, this webinar series is sponsored by the Medicaid and Medicare Coordinating Office, commonly referred to as the Duals Office. As directed in the Accountable Care Act of 2010, the Duals Office is developing demonstrations to facilitate the integration of care and support for persons with dual eligibility, which means persons with both Medicare and Medicaid.

A bit of background. In the 1980s Medicaid started using managed care contracts to provide Medicaid benefits. In the 90s Medicare Advantage or Part C was developed and has grown steadily, providing Medicare benefits within managed contracts. At that time a few states started to experiment with programs integrating both Medicaid and Medicare benefits in dual demonstrations. These were relatively small initiatives and targeted to specific populations. What was learned through these demonstrations was that these two public programs had many conflicting and inconsistent policies and rules. The ACA provide the impetus to greatly grow programs for dual eligibles, all of which are based on the principles of the Triple Aim -- improving healthcare delivery, improving health outcomes, and reducing or minimally controlling escalating healthcare costs.

Throughout this webinar series we will be presenting first-person stories to demonstrate both the barriers and failures of the existing system in the application of the DCC model. And this picture is a wonderful group of people I had the opportunity to work with in Minnesota as we developed our program there. Today I will be talking about Carmen in particular. She is a 45-year-old woman living with C4-c5 quadriplegia since a car accident at age 14. She lives independently in an apartment with six hours of personal care assistant services daily. She has a neurogenic bladder, skin breakdown, asthma and decreased pulmonary capacity. She works part-time in a professional job and has many close family and friends.

She has no regular primary care, though, and is regularly followed by a psychiatrist -- by a physiatrist, excuse me -- pulmonologist, urologist and neurologist who practice in several different health systems. Due to the immediacy of her needs the ER is her only recourse for addressing new clinical problems or symptoms. She has experienced six hospitalizations over the last 18 months, two of which required long intensive care stays for intubations with subsequent lengthy post-acute rehab hospital stays. She has also had two skin breakdowns that required prolonged hospitalization. It's certainly reasonable to believe that most if not all of these hospitalizations could have been avoided with good primary and preventive care.

Let me start by providing a definition of disability. The World Health Organization defines disability as an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure. An activity limitation is a difficulty encountered by an individual in executing a task or action, while a participation restriction is a problem experienced by individual involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which the individual resides.

Disabilities are a consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, developmental or commonly a combination thereof. This includes persons with multiple chronic health issues along with age-related decline. These needs have been seen every cross-section of people; the difference is the multiplicity and/or intensity of needs, social economic challenges, and dependency on long-term services and support for daily functioning.

Studies have identified that 14% of adults in the U.S. live with a complex activity limitation that affects their ability to participate in society, including maintaining a household, working and pursuing hobbies. The presence of a disabling condition is identified through four measures -- any limitation in social or leisure activities, any difficulty or inability to work, a self-care limitation as reflected by any activities of daily living or instrumental activity of daily living limitation, or an overall combination measure which reflects any individual or combination of limitations in the first three measures. As this slide states, persons with disabilities are more likely to live in poverty, experiencing social and economic hardship. The population of persons living with disabilities is growing due to the aging of the population and technological advances in treatment and care.

Additionally, utilization studies of the population have demonstrated that persons with disabilities experience significant health disparities. They are more likely to experience

difficulty and delays in getting care, difficulties in accessing annual dental visits as well as preventive screening. They have limitations on physical activities and a higher incidence of hypertension. It's also interesting to note that people who are blind or have a vision impairment are one and a half times more likely to be obese than the general population and three-fifths of those with serious mental illness die from preventable co-occurring chronic disease 25 years earlier than other individuals. Lastly, while less than one-half of 1% of Americans live with HIV/AIDS, 4.6% of adults with deafness are infected with HIV/AIDS.

