Event ID: 700751
Providing Disability-Competent Primary Care

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the Disability-Competent Care conference call. At this time all participants are in a listen-only mode. Later we will conduct a question-and-answer session. And should you require assistance on today's call or if you would like to ask a question, please press star then 0.

I am now going to turn the conference over to Chris Duff. Go ahead, please.

Chris Duff: Thank you, Barb. On behalf of The Lewin Group, The Institute for Healthcare Improvement, and The Disability Practice Institute, I would like to thank you all for attending this, our fourth in a series on disability-competent care. Today's presentation will be on disability-competent primary care in particular. As Barb stated, my name is Chris Duff and I'm the executive director of The Disability Practice Institute.

First, I would like to orient you to the webinar platform. If at any time your slides are not advancing, please push F5 on your computer and that should get the slides moving again. At the bottom of your screen we have circled two icons that you can see on this slide here. The one on the right is for you to be able to print out PDF slides for the presentation. You can have that during the presentation or you can save it for use afterwards. The other one circled, the red one on the left bottom of the screen, is for questions. So if at any time during the presentation you have a question, please push this icon and type in your questions. If it is about the technology, someone behind the scenes will respond to your question in real-time. If you have a question about the presentation and would like to pose it to the presenters, we will be compiling these throughout the webinar and will return to them during the Q&A.

As I said, this is the fourth in a series of nine webinars being presented throughout this fall. The previous three focused on first, understanding the model of disability-competent care and its key component. The second one focused on understanding the perspective of persons with disabilities that they experience the healthcare delivery system. And the third was on providing care coordination for adults with disabilities. A link to all three of these presentations, including the sound to go along with these PowerPoint slides, is available on our website at the address given at the bottom of each of these pages.

Today we're focusing on primary care, and in subsequent weeks we will focus on the interdisciplinary care teams working with an individualized plan of care. That will be next week. The following week we'll be focusing on managing transitions. And on November 12, the focus will be on coordinating flexible long-term services and support. We will conclude the series in early December with presentations on building a disability-competent provider network and finally participants and provider readiness.

Each presentation will be 40 minutes in length with 15 minutes reserved for Q&A at the end. As I said, all webinars are recorded and the presentation's recording and the PDF slides will be available within a few days at the link on this slide. We will send everyone who has signed up for this presentation and has joined us an email when this full presentation has been posted. We will also keep you informed of future webinars and products being produced through this initiative.

I would now like to step back just a moment to give you the genesis of this series and several other tools for integrating healthcare services for dual eligible populations. The Lewin Group, along with The Institute for Healthcare Improvement in Cambridge, has a contract with the Medicare and Medicaid coordination office as a center for Medicare and Medicaid services to provide tools and technical assistance to providers that are seeking to integrate and better provide care for individuals who are eligible for both Medicare and Medicaid, commonly known as dual eligibles.

As you are probably aware, CMS has been introducing several initiatives over the past couple of years to provide financial incentives for integrated care and to improve and streamline care for dual eligibles. Our contract is to provide technical assistance to support those providers. Lewin and IHI have in turn partnered with The Disability Practice Institute to provide specific expertise in servicing dual eligibles with disabilities, the majority of whom are under age 65.

This takes us to the DCC, disability-competent care, webinar series and our presentation today. We would like this webinar series to address your needs and questions regarding the delivery of disability-competent care, addressing where you and your organization are on the road to integration and care improvement. So please submit questions in writing and we will additionally open up the phone lines at the end of the presentation for live questions. We are also asking you to please fill out a short survey at the end of the webinar where we will be asking you for feedback to make this series and our other efforts to meet your more immediate needs.

I'm now going to turn this over to one of the presenters to Lynne Morishita who will introduce the rest of the presenters and review the webinar outline. Lynne presented in the last webinar on disability-competent care coordination. She brings 35 years' experience with primary care and care coordination of medically complex populations. She, along with June Isaacson Kailes and myself, co-authored the disability-competent care assessment tool referenced throughout these webinars.

I'll now hand it over to Lynne.

