

**Event ID: 677917**

**The Care Management Relationship (Or Person-Centered Care Management)**

Laura Dummit: Thank you. Welcome to all of you for attending the third in our series on Disability-Competent Care. My name is Laura Dummit, and I'm with The Lewin Group. First, I want to go over just a little bit in terms of housekeeping. If at any time your slides are not advancing, if you push F5 on your computer that will refresh everything and should get everything moving again. You will also notice that at the bottom of the screen, we've highlighted a red button that's circled. That is the button for questions.

So at any time, if you have a question, please push that button, type in your question. If it's a question about the technology, someone is working behind the scenes and will address that question in real time. If you have a question about the presentation or that you would like to post to the experts at the end, we will be compiling those questions and we will return to all of them.

And then there is another button that is circled at the bottom of the screen here and that is the button you use if you would like to print out a PDF version of all of the slides today. So as I said, this is the third in our series on Disability-Competent Care. We will provide about 45 minutes of content and then we will reserve the last 15 minutes for questions and answers.

We will send you all an email with information about when this presentation and the other two in the series will be posted to our website, Resources for Integrated Care. So you should expect to receive an email from us with follow-on information by Friday.

I want to step back just a moment and give you the genesis of this series and several other tools for integrating healthcare services. The Lewin Group, along with the Institute for Healthcare Improvement in Cambridge, has a contract with the Medicare-Medicaid Coordination Office and the Centers for Medicare and Medicaid Services to provide tools and technical assistance to providers that are seeking to integrate and better coordinate care for people who are eligible for both Medicare and Medicaid; that is dual eligible.

As you are probably aware, CMS has sponsored many initiatives over the past couple of years to provide financial incentives for integrating care. Our contract is to provide technical assistance to support those providers. Which takes us to this Disability-Competent Care webinar and our series today.

We would like this session to address your needs in delivering Disability-Competent Care and where you and your organization are on the road to integrating care. So please submit questions in writing or at the end we will open up the phone lines for questions. In addition, we are asking you all to please fill out a short survey at the end of this presentation where we will be asking you for feedback to make sure that this series and our other products are really hitting the mark in terms of what you need.

I'm going to now turn this over to Christopher Duff who's been instrumental in developing this series and various tools on Disability-Competent Care. Chris is the executive director of the Disability Practice Institute. Thank you, Chris.

Christopher Duff: Thank you, Laura. I appreciate it. As you said it's the third in our series that we're developing and you'll be hearing more from us in the future. Today we are very lucky to have two wonderful speakers that I will be introducing, Lynne Morishita and Mary Glover.

First Lynne. Lynne has 35 years experience in care coordination of medically complex populations and she has taught at UCLA and the University of Minnesota in their Schools of Nursing. She started her career as the first nurse practitioner at On Lok, the integrated care program for the elderly that gave rise to the National PACE Program. She has consulted in planning, program development and evaluation of geriatric health programs, disability health programs, care coordination, behavioral health training programs and care system integration.

Most recently, she developed a primary care practitioner program at Axis Healthcare which is a disability care management program in Minnesota. And she was co-author of the Disability-Competent Care Assessment Tool that you'll be hearing more about at the end of the webinar. She is the co-investigator of the Dementia Pathways Healthcare Home Project designed to keep people sustained in their community by giving them home-based primary care and care coordination.

Ms. Morishita has a Bachelors of Science in Nursing from the University of California, and a Masters of Nursing in the Community Health Nurse Practitioner track from Yale University.

Mary Glover will be the second speaker today. She's a nurse practitioner with over 30 years of clinical experience working with individuals with disability and complex medical conditions. I dare say she is the most experienced nurse practitioner focusing most of her entire career on working with adults with disabilities. She has been a practicing clinician with Commonwealth Community Care, formerly known as the Boston Community Medical Group, since its inception in 1988. Commonwealth Community Care is a group practice specializing in the care of adults with physical and developmental disabilities. Hallmarks of the model include the use of an interdisciplinary team, community outreach and home-based services to improve access and reduce barriers to care.

In 2004, Mary assumed the role of executive director of the Boston Community Medical Group when the corporation was restructured as a not-for-profit group practice and clinical affiliate of Commonwealth Care Alliance. She is currently working to expand this model and make it available to more people throughout the Commonwealth as a part of the dual demonstration in the State of Massachusetts.