In this webinar series we are specifically focusing on persons with disabilities who are eligible for Medicaid and/or Medicare. Both programs provide for healthcare needs, though there are significant differences in origin and focus. Medicare is funded fully by the federal government and is an entitlement program for those 65 years of age and older. Persons under 65 can generally become eligible once they have been deemed permanently disabled, which requires being disabled for two years or longer. Meanwhile Medicaid is funded by both the local states and the federal government and is an entitlement program based on need and income. It covers children, pregnant women, parents of eligible children, seniors and individuals with disabilities.

Other than the basis of eligibility, persons with disabilities who are ineligible for Medicaid and those who are eligible for both Medicaid and Medicare are very similar and have very similar needs. In fact, my experience is that most persons with disabilities don't have any idea whether they're on Medicaid, Medicare or both. It's meaningless to them. But those demonstrations that are being developed in many states are being designed to fully integrate the financing, benefits and consumer protections of both programs so that they function seamlessly.

In terms of benefits, Medicare covers primarily physicians and hospitals with related tests and procedures. Medicaid, on the other hand, covers all that Medicare covers plus long-term services and support. While this appears comprehensive in nature, the different funding sources, populations and priorities have resulted in highly fragmented care. For example, Medicare only covers a problem once it occurs, resulting in lack of attention to prevention, which in turn results in the occurrence of avoidable conditions. For many persons with severe disabilities, over 50% of their hospitalizations are for preventable conditions, such as skin breakdowns, urinary tract infections and respiratory infections.

Carmen, who I spoke of earlier, is a classic example of the consequences of this fragmented care. Medicare's fee for-service-system has rewarded episodic care from multiple specialists, as in Carmen's situation. The result is that the ER is her sole source for timely care for a range of predictable medical complications.

Demographically, just over 10 million are eligible for both programs. Dual eligibles represent almost 20% of Medicare eligibles, though 31% of the spending. Meanwhile, dual eligibles represent 15% of the Medicaid enrollment and 40% of program spending. Thus duals clearly represent an extensive and complex subset of these public programs.

The chart on this slide further demonstrates the complexity of a dual eligible population. About 41% of Medicare-only eligibles have no chronic conditions. Only 24% of duals live without a chronic condition. On the other end, meanwhile, 19% of duals live with five or more chronic

conditions while only 7% of Medicare-only eligibles have five or more chronic conditions.

As you would expect with the presence of chronic conditions, the utilization patterns of duals is quite different from Medicare-only eligibles. Duals have more utilization in all categories of service than the Medicare-only eligibles, especially ER visits and costly hospital services.

Cost patterns are also highly disparate. As this chart shows, the least complex -- 50% -- of duals utilize less than 1% of the cost, while the most complex 5% utilize almost 41% of the cost and the top 10% of duals represent 61% of the cost. Looking at the top 1% of enrollees only, 83% of these individuals have three or more chronic conditions and 50% have five or more chronic conditions. Therefore, the opportunity to improve care and reduce costs is with the small percent of high utilizers.

As Carmen's story clearly demonstrates, she can access good specialty care but these providers are not available on short notice and they certainly don't tend to her general health, lacking focus on screening, prevention and health education. The fee-for-service system -- or as my clients call it, the fend-for-yourself system -- repeatedly lets them down. This is further complicated by a lack of communication among payers and providers, which easily causes problems that could have been avoided. For example, attention to Carmen's positioning in her wheelchair and education regarding weight shifting could have prevented her skin breakdowns. And research has shown that these breakdowns generally cost over \$50,000 each and result in the individual being on bed rest for several months, losing her ability to work or socialize.

There were several pilot programs operational across the country over the last two decades. Lynne and I have been involved in several of them. All of them were community based, targeted individuals with disabilities and focused primarily on serving persons eligible for Medicare and/or Medicaid. These were all consumer focused based on the independent living model, which I will explain a little later in this presentation.

These pilots have all added to the body of knowledge and experience that has created what we are calling the disability-competent care practice model. The reference here is disability-competent care. The largest fully operational pilots are the Commonwealth Care Alliance in Massachusetts and the Independence Care System of New York City, both of which are participating in a state dual demonstration and will be participating in some of these webinars.