Lynne Morishita: Thank you, Chris. Now I'm going to introduce the two speakers who are going to provide most of the content today. June Kailes is a disability policy consultant with 35 years' experience working as a contractor with a variety of health facilities, managed care organizations and government-related projects as a consultant, trainer, writer, researcher and policy analyst. She is also the associate director of the Harris Family Center for Disability and Health Policy at Western University of Health Sciences in Pomona, California. She has developed training material and curriculum in the areas in the ADA, aging with a disability, disability literacy and competencies, and worked on dozens of national research and model development projects. She also teaches disability competency in the health professions, which makes her a perfect speaker for this webinar. She has a Bachelors of Arts in Psychology from Hofstra University and a

Masters in Social Work from the University of Southern California. She's going to speak about lessons learned in obtaining primary care.

Then following June's talk, Mary Glover will speak about primary care redesigns that better serve adults with disabilities, how to provide primary care as part of an interdisciplinary care team, avoiding hospitalizations and episodes of illness that are preventable, and leading practices for managing common secondary complications of living with a disability. Mary Glover is a nurse practitioner with over 30 years of clinical experience working with individuals with disabilities and complex medical conditions. She has been a practicing clinician with Commonwealth Community Care, formerly known as Boston's 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. They use the interdisciplinary care team, community outreach, home-based services to improve access and reduce barriers to care.

In 2004, Mary assumed the role of executive director of Boston's 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. Ms. Glover received a Bachelor of Science Degree in Nursing from Saint Anselm College in New Hampshire and a Masters Degree in Adult Primary Care Nursing from Boston University. She is a board certified adult nurse practitioner and has wonderfully helpful illustrative examples.

So now I'm going to hand the program over to June.

June Kailes: Thanks, Lynne, and hi, everyone. I'm speaking to you from kind of foggy, cloudy LA this morning. My disability is cerebral palsy, which I've had since birth, and it affects my walking, my balance and my coordination. As you can see from this slide, I'm a scooter user and I've used the scooter for over 20 years. As Lynne said, I've actually held jobs besides being a contractor in aging, independent living, healthcare, mental health, and physical rehab and worked with Orion Healthcare most of my life, which contributes to the values embedded in my belief system. And they include independent living, (inaudible) it is not necessarily being able to do everything independently but being in control of how things are done. I believe disability, chronic conditions and health can and do coexist.

And I've learned that planning prevents poor performance in terms of my healthcare. So I always collect my questions and I do any needed Internet research before I see a healthcare provider. I believe it's important also to get and read and understand and maintain and share my medical records. For example, I update my medication records before a visit so I can just whip them out and say here rather than trying to remember what I have. It's a good memory assist for me so I don't miss anything and all those questions they tend to ask.

I cringe at and I do not accept when I hear "You're just getting older" answers, and this occurs frequently when healthcare providers are not knowledgeable about disability, aging with disability, and what can be done to mitigate or reverse some conditions, for example, the importance of exercise or some physical therapy. As you can tell, I do believe and practice being a savvy healthcare consumer and not surrendering personal power and control just because you're dealing with healthcare providers. And for me this has evolved and strengthened over the years of experience working in healthcare.

I'm also known as an interminable question asker, which I do control and prioritize for healthcare provider appointments, but I do believe I make my doctors and other healthcare professionals better by way of the questions I am asking them.

So about the elements I look for in healthcare providers, particularly in choosing my primary care provider and other providers. Well, first of all by way of background, for many years I used my OB/GYN doctor as my primary care provider, as I didn't really have too many issues. But around seven, eight years ago, she recommended that it's time I really get a primary care provider and she recommended hers. Well, like life, you never get everything you want, and there are tradeoffs. So here are some examples of my tradeoffs regarding my primary care provider.

In terms of physical accessibility, for me easy parking is great when it's very close to a building, which means I don't have to unload my scooter from my car. And I also need geographic access, which means not too far from where I live, that is by LA standards, which I set at 20 to 40 minutes depending on traffic, but for others being on mass transit routes is absolutely key.

In terms of equipment, I wanted but I didn't get for my primary care provider a height adjustable exam table or an accessible scale, but I can use what they have with assistance. And I just had an annual physical and towards the end of the physical my doctor said, "June, everything looks fine, but I'm concerned about the fact that you didn't give me your annual lecture regarding not having an adjustable exam table." And I explained, "Oh, no worries. I decided varying the timing of delivery hoping that I would have more impact and a better outcome." But for others, a wheelchair scale or a height adjustable exam table or other accessible medical equipment like myography or other radiology equipment is critical and there are no tradeoffs, as is the availability of timely assistance with transferring on and off the equipment and assistance with dressing.