Mary Glover received a Bachelors of Science degree in Nursing from St. Anselm College in New Hampshire and a Masters Degree in Adult Primary Care Nursing from Boston University. At this point, I'll turn it over to Lynne Morishita.

Lynne Morishita: Thank you, Chris. Hello everyone. This afternoon, we are talking about Disability-Competent Care coordination, but let me back up and review what we mean by disability. Disability is the consequence of an impairment that may be physical, cognitive, emotional, sensory, developmental or some combination of these. It manifests itself as some kind

of functional disability. We will begin by defining Disability-Competent Care coordination in this presentation then follow up with lessons from recent care coordination research. I will then give an illustration of Carmen and how her care was coordinated. We will emphasize the importance of developing a trusting relationship between each participant and their care coordinator.

Mary Glover will then discuss the role and function of the care coordination team and the care coordination process. Last, we will have a Q&A session.

Let's set the stage with Carmen's story. If you recall, from the last webinar, Carmen is a 45-year-old woman living with quadriplegia since a car accident at age 14. Carmen chose and hired her personal care attendant who provides her personal care such as bathing and dressing. Carmen works part time as a researcher. Though her physician thinks this is a stressor, it is her choice to work.

Carmen had to appeal to her health plan to cover her rent before she moved into her apartment. This required coaching from a social worker to work the appeals process which was finally approved. Her medical conditions include neurogenic bladder, skin breakdown, asthma and decreased lung capacity. She takes 8 to 10 medications daily which are prescribed by her specialist, a neurologist, a urologist and pulmonologist, but she has no primary care provider.

A primary care provider can often put the clinical picture together in an overall different way than the specialist who is only looking at one organ of the body. She has multiple hospitalizations including two with intensive care stays which required intubation and extended rehabilitation. She has had pneumonia and skin breakdown. She goes to the emergency room for primary care and is quite satisfied with this arrangement since transportation by ambulance is easily accessible.

So what is Disability-Competent Care coordination? It is a means of providing oversight of care, guided by the participant's goals and preferences. This contact is frequent enough to monitor medical or psychosocial conditions and develop a trusting relationship, which is the key to successful care coordination. It is best if the participant wants to call the care coordinator when he or she is experiencing change in their health or psychosocial situation.

The interdisciplinary team will be talked about in detail by our next speaker Mary Glover. The team consists of those providers who have competencies that meet the participant's needs. These may be in primary care, nursing, behavioral health, social work or community-based service. The participant is a key member of the team as well as any informal support providers that they would like to be included.

Before telling Carmen's story, let's go over some of the lessons from the Medicare Coordinated Care Demonstration. The Medicare Coordinated Care Demonstration followed 13 sites. They included care coordinators that were clinic-based. And the results of the demonstration showed that care coordinators who did best were those who had face-to-face contact with patients -- face-to-face contact with the physicians, you might ask how is this done? In select complex cases, this is most easily done by accompanying the person to their appointment. There are many care

factors that are not known by the physician who has never seen how the person functions in their home. Valuable information is shared about how the person functions in their home and plans of care can be adapted.

The care coordinators who had most favorable results included patient education, included managing care transition which means four things -- medication reconciliation, instructing patients on red flags about which to call, having a centralized electronic health record and follow up with primary care. They acted as the communication hub for the team and medication management was emphasized.

In the Medicare Demonstration, Peikes et al found that care coordinators with face-to-face contact were able to build trusting relationships. Through these relationships, they were able to provide effective teaching and help improve adherence to care plans. Through this relationship, care coordinators were also much more able to identify and address barriers and additional needs that they were not able to identify over the phone. The care coordinators were more able to focus on the highest risk participants and thereby increase cost savings.

To further make the case for face-to-face contact, Wash U in St. Louis made a programmatic change with a significant impact on their results. Their original care model had care coordinators doing telephone care coordination by a group in Southern California. There was no impact on the rate of hospitalizations or expenses.

So what did they change? They hired local St. Louis care coordinators who can have face-to-face contact with participants. Care coordination effort was focused on those with the highest risk for hospitalization. And strong transition care with an emphasis on medication reconciliation was done. The result was a decrease in hospitalizations by 12% and a decreased cost of care for participants by \$217 per participant per month; more than the cost of care coordination which was \$151 per participant per month.