At this point I'll turn the webinar over to June to further describe the population and the disability-competent care model.

June Isaacson Kailes: Okay. Well, greetings from LA. It's a very warm, sunny day.

Looking at the population, the current populations to benefit from this model include those who have significant primary disabilities, including people with spinal cord injury, brain injury, stroke, cerebral palsy, spina bifida, and in addition they also experience multiple other chronic conditions, like obesity, chronic obstructive pulmonary disease, diabetes, asthma, vision, hearing and intellectual disabilities and mental illness. Studies report 45% of older adults, including people aging with disabilities, also experience depression and some say these estimates are pretty

low. We know that mental health in multiple issues is really grossly undertreated.

We'll go into much greater in depth, applying these core values throughout this webinar and subsequent webinars, but these values include patient-centered directed care and participants as primary sources of planning their care goals and needs because, as Chris will talk about later, in applying the independent living model, being in control of one's life means defining one's own support system, including the tools, strategies and people support needed to accomplish these tasks. So note, core value participants have the right to take risks and the practice that moves away from an institutional bias.

Unique values of the practice model include care coordination relationships and responsive primary care and flexible home and community-based services. So in terms of practice elements, the first is that very impairment care coordination relationship or, as it is referred to in the DCC tool, relational-based care management. In the model success really hinges on the developing of a relationship based on trust and connectedness with care coordinators. Health is viewed broadly as optimal quality of life including all elements, like housing, relationships, purpose, and community participation. And because this model blends and expands the medical focus with a more expansive health, whole person and independent living model of practice, it values the individual's need to live, work and participate in community life as one choose.

The model acknowledges the participant's right to self-determination as well as, again, the right to take risks. An individual's goals are the primary drivers of the care team's processes and its activities. Participant-centered care has incorporated a very impairment piece, which is that participant is not a passive recipient of medical care but they are active team members and primary sources for defining their goals and their needs, thus recognizing that participants are often the best stewards of resources needed to support maximum function. And this has critical implications for the need to augment their training. For example, motivational interviewing on the part of the care management team is an important skill set in helping participants develop or strengthen their self-help, self-care and self-management skills so they are the best and the strongest managers of their needs and care.

Woven into participant-centered planning is the value again of self-determination and the dignity of risk, which honors and respects the participant's choices even if they are inconsistent with the recommendation of the team. That is the right of the individual to choose to take risks and engage in life experiences, again, even if the choice would not be one that health professionals would make, like choosing to smoke.

So back to Carmen, for example. Her choice is to work and that choice is honored, even though her team has concerns regarding how this adds stressors to her health. This team's competencies include primary care, nursing, mental health, community-based long-term support services. They have competencies in comprehensive timely assessment and reassessment and in personalized plans of care, incorporating the individual's healthcare goals and preferences, and in careful attention to transitions. As Chris mentioned, Carmen needs very careful discharge planning from her hospital stays back to her home and community.

Also a highly responsive primary care network is really vital to incorporating the flexibility of

timing and flexibility of setting needed so the care can take place not just in an office setting but in the community or in the participant's home. And of course again this reduces avoidable escalation in needed care included in a network with a capacity to assess and address new and emerging symptoms, including the allocation of care and services.

If, for example, Carmen thinks she may be getting the flu or a urinary tract infection or is developing a pressure sore or her motorized wheelchair stops working, she knows she can immediately call and has 24/7 access to help and she does not have to wait to see if things get worse. Carmen says when I call during the day I'm speaking to a person I trust and I have a relationship with and, if I have to call after hours, I know that whoever I talk to is someone with direct access to my records and this shortcuts my having to start the story from scratch, with a long, drawn-out and sometimes exhausting explanation of what I need. Carmen knows her team works together as a unit, with sharing and backing up each other. And Carmen says when I call I don't get the runaround or the response that's not my job or that's not my problem. And a response to Carmen's calls can include home visits from nurses or nurse practitioners embedded in her care team who can deliver the kind of care that ensures that she gets what she needs and is able to avoid a protracted or expensive pressure sore treatment or help to quickly get what she needs to avoid a much more serious escalation of a urinary tract infection.