In terms of communication, I have the ideal setup for me, which is I have a provider willing to communicate via email, which I don't abuse and use sparingly, but it's great as it saves me an enormous amount of time, including annoying and unnecessary telephone tag and wasted travel time. I get quick answers regarding over-the-counter medication suggestions or referral, a form signed or insurance approval or a prescription renewed. And I know I can communicate during my frequent periods of travel if the need arises.

For others in terms of communication, there are issues regarding longer appointments. If one uses an interpreter or assisted listening device or an augmented communication system, that all effects the lengthy appointment, as does someone who has speech that is more difficult to understand. And also potentially time needed to maybe record follow-up instructions on voicemail or smartphone for people who don't read or can't read.

Regarding disability knowledge of my primary care provider, well there really isn't any, but in general that's kind of hard to find from primary care providers. But what's important is that my doctor is willing to learn from and respect my deeper knowledge in this area and he's willing to talk with other providers when needed or do some research.

In terms of trust, if I need something in a letter or a form I may fill it out, I may draft it and he signs it, again, respecting my knowledge and my skill sets. In terms of the relationship, I look for trust, respect, a partnership, and mutual problem solving. And of course dealing with my personality, sometimes people call me doctor-want-to-be and I do teach self-advocacy and have written much material on being a savvy healthcare consumer, so providers have to be able to deal with that as being a part of who I am. And just by way of a little humor to illustrate this to you, a surgeon once told me she was going to take my case to present at grand rounds because of its uniqueness. I said, "Great idea. When?" She said, "You can't go to grand rounds. You're not a MD." I said, "You mean major deity? Yes, I have one of those."

Anyway, trust and consistency I think is key. When my husband, who has the same primary care provider, ran into a medical problem, I emailed my primary care provider late one night and by 7:00 am the next morning he shows up at my husband's bedside in the hospital. Now, the value of that is almost priceless.

So with regard to primary care provider, these are just some of my thoughts regarding key elements in tradeoffs. So, Mary, over to you.

Mary Glover: All right, June, thank you very much. June spoke about some of the fundamental elements that are critical in an effective primary care relationship. I'd like to start out by telling Pedro's story, which I think illustrates some of these core principles. Pedro is a Spanish-speaking man from the Dominican who had sustained a spinal cord injury resulting in quadriplegia about five years prior to our meeting him. He came to the United States for medical care and he was admitted to the hospital with a myriad of issues, including pneumonia, urinary tract infection. He had a permanently, at that time, indwelling urinary catheter. He had a tracheostomy for chronic respiratory insufficiency, constipation, multiple pressure ulcers, incontinence.

He was transferred after an acute hospitalization to a rehab facility, which is where our primary care team first met Pedro. Our team is generally led by an advanced practice clinician, either a nurse practitioner or a physician assistant, and in this case the physician assistant met Pedro at the facility. At that time a discussion ensued about his goals. He identified that his short-term goal was to increase his independence with self-care and transfers and he wanted to be able to wear sneakers again which had become impossible because of lower extremity spasticity. Long-term he wanted to be able to drive. He wanted to be more independent, a job and a girlfriend, not necessarily in that order.

So some of our initial plans and interventions at discharge so that he could get into the community centered around ordering durable medical equipment, including a hospital bed, an air mattress, an air cushion for his wheelchair to reduce pressure when sitting, and some bath equipment. We were involved around housing advocacy and arranging transportation. His bladder management was adjusted so that his catheter was removed and he was instructed in an intermittent catheterization regimen for his bladder. He was started on medications to reduce incontinence. A bowel program was developed. And he was taught various strategies and techniques for managing his respiratory condition and managing his secretions. At that time he was referred for some home health follow-up, particularly around wound management.

So Pedro's care plan really involved multiple disciplines. Medically, the primary care team made home visits, followed up on his bowel and bladder program and respiratory status, provided wound follow-up and assessment, and coordinated all services, such as the home health services specialists, obtained labs, updated immunizations since no records were available and the history was unknown. We managed multiple episodic episodes of urinary tract infections, changes in his skin, and respiratory exacerbations. He was referred to specialists, such as pulmonary and ear, nose and throat specialists because he wanted to talk about removal of the tracheostomy tube and to review his pulmonary management. He was referred to a rehab physician within our group to be considered for Botox injections to treat his spasticity. And our social service team was involved around housing advocacy and access of financial benefits.