So now to illustrate how care coordination works let's tell Carmen's story. To begin care coordination with a nurse practitioner, the nurse and social worker visit Carmen's home to do a comprehensive assessment. The nurse practitioner does a complete history and physical exam with a focus on maximizing functioning in the home. The nurse does a complete medication review which can take awhile especially with all the over-the-counter medications.

The social worker assesses the home environment, focusing on safety. From there, the team determines the other members that might be called in depending on Carmen's needs. The NP starts a list of diagnoses with possible management plans. The social worker and nurse add to the list of needs and they discuss a plan of care with Carmen who approves of the plan.

The NP offers to be Carmen's care coordinator. Carmen appreciates the idea of the nurse practitioner's offer to coordinate among her subspecialist physicians. They plan according to Carmen's preferences and goals. She would like to continue to work and she enjoys seeing friends and going to the theatre.

The nurse knows of a chair exercise class that is done in the community and Carmen thinks she would like to try it, and transportation is arranged.

Carmen has a neurogenic bladder and is given the choice to void or self-catheterize every two hours. She chooses to void every two hours which she thinks will be doable at work. The nurse practitioner answers any questions that Carmen has about what her medications are for and how to take them.

The nurse practitioner makes sure that Carmen sees physical therapy so that she has access to seating and wheelchair assessments to minimize pressure to prevent skin breakdown. She helps find a durable medical equipment company that will provide a loaner wheelchair in case Carmen's needs repair.

The nurse practitioner will visit monthly so that they can develop trust. The NP would appreciate her calling for any urinary issues, respiratory distress or sign of skin redness which would lead to breakdown or any other need that arises. It is important that the nurse practitioner develop a trusting relationship with Carmen so that Carmen will want to call her for any changes.

With Carmen's permission, the nurse practitioner will start providing primary care on a regular basis in Carmen's home. This should prevent the need for emergency room visits if done at frequent time intervals. It is important to have assessment and timely reassessment to ensure being able to catch preventively any sign of change in health status. This may prevent avoidable hospitalizations or ER visits which are no piece of cake for participants.

Plans of care are based on Carmen's goals and preferences. She chooses to void every two hours rather than self-catheterize. She felt that this would suit her work situation and she would like to try the exercise class in the community where she may meet other people. She will do her exercise in the wheelchair while others do exercise while seated in chairs.

Carmen chooses to work so that she can remain independent. There is coordination among providers. If Carmen did need to go to the emergency room or is hospitalized, the nurse practitioner would communicate with the staff to help coordinate discharge instructions and any followup that may be needed.

Carmen and her personal care attendant both receive education and support in order to follow through with Carmen's plan of care and are on board with the plan. Many people with disabilities have need for behavioral health but Carmen does not.

The nurse practitioner also provides flu shots and any other usual preventive care that she needs. The care team respects the dignity of risk and just makes sure that Carmen is informed of the risk that she may be taking. Carmen's pulmonary specialist thinks that work is a stressor and may be a risk; Carmen understands this but Carmen finds her work inspiring and enjoys it so she chooses to work which gives her independence. She believes that it would be a risk if she did not work. Carmen is just one example, but these principles have held up in demonstration projects (technical difficulty) that I have already described.

Just to review, care coordination is a means of providing coordinated care guided by the participant's goals and preferences. This means that contact is frequent enough to monitor medical or psychosocial conditions and most importantly develop the trusting relationship so that Carmen will want to call in any changes. I hope the illustration with Carmen gives you a feeling for how care coordination works and the sense of the complexity involved.

The interdisciplinary team will be talked about in detail by Mary Glover. Just a quick note on how Disability-Competent Care sets itself apart from disease management or case management. It is different from disease management in that disease management focuses on implementing best practices to manage one disease as opposed to multiple chronic conditions.

It is also different from case management which is often telephonic and focused on managing care; while Disability-Competent Care coordination is focused on meeting the goals and preferences of the participant through a trusting relationship. So I think you can see the difference.

Let's review the elements of care coordination. They are comprehensive and timely assessment and reassessment by the team; an individualized plan of care organized around the participant's goals and preferences; coordination of decision making across all settings with access to electronic health record which Mary Glover will describe further. Each person has one designated care coordinator or someone on-call for this person that they can call 24/7 if any need arises. This person can access other members of the team that may be needed.

The team is identified by the participant to include family, personal care attendants, clinicians, and anyone who helps to provide support for the participant. And the respect for dignity of risk and informed decision-making are key.