In comparison, standard treatment for a UTI can involve two to four days -- experiencing the initial symptoms, a visit to a primary care provider, lab tests, waiting for and interpreting the lab results, getting a call to inform one about medications needed, sending the prescription to the pharmacy, getting the medication, starting treatment -- which, you know, this can work for people without these complex conditions but for Carmen, who lives with a much smaller margin of health and a smaller amount of health resiliency. Treatment needs to start quickly to prevent serious complications and this is accomplished by home visits to retrieve those specimens, deliver medication, or other workarounds.

And Carmen also knows that if and when she gets referred to a provider, her physical access needs are part of the equation, that is, the physical accessibility in the provider's office, including parking, waiting area, bathroom, and accessible medical equipment, including height-adjustable exam tables, chairs, radiology equipment, scales as well as all-important transfer assistance.

Now these comprehensive long-term care services and supports involve a full range of home and community-based services and supports that, again, support community living again because as already mentioned, an individual's goals are the primary drivers of the care teams care process and activities. Delivering these appropriate long-term support services involves identifying functional needs, prioritizing the allocation of resources and equipment to support the health and the safety of participants. For Carmen this involves investing in proper wheelchair seating, including cushioning and positioning to prevent skin breakdown and pain.

It can require more than the traditional investments in home modifications and resources to again prevent avoidable secondary conditions and complications or progression of an existing condition. Again, for example, the importance of home visits, expedited care and home modifications like widening of an entrance, lowering a counter, installing an air conditioner, making a bathroom more usable and accessible, i.e., using grab bars, no step or zero entry

showers, and dealing with requests for repair of mobility devices, like wheelchairs and other critical equipment, helping, for example, to get an emergency replacement as a personal assistant out to people in time so they're not left alone having to possibly put their safety in jeopardy as well as their health.

And lastly, supporting employment options like Carmen's, using an expanded way of thinking about who can work and applying new models of how and when one can work.

Chris, back to you.

Christopher Duff: Thanks, June. June just went over the three core components of the disability-competent care model. We hope to do a webinar on each one of those so we can drill in much further into some of the ideas, some of the learnings that have been gathered out of practices throughout the country, so don't feel overwhelmed by the complexity of this or the difficulty in trying to accomplish all that we've described in this model. I don't believe that there's any program in this country that is 100% there. It's always a work in progress; the goal is to keep moving in that direction and keep being aware of what you need to do.

Most importantly with the DCC model is it needs to be scaled to be both functionally and financially viable and modified to local context and funding. For example, if you're serving the wide prospects of adult disabilities, it is likely that only a portion of participants require any home or community-based care and even fewer require home-based primary care. We spoke earlier of the importance of segmenting the population being served so that the interventions are targeted to the unique needs of each individual.

This diagram separates the population into low, medium and high care needs, with participant characteristics and care needs related to each level of care. For example, in this highlight with over 50% of your population we'll have low needs, which will be characterized by minimal prior reliance on the healthcare system. These individuals will likely function well in the standard healthcare home. Individuals with one to three chronic conditions with one or two dependencies in an activity of daily living or co-occurring behavioral health needs could be characterized as medium care and with benefits from a healthcare home with a provider or system-based care coordinator. Those participants with several activities of daily living dependencies and/or chronic conditions, commonly with 10 or more medications, would be considered as having high care needs and would benefit from a close care coordination relationship and redesigned primary care delivery. The specific population a plan or provider sees will lead to the size of each tier and local providers or plans may choose to modify the cohort characteristics based on their unique context. Regardless, the size of each cohort with the identified characteristics is indicative of care needs.