Just to give you a little picture of what we found when we first started to be involved in Pedro's care, there's no substitute really for home visiting. There's no substitute for really seeing with your own eyes kind of what circumstances people are dealing with. And when we first saw him he was living with his mother in a small unsubsidized inaccessible apartment. SSI was the only source of income and his mother was his primary caretaker. We found numerous code violations in his apartment. There was water leakage in the ceiling of the bedroom and the bathroom. The carpeting was soaked and moldy, and he was using a space heater to keep warm. This was particularly problematic given his lifelong history of asthma and his respiratory status at the time. So this became a major issue for the team to support Pedro and his family and accessing new housing.

So throughout the course of the next few years our care team really provided this support on an ongoing basis, as well as coordinating various specialty interventions. Urology was involved around treatment of kidney stones and erectile dysfunction. ENT was involved around multiple attempts to remove the trach tube and to treat what ended up being some tracheal stenosis and narrowing of his trachea which caused some respiratory distress when we did try to remove the tube. His pulmonary status stabilized. He was referred to the independent living center and was approved for personal care attendance, and he obtained housing. Our team physiatrist effectively managed his spasticity with repeat Botox injections and he was ultimately able to wear his sneakers.

So all of these services were coordinated by our primary care team. The lead PA often accompanied Pedro to specialty appointments when that was appropriate and needed around some of the complex issues that we were dealing with in an attempt to increase communication and really try to coordinate these plans which involved multiple outpatient procedures, some inpatient stays, and some follow-up at home. So on average he received 10 visits a year by our primary care team during that period of time.

So just to give you a quick snapshot of where he is now. He's 32 years old. He's gained 30 pounds. He had originally been described as cachectic in the first notes in his medical record. He is living in an accessible subsidized apartment with his mother. He employs personal care attendants. He is independent with power wheelchair mobility, and he attends a weekly peer support group which is organized by our social service team. He was referred to mass rehab commission for ESL classes.

He does continue to have some chronic skin ulcers, although they are mostly small and manageable, except for some of his extended trips to the Dominican to visit family and friends and we work with him around those issues. He continues to have the tracheostomy tube but he is off the ventilator and his respiratory status is stable. He had a feeding tube for a period of time, which is now removed, and he's able to eat without aspiration. He's had one hospital admission for urosepsis since 2009, and he describes himself as stronger.

So what are some of the key elements of effective primary care that were illustrated in this story about Pedro? First of all, I think that building the relationship from the beginning was essential. The fact that our team went and spoke to him and really talked to him about what his goals of care were, what was important to him and supported those efforts. It involved actively listening. It involved shared problem solving. There was an implementation of preventive strategies to reduce or eliminate some of the predictable and secondary complications. Some of that was accomplished through teaching, some through equipment, et cetera.

And I think what stands out, too, is that the team had really an appreciation for the totality of the human experience, that the care plan really did not focus on the disability. It did not focus exclusively on medical or health-related issues, but there was an appreciation of the importance of the context of psychosocial, sexual, vocational goals and concerns that he had. There was also an understanding of the importance of consumer-directed personal care and the importance of having a flexible durable medical equipment benefit.

So our model of care did not develop overnight. We did not just wake up one morning and say, "Aha, this is the answer." We still aren't quite there yet, but we have, I think, learned some lessons over the years in working with people with disabilities and providing primary care, and I think we've learned that it takes a team. It takes an interdisciplinary team. It takes people coming from different perspectives and different skill sets and coming together to work together towards common goals.

It takes community outreach and integration of services, a person-centered approach to partnership, a relationship, again, that's built on strong listening skills and active listening and shared decision-making, a partnership. It also involves integration of hospital care and primary care teams to improve transitions of care when people do require hospitalization or other clinical settings. There also needs to be an emphasis on long-term services and supports, including and very importantly consumer-directed personal care and a flexible, durable medical equipment benefit.

I think Pedro's story illustrates some of the key disciplines involved in the care team. I'd like to add one, actually, to this list, one that I haven't included before and I probably should, is I think the health plan is an important part of the care team. I think without the financial support and the recognition of the importance of primary care investment without the ability of the clinical team to access flexible benefit plan. I think these are important tools for the team to have access to in order to be able to facilitate appropriate primary care.