In Carmen's case, the key elements that led to successful care coordination were the trusting relationship with the care coordinator; honoring Carmen's goals and preferences; with Carmen's permission, direct communication with her specialist; comprehensive, timely assessment and reassessment by the team. Carmen was coached on when to call her care coordinator and monthly visits and weekly calls took place in the beginning to develop the relationship.

These may be fewer in frequency over time. I hope that you will refer to the Disability-Competency Guidelines that we developed and take a look at those related to care coordination. I hope that this has been helpful in giving you insights as to how to succeed with Disability-Competent Care Coordination.

Now, I am going to hand the program over to Mary Glover, Executive Director and NP Extraordinaire of Commonwealth Community Care.

Mary Glover: Thank you very much, Lynne. So the focus of this next section is on the interdisciplinary team including the composition, the roles and the functions. So central to the team is the consumer, of course, as you saw exemplified in Carmen's story. She has been the driver of the care plan and involved in all care planning decisions.

So Carmen or any consumer is central and key to the team, working of course in close partnership with the consumer is the interdisciplinary care team which is composed of primary care provider which can be a physician, nurse practitioner, physician assistant, RNs, social workers, behavioral health specialists, physical and occupational therapists, and then working in collaboration with other community resources and other team members such as personal care attendants or other services in the community such as Meals On Wheels, et cetera. All of these components need to work together in a collaborative way communicating regularly so as to function at maximal efficiency.

So to talk a little bit further about the composition of the interdisciplinary care team, the nurse practitioner, physician assistant or a physician functions as the primary care provider. In our model, also the nurse practitioner functions as the care coordinator. With the complexity of folks that we follow we find that integrating that function actually is very effective and efficient.

As Lynne mentioned, part of the role is to do a comprehensive assessment to work with the consumer around care plan development, to be the first responder of any unexpected clinical issues that arise, provide 24/7 availability, and to integrate specialty hospital care and 24-hour coverage into that role.

Also on the team are behavioral health specialists who get involved as needed. In this situation, Carmen was not in need of behavioral health specialists so this service was not provided but is available both as a consultant to the primary care team, but also as a direct care provider to the consumer. Often in our model the behavioral health specialist is involved in consulting with the consumer, doing an assessment, and matching that individual to a network provider for ongoing care. Often can also provide bridge therapy in the home when there is a potential delay in accessing services or if the consumer is more willing to accept that model of care.

We also have social workers on our team who are really specialists in long term services and supports, they respond to any housing issues, financial issues, eligibility for services, maintaining insurance eligibility, accessing food stamps, et cetera, also can get involved in crisis management, family, social issues, personal care attendant issues and the like. Our rehab specialists focus on high-end rehab equipment and ordering of durable medical equipment and supplies.

Our durable medical equipment coordinators and non-clinical person who really works in the office and functions as a liaison between the vendors, our clinical team, and the consumer to make sure that sometimes the complicated process of ordering equipment does not go awry.

Soon to be added to our team through the duals]demonstration which in Massachusetts is known as One Care will be the inclusion of peers, health outreach workers, and other long-term service coordinators who are specialized in community services.

The core values of an interdisciplinary team are that it is participant- or person-centered that it ensures the participant's dignity of risk taking and that there is no medical or institutional bias. The goals of the interdisciplinary team are to support the consumer, to maintain maximum function, health, wellness, and life in the community of the participant's choice.

So the team provides care and support as needed at any time and in any settings. Eighty-five percent of the work that we do is done in the community in terms of home visits, visits to day programs, group residences, even worksites. We are a mobile primary care team and take the care to the individual trying to meet them where they are, reducing barriers to care and trying to disrupt their life as much as possible.

These care structure includes routine follow-up visits in the home or in our accessible office, responsiveness to episodic issues, 24/7 on-call by the primary care team, and I think this is critical. It is 24/7 call by the team of clinicians who are knowledgeable about that individual's care, knowledgeable about disability, familiar with the care issues, with access to the electronic medical records, so that it is a seamless process.

We also participate in the in-patient management and in transitions of care. We have a specialized hospitalist team, a special unit where all of our patients are hospitalized unless they need intensive care. In that way we build relationships with the nursing staff. We build relationships with the hospitalist team. They get to know our consumers, they get to know us, and we all build trust in each other so that transitions are more fluid. This obviously is important in terms of reducing errors, reducing miscommunications on discharge and confusion around medications, et cetera.