The challenge or art comes in flexing the level of care and support based on the evolving needs, expectations and capabilities of each consumer. This slide demonstrates that the level of primary care and care coordination intensity is inverse to the consumer group as a whole. This demonstrates that a relatively small subset of the population will likely need the most intense intervention and support. Each health plan or provider will need to identify their own criteria for the differing levels of care and support. It is important to note, though, that all of the pilot

programs have learned that the level of need cannot be determined merely by diagnosis, ADL dependency, or recent ER or in-patient care. Other factors such as behavioral health or chemical health issues, family support, cognition and capacity to self-dress are all important to consider.

It is also important to note that individual's care needs can increase or decrease over time based on a variety of factors such as progression of illness, health, or social or financial crises in some manner or other factors. It is important that whatever processes are developed they be able to reflect the care, support and interventions provided.

This slide demonstrates how the DCC model of care can be financially viable. Though specific utilization patterns vary from one group of people living with disability to another, the prevalent healthcare delivery system of the last decade has experienced that over 50% of the healthcare dollar is spent on acute and specialty care. To be financially viable, the disability-competent care model needs to focus on reducing these costs to no more than 30% of the healthcare dollar and using the savings to fund highly flexible and responsive primary care and the care coordination relationship.

This chart shows the historical cost utilization experience of a sample group of adults with disabilities as compared to the cost utilization experience of a melding of the DCC pilot programs. This line shows that 50% of costs are utilized on acute and specialty care whereas the DCC experience has cut that almost in half to 30% of total dollars. Meanwhile it shows that primary care and care coordination spending increased from 2% and 1% respectively to 12% each in the DCC experience.

It is also important to note that there is very little opportunity to reduce long-term services and support and pharmacy costs. There may be some opportunities here and there, generic medications and so on, but relatively little opportunity with those two categories of cost. Therefore the focus must be on capturing the avoidable episodes of illness and care that is utilizing the majority of the healthcare dollar.

This last chart talks about the paradigm change that is inherent in the disability-competent care model. As has been evident through both June's and my comments, disability-competent care requires a paradigm shift in terms of attitude, language and value. In the traditional medical model the disability itself is seen as the problem whereas the independent living model views the problem as the environment or attitudinal barriers. In the medical model the problems resides in the individual and in the IL model it resides in the environment. Persons trained and operating in the traditional medical model, as most of us have been trained, focus on fixing the problem through professional intervention, while the independent living model calls for a focus on the removal of barriers and consumer choice and supports.

Being independent does not have to be viewed as always performing the tasks that can be done without help. Independence is not necessarily the quality of tasks one can perform without assistance but is the quality of life one can live with assistance, assistance not given in the context of duty and charity but in the framework of a service under the direct control of the person receiving the service. Putting it more succinctly, independent living is not doing things

by yourself; it is being in control of how things are being done. Therefore, the individual needs to be seen as a consumer or a participant versus the perception in the medical model as the individual being a patient. And of course the IL model expects that the control resides primarily with the consumer and not solely with the professional.

So in summary people with disabilities are a complex subset of the general population and represent both the greatest challenge and the greatest opportunity to realize the Triple Aim. The DCC model is a tool to help providers and health plans meet the unique needs of this population. The DCC model requires a change in both mindset and practice, and that's what we hope to demonstrate throughout the entire web series.

Now it's time to open the presentation to the audience for questions so I'll hand it back over to Laura.

Laura Dummit: Thank you, Chris and June. Roxanne, can you please open the telephone lines now for questions?

Operator: Certainly. Ladies and gentlemen, if you would like to ask a question please press star then zero. You'll hear a tone and an operator will then take your name and further instruct you. If you're using a speakerphone please pick up your handset before pressing the numbers. And once again, if you have any questions or comments, please press start zero.