So I think Pedro's story illustrates some of the more complex situations that we might find ourselves involved in. I'd like to take a step back and talk a little bit about some of the issues that June has already raised around some more routine procedures that you might identify with primary care, and we've already mentioned pap smears, mammograms, weights. I think it's really important to understand that people with disabilities historically really experience disparities in these areas. Healthcare Voices in Massachusetts identified 32% of people with disabilities had experienced barriers to health care, either around physical access, communication access or cost.

The Disability Policy Consortium in Massachusetts has identified several areas where people with disabilities do not experience the same health care that people without disabilities experience. Two of these key areas are in the clinical breast exam and in cervical cancer screening. People with disabilities often receive these procedures less. This increases their risk for late diagnosis of breast cancer and cervical cancer and can certainly result in poor outcomes and higher morbidity and mortality.

There are numerous examples that we could talk about in this arena, but the reality is that the availability of accessible medical equipment is an important part of providing accessible medical care. And healthcare providers have a responsibility to ensure that medical equipment is not a barrier to people with disabilities. Some of these equipment we've already spoken about, accessible height exam tables, wheelchair accessible scales, adjustable height radiologic equipment, portable floor, overhead track lifts, et cetera. Being weighed can be a really critically important event. It actually can influence medication dosages, certain tests and procedures are dependent upon an accurate weight. So we can actually really do harm to people if we're not able to have an accurate weight.

And a critical but often overlooked component of this whole area is adequate and ongoing training of staff, and this is really essentially. The equipment doesn't do you any good if people don't know how to use it. And I think it's important to encourage staff to ask the individual questions about how they want to be assisted and how they want to use the equipment because not every person uses mobility devices in the same way. Everyone has different physical capabilities, et cetera. And so it's not wrong, in fact, it should be encouraged to talk to the individual and to ask them how they can be assisted or how they want to be assisted if they want to be assisted.

Another key component of our care structure is our ability to be responsive, and we really build our teams around this need. We really feel it's valuable to not only be able to provide ongoing predictable care, but also to be able to be responsive when unexpected things come up. I'll just illustrate this with one example that happened in our practice just probably about a month ago. This was a new person to our practice. She was 65 years old. She had recently undergone a neurologic decline which resulted in her requiring a ventilator for respirator support. Her primary care, which was primarily carried out through an outpatient setting, felt at that time given her change in status that they were not able to meet her needs and so she transitioned to our practice.

Shortly after an extended hospital staff followed by a rehab stay she was in the community and her family called our office to say that her oxygen levels were low. The average primary care response in those situations might be to send her back to the hospital or have her at least come to the emergency room for evaluation. However, this woman really wanted to stay home. She was not in any distress. She had kind of had it with hospitalization and so she really did not want that.

Our nurse practitioner was able to go out to the home and make an urgent home visit. She was able to stabilize her status with suctioning and Ambu bag breathing and was able to consult with the physician over the phone for ongoing plan of care, coordinate with the respiratory company to obtain some additional supplies and equipment that could be used in the home to help this individual manage her respiratory status. Her caretakers, family, et cetera, were taught how to utilize this equipment. And we were able to coordinate with social services around accessing increased personal care at home.

So this is just one example but we have many examples where our ability to really just get out there and see people can really avoid emergency rooms and hospitalizations and we were able to avoid it in this situation. That was several weeks ago and she has not been back to the hospital since. So it was a successful strategy and I think it's empowering to people to be able to take charge and really manage their issues and not feel like they're reliant on the hospital at all times.

Another strategy that we have initiated is the designated inpatient unit, and that's pretty self-explanatory. We have a designated hospital unit where all of our folks go. It allows us to build relationships with staff. It allows us to have daily communication and good coordination of transitions. But one of the newest issues here that we are working on is the integration of personal care attendants into the hospital team. This is something that's been done informally for many years. Many of our folks do ask that their PCAs can come into the hospitals and provide some supportive care. Sometimes it works, sometimes it doesn't. It's been pretty ad hoc and pretty dependent on the unit and sometimes the individual nurse at the time.

However, we are working with our hospital to really formalize this process so the PCAs, when the consumer requests and wants it, can come into the hospital, be part of the primary care team, can actually provide services in the hospital. We think that this could really improve satisfaction with care in the hospital. It can reduce some strain on hospital resources. We're hoping that it will reduce lengths of stay and allow people to transition in and out of the hospital more smoothly and less traumatically.