So what is the process that the interdisciplinary team may undertake? So the whole process starts with a comprehensive assessment and Lynne spoke very well about the details of that, the importance of the comprehensive assessment and periodic reassessment.

It's critical that there is face-to-face interaction with the consumer so that the care team fully understands the goals and wishes of the consumer, and the consumer has full access to the clinical team to communicate those wishes. As the result of that assessment, the individualized care plan is developed and the care coordinator and the clinical team and the consumer work together to devise a plan on how that care plan is going to be carried out and to reevaluate the care plan periodically to be sure that the interventions are appropriate and the goals are being met. It is a living document, it is not just a piece of paper that is developed and then forgotten about. The care plan is really a dynamic process that is constantly undergoing updating and review.

Some common practices or things to consider in terms of care coordination are the importance of it being culturally-sensitive and language-competent. So we make every effort to include culture and language competency on our teams; if that's not possible, and it isn't always possible, it's very important that the care team have access to trained medical interpreters.

Another key component of this are the flexible benefit packages. It is very important to be able to go beyond what is contractually required of Medicare and Medicaid services. There are so many examples of how this is helpful and empowering to the clinical team and empowering to the consumer. The areas of durable medical equipment are the most obvious examples of this; being able to order customized equipment that may go beyond the traditional fee structure, being able to repair backup wheelchairs for example. There are many times when an insurer will not repair



a backup wheelchair, it will only repair a primary wheelchair. But if the primary wheelchair malfunctions that individual might be confined to bed, might not be able to get to work or to school or might have to sit in a very uncomfortable and non-functional manual chair until the power chair is repaired.

So these kinds of things are incredibly meaningful to people's lives to be able to be flexible and to make modifications in the benefit structure. Being able to approve a temporary perhaps increase in personal care attendant hours around an illness that might allow that individual to manage their care at home. Their baseline need -- their care needs may exceed their baseline needs for a period of time because of an acute episode, being able to authorize additional personal care attendant hours.

We're working with our hospital to integrate a process where personal care attendants can provide care to our folks when they're hospitalized, if the consumer wishes that. That provides a lot of continuity and confidence for the individual when they're hospitalized that their basic care needs can be maintained in a manner in which they want them to be.

Transportation benefit, we often use the transportation benefit for non-medical reasons; things that have value to the individual for their emotional health, being able to go to church, being able to visit a family member who's hospitalized or in a nursing home. These kinds of things are traditionally not covered as part of a medical benefit but can have tremendous meaning to people's lives. So these are things to consider.

Obviously there's frequent monitoring of people who have chronic conditions, the emphasis is on education of individuals to self-manage their issues as much as possible, and to participate to whatever extent is needed in coordinating care around more complex issues. A centralized information system with such a large team is obviously really critical for sharing information among providers.

So the interdisciplinary care team also integrates other community-based services into the care structure. I think many of these have already been mentioned. I will again emphasize the issue with durable medical equipment. I hear this time and time again from our consumers, how important it is that we provide such specialized attention to wheelchair purchasing, and it involves more than just being seen in a wheelchair clinic or getting a wheelchair that feels comfortable in a clinic setting. It's really critical to assess the whole environment to see what the home situation is, does the individual use a van, do they work, what's the height of the counter tops, et cetera.

It's really important to know how that person lives in order to know whether that piece of equipment is going to meet their needs or not. There are many other examples of very specialized equipment, speech devices, environmental control units, et cetera.

The other real key factor I think to remember is -- the real importance of embracing an independent living philosophy and trying to move away from a traditional medical model where safety is really valued over independence. And it's really critical to the disability community I think to really embrace respect for choice, the dignity of risk, and the importance of informed

decision making, and to respect and recognize the individual's right to make choices about how they want to live and what care they want to receive.

So the interdisciplinary care team must have a common goal; there must be synergy among the team members. And generally a team is able to accomplish more than each individual discipline could accomplish on their own or independently. So some of the purposes -- one of the key issues for the team is to have regular meetings. We have weekly meetings and part of the purpose of that is to build relationships among the team members.

You want to share information, you want to work together to identify issues and to solve problems together to learn from each other. It's an opportunity to develop and refine care plans with input from all disciplines. There are educational opportunities for team members. Our teams are getting larger and larger now. So we have a vast array of clinicians, some of whom are newer to this work than others. It's really important that they learn from each other and that they have behavior modeled by more senior clinicians with experience.