Laura Dummit: Thank you, Roxanne. This is Laura again. We have already gotten a couple of questions in over the chat line and actually these first two questions both have the same theme so let me read a question from Karen Nichols from AmeriHealth Caritas. Her question is how do you recommend managing a participant with behavioral health disability who is choosing a risky behavior? Is a person's capacity a determining factor in allowing self-determination? I wonder if you might want to address that, June?

June Isaacson Kailes: Well, you know, it's the answer of -- I'll attempt to start with it depends. It's hard to answer without digging deeper into what the situation is but holding self-determination and dignity of risk is always a core value. There are some it depends gray areas that always need to be taken into account.

Chris, do you want to add something to this?

Christopher Duff: I have a few thoughts. First of all, you need to take into consideration the state laws regarding self-determination and some of the context requirements that you all have in these dual demos. That will give some guidance.

Underneath this, the basic assumption is that our job is to follow the person's directive. If we have concerns about what they do or how they do it, our job is to help them with those concerns. What's really important is that we not allow ourselves to get into a power struggle with the individual, but our job is to constantly assess the situation, advise, consent and, if the individual's -- we're very concerned the individual is not able to make informed decisions, which is generally the criteria most states use, then it's time to pull in some other people into the

plan of care, whether that may be family members or maybe some other public official.

Laura Dummit: Thank you. Roxanne, do you have anyone on the line?

Operator: Ladies and gentlemen, if you have any questions or comments, please press star zero. If you've already given your name to an operator, please press star one.

We have a question from the line of Dave Danielson. Please go ahead.

Dave Danielson: Yes. Thank you for the presentation. Can you elaborate more on the use of the assessment tool and how we can use this in determining the needs of members in a health plan?

Christopher Duff: Yes. That is a very astute question. Let me clarify. When we talk about assessment tools, there are two kinds of tools. One is that online tool that Laura mentioned earlier in this webinar and you can access online. It's very long but it's really a tool to take through a provider system or a health plan, to take you through all the different areas that need to be considered in providing support and care for this population. So it's really a working tool where you identify your strengths, your weaknesses, your gaps and then eventually move toward prioritizing and developing a work plan.

Often when we use assessment also we're talking about the principle of care coordination is that every individual will have their own individual assessment, so I just want to clarify those two kinds of assessment. One is a tool that the plans and providers use and the other is an assessment tool that we'll be getting into in greater detail in the care coordination webinar, which will be Webinar 3. That is individual assessment and discussion that then leads to the identification of the entire plan of care and so it's really foundational in all disability-competent care.

Dave Danielson: Thank you.

Operator: At this time there are no other questions in the queue.

June Isaacson Kailes: This is June, Chris. I wanted to add to the point about the tool we mentioned that's online. I think the nice thing about that tool is that it is for everyone a work in progress, that it's something that you all can turn to again and again to look at what areas still need attention and where you've really mastered some of the elements of the tool. It's really your own self-inventory of where you are and given, as Chris said, this isn't something that gets done all at once, it definitely is a work in progress over time.

Laura Dummit: Thank you. This is Laura and I'm going to read another question that just came in through the web chat from Karen Cello from Montefiore Medical Center. Her question is are the relational care coordinators telephonic or do they meet with the client in person? If telephonic, do they utilize video relay services in working with the deaf or hard of hearing or are they using TTY or speech-to-text services?

Christopher Duff: This is Chris. I'll take a shot at that. First of all, I think that the nature of

your question shows that you've really thought this through and that's really important.

In serving this population it is our recommendation that all initial assistance be done in person. At that point you establish the relationship and then you can determine what's the nature of the ongoing care coordination and support they may need. With some individuals it can be more telephonic on an ongoing basis but with many individuals it needs to continue to be individual in person.

We of course are always using every available system and service to assist with communication and June will be going into some of that in the next webinar. In Webinar 3 we will be talking more about the assessment and the importance of doing it in person.

I can't emphasize enough that the medical director of a program I worked with in Minnesota, he would always say to me Chris, the only tool we have is the relationship we have with the consumer. If we establish that relationship, they will connect with us and we can help guide them optimally. So a basic premise of the first foundational component of the model is relationship.