And most importantly provide increased autonomy and independence to the individual to be able to have the same care that they receive at home in the hospital. Despite how well trained hospital staff is, there is no substitute really for the individualized care that a PCA provides under the direct supervision of the consumer. PCAs get to learn individually how people like to be positioned, how they like to transfer, how they like to be suctioned, et cetera, and there is really no substitute for that kind of individualized care structure. So we're very excited about that opportunity.

So just to summarize, yes, there are some problems. There are some challenges in primary care but I think there are also opportunities, and I think we've talked about a few approaches that we've taken to try to improve primary care and improve access to primary care. And just to quickly summarize, we've talked about a team approach an interdisciplinary team, 24/7 access by the primary care team and I think that's critical. We don't send that out to some anonymous call service, it's our team that takes those calls.

We have the capacity for home visits and transferring clinical decision-making into the home, meaningful consumer involvement in the care plan, design and development. And organizing hospital and specialty services in close collaboration with the primary care team and fully integrated, along with a fully integrated electronic medical record for communication and data support. And these are things that we are working on diligently as we speak.

So I think I'll just end there and I guess open it up to questions.

Operator: Ladies and gentlemen, if you wish to ask a question please press star then 0 on your phone. You will hear an acknowledgement tone. If you are using a speakerphone, please pick up the headset before pressing the number. Once again, if you have a question please press star then 0 at this time. If you wish to remove yourself from the queue, please press the pound key.

Chris Duff: Thank you, Barb, I appreciate your giving those instructions. And, Mary, and, June, thank you very much for your presentations. We have a couple questions that came in while you were speaking. First of all, Mary, how long were you working with the first person you were speaking about, I think it was Pedro? And the changes that came across, can you give us a bit of a sense of context? Misty Price was wondering about how the changes of getting back on top of his care, how long that took?

Mary Glover: Well, we've known him four to five years at this point, but many of the changes in terms of housing and that sort of thing was able to be accomplished in probably the first year or so. It actually was quite a complex process and I didn't go into a lot of detail about it, but he had been living in Puerto Rico, so we had to do a lot -- there was like a list of six or eight things that had to be accomplished in order to even get him on the waiting list for housing. So that was actually fairly complex. He had to get information from his landlord in Puerto Rico. He had to get [query] information from out of the country. We had to get income verification. We had to do reasonable accommodation support letters, et cetera, et cetera. And then that's just to get on the waiting list. So that took a year or two.

And the medical issues have really been settled for probably the last couple of years. He went through quite a long process with his tracheostomy issues and multiple laser procedures, et cetera, to try to overcome that issue. So that was kind of an ongoing thing over probably three or four years.

Chris Duff: Thank you, Mary. Lynne, I'd like to kind of pose that to you. In Mary's experience with Pedro, which is basically a lot of time upfront, a good year maybe two years, and then the person often stabilizes and needs less intervention. Is that a common experience?

Lynne Morishita: I think that's a very common experience, as long as the team hangs in there with the person and there's good oversight.

Chris Duff: Thank you. [Dennison Bryson Flemings] has a question for Mary again. How does the PCA get paid for these services they provide in the hospital?

Mary Glover: Well, that's an excellent question. Thank you for asking, because I forgot to mention that. This is one of the benefits of a global payment or capitated model of care is that we are able to be flexible with the benefits and we can really make those decisions that we think are in the best interest of the individual and perhaps even be cost effective in the long run. And so under a global payment system, we're able to approve services when people are hospitalized. Under a traditional system they can't be. So in the past when people had their PCAs come into the hospital, sometimes it was because they just wanted to help the individual and they didn't get paid or there were other arrangements made but it wasn't officially reimbursed.

Chris Duff: Thank you. And we have a question from Mary [Steinkamp]. She was wondering, Mary, did your unit have a hospice and palliative care program, and how do you integrate that with your team?

Mary Glover: Another very good question. We actually have focused on a palliative care approach because of the way the hospice benefit is formally structured. It really often means a transition to a hospice team as opposed to our team. And since so much of what our team does really is what hospice would do, the home visiting, the support, the social service support, behavioral health components, et cetera, we have kind of created a hospice light so to speak and we have a palliative care consultant within our team. And we also have relationships with hospice where we actually have contracted for sort of a la carte services. So if there is a certain component of hospice care that we feel our patient can benefit from that our team just isn't able to provide, we can actually access that particular benefit rather than needing to buy the whole hospice package if that's not what's needed.