It's also a way to provide support to the team members. Sometimes work can be stressful and there are times when you feel like you're not necessarily meeting all the needs of the individual that you're working with and so it's really important to support each other and to understand the difficulties in some of the situations that we face that really may have -- not an easy solution.

So one of the questions that always comes up is how do you allocate team resources and how do you stratify the population so that you're providing the resources to the right folks? So we look at this in two ways; there's the scientific approach which I think is probably more well-known in that you look at risk profiles, you look at diagnoses, you look at chronic conditions, you look at utilization history, what hospitalizations has that individual had, how many ER visits, how many avoidable hospitalizations.

But there's really an art to it as well. And the art really has to do with looking at the context of that individual's life. And it goes way beyond what diagnoses that individual has, and I'm sure we all have examples where we have two people with very similar clinical situations and diagnostic patterns and yet their lives are very different; they deal with those diagnoses very differently.

And some of the factors that need to be considered are the financial situation, the economic challenges that that individual has, what kind of supports do they have or do they not have among family or extended family, friends, how old are they, what's their cognitive situation, are there are other secondary conditions or co-existing conditions, is there a mental health issue. All of these things can really affect how that individual is able to deal with their diagnosis or their medical situation.

So it is definitely not a one-size-fits-all situation and every care -- every individual's care plan has to really be developed individually. There is a human element to that and a lot of that is dependent on the skill of the clinical team and the team members to really draw that out in the assessment process.

So there are various levels of care coordination that we talk about. There are those issues where the goal is really self management. And with education and support, the individual is really able to manage their situation. Then there are those situations where it requires episodic management from the team.

The importance of timely intervention can't be overestimated, it is so important to really be available, to be responsive, to be able to intervene early when -- at the first sign of a clinical situation, so that more complicated situations don't develop. And then there are those chronic situations where they really need to be continually managed and watchful for the development of complications or secondary conditions. So, all of these approaches are appropriate and key to success.

So just to summarize, care coordination must be face to face to develop trust so that that individual will call you when they are first experiencing early symptoms and they trust that you will respond to them. It's important to target those who are most at risk for hospitalization with a particular focus on transitions, medication management for continuous care coordination.

Ongoing oversight as needed by, and which is varied by each individual's needs and desires. And the importance of direct communication lines among all team members particularly, specialists or physicians in the community, unless that individual is part of your direct care team.

But the importance of communication can't be again overestimated. And having access to an electronic medical record among the team, and now with newer developments in technology, even those outside of the immediate team can have access with permission from the patient. So I think again, stressing communication among all folks with the consumer is key.

So I think I'll turn it over, I guess to questions.

Laura Dummit: Thank you Mary and Lynne. Tanya, would you now open the phone lines so that we can start accepting questions, please?

Operator: Certainly. Ladies and gentlemen if you would like to ask a question, please press star then zero, you'll hear an acknowledgement tone. An operator will take your name and further instruct you offline. Once again, if you do have a question or comment, please press star then zero at this time. And it'll just be a moment while we gather names.

Laura Dummit: Great, thank you. I'm going to jump in here with questions that we've gotten in writing. The first question, I will refer to Mary, which is, do all members of the interdisciplinary care team meet with the members in their homes for the initial and ongoing assessments?

Mary Glover: Well, in our care model, it is not common for the entire team to meet together for the initial assessment. Certainly, the individual has the right to request people to participate in that initial assessment or in any visits along the way or in any ongoing assessment process. But generally, for us, our initial assessment is really by the primary nurse practitioner or a physician. And then we bring in other team members as needed and as has been identified as a need in the assessment process.

We often though after the initial assessment, we may frequently at times of crisis or for care planning purposes we may then after there are various disciplines involved, we may then have team meetings with the member. But generally, the first meeting is really an assessment process by the primary nurse practitioner.

Laura Dummit: Thank you. I have another written question here, which I'll direct to Lynne.

Lynne Morishita: Okay.

Laura Dummit: Our experience in doing care coordination is so that about 5% of our members demand about 80% of our time and attention, which really doesn't correlate with their clinical complexity. How can we control this and make sure that we attend to our members when and how they need attention?

Lynne Morishita: I think that's a huge challenge, but I think that the way that Mary outlined looking at it scientifically based on past utilization, past chaos. And in making sure that the art is included, is really important.