June Isaacson Kailes: I'd like to add, Chris, that your question reflects what's the best way, what's the best communication access for the participant, and that's always somewhat dictated by what works best for the participant. Some people who are deaf really do well with email or texting or video relay; some are still using, but less and less, the old TTY. So I guess the critical component here is what works for the participant and honoring that as well as the tools available to the team.

Laura Dummit: Thank you. Right now you will see on your screen our short survey that I mentioned earlier and we would really appreciate it if you would all take a few minutes to complete that survey.

And I will say we have a few more minutes for questions; as we're waiting for some more of those questions to come in, however, I want to give you information about the next two webinars in our series. Number two will be Understanding the Lived Experience of Disability, which will take place on Tuesday, September 10th at 2:00. The third webinar in the series, which is Understanding the Care Management Relationship, is scheduled for September 17th -- again, that's a Tuesday -- at 2:00.

I'm going to read a couple of more questions that we have gotten through the web chat. A question from Nancy Schmidt from Western Wisconsin is durable medical equipment vendor providers often note the difficulties of submitting authorization requests and claims through Medicare. This causes delay and health risk to the consumer. Is there any discussion with Medicare to improve these processes?

Christopher Duff: Why don't I start and June, you can add in. You're actually on one of the key barriers that are experienced by people with disabilities, accessing appropriate medical equipment but also supplies. There is a strong community that's always in communication with Medicare about this and there have been some recent changes in the procurement process for

Medicare. We are not directly involved with that.

In the demos it is my understanding -- and talk to your local state about this -- but that the individual contractors, the health plans or provider systems, will have some flexibility in how they purchase supplies and equipment for their members, so they can do some workarounds. That was really very, very important because, as June mentioned earlier, if we don't get the people in the right equipment they're going to have secondary problems, whether it's orthopedic, whether it's skin, whatever. The ME is a key component of the model of care.

June, do you wish to add to that?

June Isaacson Kailes: I guess this is an ongoing issue. We as advocates are always dealing with the issue and struggling to improve it but, as Chris says, it's weighing the cost of what will happen if they don't get what they need and looking at what a workaround is while you wait on some of these difficult waits with the ME providers and reimbursements. Sometimes you just have to work around it and say we're going to do this because we have to; otherwise we may indeed be looking at something that's much more expensive and intensive treatment down the road.

Back to you, Chris.

Christopher Duff: I'd like to give one example of a workaround that is indicative of how the team needs to understand the individual.

We had a member who actually said to us will you buy me an electric leg bag emptier, so a device where she has a button on the armrest of her chair and it will empty her leg bag. Well, that's obviously not in the Medicaid benefit set or the Medicare benefit set but we stepped back, we thought about it, we engaged with the member, and she said look, I can probably reduce my PCA needs one or two hours a day just by not having a person sit around and look at me until I happen to need my leg bag emptied. So that was an opportunity where we spent a couple hundred dollars and saved a lot of money and the person was far more independent; they didn't need to have that caregiver around them.

So that's an example of the kind of thinking that we encourage be developed in the relationship with the member and their care team.

Laura Dummit: Thank you. Roxanne, are there any more questions on the line?

Operator: At this time there are no other questions.

Laura Dummit: Thank you. We have one final question, which is where can the online assessment tool be accessed, and I will be glad to answer that. At the bottom of every slide is a web address, www.resourcesforintegratedcare.com. On that web address you will be able to access the disability-competent care gap assessment tool and in a couple of days you will be able to access this complete webinar as well.

And I would like to thank Chris Duff and June Kailes and the entire audience for participating in this webinar and we hope to have you back to the second in the series. Thank you very much.

Operator: Ladies and gentlemen, that does conclude our conference for today. Thank you for your participation and for using AT&T Executive Teleconference Service. You may now disconnect.