Chris Duff: Thank you. Just thinking about it from the perspective of your participants or members, how nice to be able to bring that knowledge and competency by the people who that person already knows versus getting a whole different group of people coming in and providing some services, and that makes a lot of sense to me. Barb, do we have any questions on the phone lines at this point?

Operator: And our first question does come from Melissa Miller. Please go ahead.

Melissa Miller: Yes, I'm Mellissa Miller and I wanted to know how the physician gets reimbursed for the added time that's necessary to address all the psychosocial issues and the complex care needs of social and support services of disabled patients and added visits that may be necessary, 10 visits rather than the usual four per year, how doctors will be incented to spend the added time that's likely necessary for complex care?

Mary Glover: Well, again, I think it brings us back to the payment structure, the global payment or capitated structure where we're not reimbursed on a fee-for-service basis. So you're not locked into that you have to make X number of visits a day in order to bring in enough income to support the practice. We have the luxury and the great benefit of being able to really address people's needs individually. And if it's 10 visits a year, if it's two visits a year, if it's an hour long visit or if it's a 15-minute visit we can actually do what makes the most sense for that individual, and sometimes a longer visit actually ends up being more effective and more efficient in the long run.

But you have to take the long view of this, and I think that's what's hard sometimes for people and for insurances and for the people responsible for the financing, because it is an investment and it's an investment somewhat on faith that if you really invest the financing upfront into a really robust primary care system that you will in the long run reduce complications, reduce hospitalizations, reduce expensive modes of care. And invest it not just a [pay-let] but actually invest it in things that actually improve people's quality of life, primacy care, durable medical equipment so people can function more independently in the community, et cetera. So that's really the benefit of a global payment structure.

Chris Duff: I also think that's a question I hear from a lot of plans, and I wanted to share a few of the things that have worked and have not worked. An example of something hasn't worked in Minnesota, several years ago we established a plan where we worked with the clinics and we actually provided the clinics a $20 PMPM for all the members who were assigned to that clinic. That enabled us to get the contract with the clinic and that was great, but that never transferred down to the practicing physicians or nurse practitioners. So they still experienced the pressure in their daily schedule when one of our members would appear so they knew that took more time. So that PMPM to the clinic just didn't seem to work.

We then moved and we're beginning to work with actually purchasing time from physicians in their schedule. So we would purchase two two-hour blocks throughout the week where the physician would not be scheduled but be available to the care teams for consultation. That wasn't necessarily the timeliness that we wanted to the immediate response but it did give some dedicated time to problem solve with the care team. So that was effective.

Some other practices that I've heard have worked is paying a fairly large -- I've heard in the amount of $60, $70 PMPM, to physicians who then would carry a fairly large panel and would keep up to 20 hours of their time free every week to be able to respond. Another option is -- and (inaudible) this is done in a couple states where they actually share savings with the clinics at the end of the year as a result of reduced hospitalizations. So that's kind of an after the fact kind of a rewards, a promised reward incentive.

So what I'm trying to say here is that the key, that the best thing would be the team practice concept that Mary was able to put in place. Short of that, there is a variety of practices that have been used to varying degrees of success and you'll just need to be flexible and see what your priorities are within your practices, your working life.

Barb, do you have another question?

Operator: Yes, our next question comes from Mary Steinkamp. Please go ahead. Mary Steinkamp.

Mary Steinkamp: Actually my question was already asked. Thank you.

Operator: Okay, thank you. And again, if you have any questions press star 0. If your name has been collected you want to press star 1.

Chris Duff: Okay. Another question that came forward was do you use all levels of primary care practitioners, physicians that are practitioners, physician assistants? And if you do use different levels, how do you decide who to use when within your model and approach? Mary, could you [take a start] at that?

Mary Glover: Sure. So our primary care teams are generally led by either a nurse practitioner or physician assistant and there is no real distinction in our practice in terms of other than geography. Because of the home visiting component of our practice we really have to organize our teams somewhat geographically based to make it somewhat efficient. The RNs on our team are assigned to each -- each NPPA team has an RN assigned to their team. The RNs at this point in time do a lot of the initial assessments that are required by the state, and also to do some skilled nursing to reduce VNA use if that's possible, integrate that role into our care team, provide some care coordination support and some assistance with care plan development, et cetera. And our physicians are always available and are part of the team, very active members of the team. We meet regularly and have interdisciplinary care team rounds and our physicians are always available to see folks, to consult with us over the phone, et cetera.