Laura Dummit: Do you --

Christopher Duff: May I? This is Chris. May I also just add that the involvement of behavioral health competency on the core team was also very helpful for us in just helping our staff sort through that issue of the 5% of people who are just like always there. And I think every provider in this country can look at that when they look at the number of people they work with.

So often it's just the secondary mental health issue that is coming forward a lot and so making sure that there is that behavioral consultation on the team has been of vital importance.

Laura Dummit: Tanya, do we have anybody waiting on the phone with questions?

Operator: Yes, I have two questions on queue. The first one comes from the line of Fay Capers, please go ahead. Your line is open.

Fay Capers: Yes. Thank you. I actually wrote a question in the box too and that question was just, are we able to get a copy of the PowerPoint?

Laura Dummit: Yes, we will send you an email in a day or two about where you can access the PowerPoint, or you could also push, there's a button that's third from the right on the bottom of your screen. If you press that, you ought to be able to get a copy.

Fay Capers: The resource list?

Laura Dummit: Excuse me?

Fay Capers: The resource list? You said third from the right, right?

Laura Dummit: That's right.

Fay Capers: The alternative text document or -- the third from the right or the left is the resource list, so.

Laura Dummit: I can follow up with you offline and make sure you get the PowerPoint slide.

Fay Capers: Okay, I appreciate it.

Laura Dummit: Okay. The next question?

Operator: Okay, the next question will come from Diana Plus, please go ahead.

Diana Plus: Hi, thanks so much for this webinar. It's been really helpful. I'm really curious about how you organized the flexible benefit packages. We're doing a project here in Pittsburgh for children with special healthcare needs. And we're at the very beginning of, I think in something (technical difficulty) idea of stepping out of the box of the current restrictions and limitations of what Medicaid approves. So I'm hoping I can learn something from you about that.

Mary Glover: Well, you want me to take that? This is Mary. So in our model, it has really been up to the care team to really make those decisions. We have developed and we are continuing to develop and modify decision support tools that the clinical team has that -- they're available to them, to give them some guidance around what kinds of things to consider in trying to make those out-of-the-box decisions.

But in general, the bottom line is that the decisions are really up to the care team. And over time, we've done assessments of what the results of those decisions have been. And so far, it has not been a financial disadvantage, let's just say, to make those kind of flexible decisions.

We found early on that by being proactive and aggressive with ordering pressure-reducing mattresses for people, for example, who were at high risk, but didn't necessarily meet Medicare criteria to get a certain level of mattress. We found that when we were aggressive and proactive about waiving those regulations and just ordering things based on the clinician's assessment, that we dramatically reduced hospitalizations and surgery for flap closure of pressure ulcers. And so anyway, the results have been positive over the years; that those kinds of decisions are actually very cost-effective in the long run.

Diana Plus: So you started with operating under the assumption or the trust that providing good care proactively would save money?

Mary Glover: Right. If you do the right thing for the individual upfront, it might be an investment in the short run, but in the long run if someone is healthier and getting better care, it will be cost-effective. That's what we have found. We found that our two biggest cost drivers in our program so far have been the primary care team and durable medical equipment benefit.

Both of which, I think, really speak to the quality of life and keeping someone at home or in the community as opposed to hospitalization; or hospitalization's like fourth or fifth on the list of cost, which is not usually the case for a population of people as complex and with as high level of disability that we serve. So, so far so good, let's just say.

Diana Plus: So it sounds like your leadership supported that. That's my challenges then. I want our effort to be driven based on need and goals as opposed to saving money.

Mary Glover: Yes, it's very hard, I think for leadership to have that kind of trust. I think we we've been very fortunate to have the leadership of Bob Master who really did put his faith in the clinical team and really believed that if you did the right thing, it would pay off in the long run. But that's very hard sometimes for an organization to really have that kind of long-term view and faith.

Diana Plus: Did you know how long it took for you to demonstrate savings?

Mary Glover: Well, that pressure ulcer study that I referenced was really like the first year or two. We really saw a pretty dramatic reduction in hospitalizations related to skin issues. So that was pretty quick. I think other things and depending on your population can certainly take longer.

Diana Plus: Sure. Okay, thank you so much.

Laura Dummit: I'm going to jump in now with another question that we have online from Mary Fitch from the Wisconsin Department of Health Services, which is, how are you able to get physician buy-in to this model, especially visiting individuals face to face in their homes?