The other members of our team, behavioral health, social service, PT/OT, et cetera, health outreach workers, are really kind of brought in on an as needed basis, probably more often than not. They're certainly part of our care team discussions, et cetera. They may not always be called into see people face-to-face depending on the issues that are being presented. So I don't know if that answers your question well enough.

Chris Duff: Thank you, Mary. And I have a question here for June, I think. How would you recommend setting up a waiting room that has room for wheelchairs? And the clinic this person works at people use wheelchairs and usually hanging out in the middle of the aisle and she'd like to have some ideas for change, and this was from Kristen Hauschmidt.

June Kailes: Yes, Chris, good question. I think that waiting room access should be part of the way we look at accessibility. If it's a small waiting room at least one space for wheelchair user so they don't feel like they're on display waiting in the middle of the room, if they could even get to the middle of the room. Attention to aisle width is also important, as is attention to reach ranges in terms of being able to reach public education material and brochures and that kind of thing. If it's a large practice with multiple rows of seating areas, then certainly more than one space should be created. And we also need to remember to also create bariatric seating for people who are extra large and don't fit into traditional waiting room areas. So good point. That should be part of our looking at accessibility.

Chris Duff: Kristen, also I believe in our second webinar series about the experience of people with disabilities and obtaining their healthcare services, we had a list of a variety of resources and I think one of those specifically addressed accessibility issues within a practice setting. So I would encourage you to go to that list.

Barb, do you have any other questions on line?

Operator: There are no more questions at this time. You may continue.

Chris Duff: Okay, great. Another question that we have received, and I think I will -- I think this is best for Mary. And I know, Mary, that the Massachusetts program is starting on January 1 and you're now opening for enrollment. The question that we received was that they are expecting to enroll thousands of members each month. How do they modify, how do you modify your model because they simply aren't able to conduct in-home assessments, in-home in-person assessments with that number of people every month. So how do you triage and prioritize to make sure that you are getting the attention to the people who are in most immediate need at the time?

Mary Glover: Well, that's an excellent question and we're grappling with that as we speak, Chris, because we actually went live October 1.

Chris Duff: Oh, congratulations.

Mary Glover: We have 1100 people enrolled in month one.

Chris Duff: Wow.

Mary Glover: Yes, and about that many coming in month two. So it obviously does make us kind of change our strategy in terms of how we approach at least this initial phase of the assessment process. And I think we have to look at the assessment as a process and not an event, and it actually has to take various forms. And so our initial outreach is really through our member services to do a phone outreach, a welcome call.

We have a clinical operations department centrally that is doing phone health risk screens and trying to do that stratification, trying to identify who has primary care engagement, who does not, who has the most complex issues, who might have a pressing immediate need, prioritize those folks for an in-person assessment. We are required to do a face-to-face as part of the assessment process on everyone, and so it's resulting in us having to really pull resources together from multiple areas within the organization and contracting out to do some of this initial outreach.

In our senior care options program we've been successful with like an enrollment nurse model in some areas where there is actually a designated nurse who really does the initial assessment, becomes very expert at it and then can do a handoff to the team identifying the priorities and the immediate issues that need to be addressed. Then the primary care team can kind of take it from there and start to go through the process with the individual. But it certainly does present logistical challenges and we weren't quite sure what to expect in terms of enrollment, but it is pretty robust. So we're looking for strategies on how to deal with that.

Chris Duff: I think that's a great way to end up. I think what we're really saying throughout this presentation, as well as all the webinars we've been doing, is this is all a work in progress and everyone needs to just simply step back and think about what will work in your context. We're just really trying to present what we've developed and some of the programs that have been out there in the past.

So I'm going to wrap it up at this point. We've reached the end of our time today. As I indicated at the beginning, we have five more webinars within the next two months. Everyone who has signed up for a previous webinar, as well as for this one, will receive notice of all future webinars. I would also like to say there were several questions received that we were not able to answer and we will make sure that they are answered offline by the presenters.

I would again like to thank the speakers for their presentation today and I would like to ask that all of the participants take a minute or two and go to the participant survey that we have in the presentation deck so that we can learn from your experience and get your ideas for the future. Please join us next week for the next presentation which will be on working as interdisciplinary care team to develop and individualize plan of care.

Thank you, everyone, and we appreciate your attending. Back to you, Barb.

Operator: Ladies and gentlemen, that does conclude your conference for today. Thank you for your participation and for using AT&T executive teleconference services. You may now disconnect.