Mary Glover: Well, again this is Mary. I think that recruitment in general of the clinical team, can be a challenge. It is a very specialized population and a specialized model. And so, we actually spend a fair amount of time in the recruitment process, really making sure that any clinician coming in has a real understanding of what our model is, what the model of care is, what the philosophy of the practice is, and that it's a style that they feel comfortable with.

But we are very fortunate that we have physicians and nurse practitioners and PAs who really do embrace the model.

Christopher Duff: Mary, I believe you have two models, one is a delegated model, one is a staff model. Can you talk a bit about your delegated model and how you work community-based practices?

Mary Glover: Sure. With the delegated model, folks come in to particularly our senior care options program. Soon, they will be also coming into our duals demonstration through One Care, who already have a primary care provider in the community. And they want to maintain that relationship but yet they need the team to wrap around that system.

They either aren't able to or aren't willing to go in to the outpatient setting on a regular basis. And the provider in the clinic or in the practice really doesn't have the capacity to do the kind of outreach or the kind of interdisciplinary approach that that individual might need. So we wrap the other services around the individual and around the provider in the outpatient setting.

And so in that case, it's, I guess, less common for those providers to make home visits with us. Most of our communication is phone or through email or through the electronic medical record. Our clinicians will often accompany the individual to go to a clinic appointment, A, to assist them with getting there or improve the chances that they will get there; and B, to participate in the conversation so that we're all on the same page.

Although there are exceptions, there are some of those providers who can get away and can come in to the community with us and make visits. But it's less frequent than the physicians that we have in our primary practice here.

Lynne Morishita: I would also say, in Minnesota, that we had a home-based primary care practice that experienced a similar thing. And the main thing we did was communicate to those primary care providers that weren't able to be involved in the home visit to keep them in the loop in terms of the plan. I think they realized that we were able to do things that they couldn't do. And so, they were convinced ad hoc.

Laura Dummit: Thank you. I'm going to turn to another question. But first, I'm going to ask gently to push forward, you have a link on your slides now. That is the link to our participant survey and we would really like it if everyone who's on the line will please complete the short survey.

And in the mean time, I have another question here. Can you clarify what you mean by ensuring participant's dignity of risk taking and no medical institutional bias? That's from Rachel Robertson from CareMore.

Mary Glover: Well, I think that often in the medical, in the healthcare field, there is a bias towards the medical model of care which really means that the clinical team are the experts, that we know what's best and that the safety of the individual is the highest goal.

And I think sometimes it's very hard for healthcare providers to accept an individual's decision that might differ from what they think is the most appropriate medical decision to make, or might not be the safest or might not be in their best interest of their health.

And I think that that creates a lot of tension and conflict sometimes between consumers and providers. And I think that what we have come to really embrace is this idea that there is dignity in making decisions. There is dignity in people being allowed to determine the course of their life and make their own decisions.

And just because they had a disability and they have some kind of complex issue and they're more heavily involved in the healthcare system than other people are, doesn't mean that that

right to make those decisions should be taken away, and doesn't mean that we have the right to disrespect those decisions.

We have a situation where one of our individuals with cerebral palsy, who was nonverbal, who was on a vent, ended up with a significant pneumonia, was admitted to a hospital, went to a rehab facility, ended up there for nine years. And she maintained her desire to get back into the community and finally was successful last month after nine years. But the institution actually went to court and got guardianship because she wanted to leave the facility and they didn't think she was making the right decision.

And in my view that's a violation of her human rights. She was a competent adult, but she was so significantly disabled and was nonverbal that the institution was successful in getting guardianship assigned to her, so that she couldn't make her decision to go home. I mean, that's an extreme example, but that can happen. It did happen.

Laura Dummit: Thank you. This is Laura again. I'm going to have to wrap this up. We've reached the end of our time. We have three more webinars in this series that we are going to launch in October. And to all of our audience members, you will be receiving an email with information on the exact date and how to enroll in those.

And I'd also like to say that there were several questions that we received that we were not able to answer, but we will send those questions out to the individual speakers. And I'll assure all of you that you will get personal answers. And once again, I would like to thank our speakers, Lynne, Mary and Chris. And to all of our participants, thank you very much. And stay tuned, we have more information and webinars coming.

This last slide gives all of the contact information you're likely to need. Thank you very much.