Strategies for the Implementation of Disability-Competent Care
Disability-Competent Care; What Is It and Why Is It Important?
May 6th, 2015 - Transcript

Operator: Ladies and gentlemen, good afternoon. Thank you for standing by and welcome to the Strategies for the Implementation of Disability-Competent Care. At this time, all lines are in a listen-only mode. Later there will an opportunity for your questions. Now, if you do wish to ask a question or need operator assistance today, please press * followed by the 0 and an AT&T operator will assist you. Once again, for questions and operator assistance, please press * followed by the 0.

At this time, I would like to turn the conference over to our host, Mr. Chris Duff. Please go ahead.

Chris Duff: Thank you, Tom. On behalf of The Lewin Group, I would like to welcome you all to our webinar series, Strategies for the Implementation of Disability-Competent Care. As Tom stated, my name is Chris Duff, and I am a disability practice and policy consultant working with The Lewin Group. The Medicare and Medicaid Coordination Office with the Centers for Medicaid and Medicare Services has contracted with Lewin to develop technical assistance and actionable tools to support providers in their efforts to deliver more integrated coordinated care to Medicare and Medicaid enrollees.

First I would like to introduce you to our platform for this presentation. If your slides are not advancing, please push F5 on your computer keyboard. Please note the icons at the bottom of the screen. The second icon from the right allows you to download the slides for this presentation. The Q&A window is open next to your slides. Please enter any questions you may have regarding the material and we look forward to discussing them during the Q&A portion of the webinar.

This series will consist of eight webinars running on Wednesdays through this -- at this time through June 24. All the webinars will be recorded and available along with a PDF of the slides at the link in this slide.

In 2013, we published a Disability-Competent Care Self-Assessment Tool describing Disability-Competent Care in three pillars. First is individualized care coordination provided by an interdisciplinary team. Second is redesign primary care. And thirdly, flexible long-term services and support. We have since provided two webinar series focusing on specific components of Disability-Competent Care. These are all also available at the RIC website.

Our previous webinars were all more content-laden with little time available for discussion and Q&A. For this series, we are switching that around with only summary content being provided to allow for a discussion if the participants are interested. We would like to solicit your opinion on this series as well as past webinars and incremental resources. Please take the time to complete our survey at the end of the webinar and send us your ideas for future topics and content. Contact information will be listed at the end of the presentation.

Beyond the Q&A feature, throughout this webinar, you can submit questions and comments anytime. We will also be using an instant polling strategy to ask specific questions to help guide our presentation. To demonstrate this process, here is the first question. What type of organization are you working within? Are within the health plan? A AAA or aging disability research center or something along those lines? A consumer or advocacy organization? Or other? Please make your choice and submit. We'll all be able to see the tabulation of your answers in a little bit.

Today's webinar will be presented by Dr. Adam Burrows and myself. Dr. Burrows is currently Medical Director of the Upham's Corner PACE Program and a Senior Medical Director of the Senior Care Organization at the Commonwealth Care Alliance both in Boston, Massachusetts. He is an internist specializing in geriatrics and is a national leader in the development of provider-centered care delivery models focusing on adults with complex health needs.

Today we will present an overarching definition of disability and some better information to inform the needs for the Disability-Competent Care model. We will describe the shift in attitude and compare the traditional medical model of care with an approach that shares responsibility and accountability with the participants. We will follow that with an overview of the three pillars of the DCC model.

Before turning the presentation over to Adam, I wanted to review the results of the poll survey. I see the majority of you are with health plans. And this is -- I am pleased to see that it was interesting to note that in our previous webinar series, we tended to have more AAAs and state agencies and advocates. So I think why this is happening is I think the health plans are beginning to kind of see more and more people with disabilities and think, oh, how can we meet their needs, and so I am really glad that there is such strong attendance in this.

I just want to provide you some more context for the training. The Affordable Care Act, commonly known as Obamacare, provides opportunities to integrate care and support for persons with Medicaid and Medicare and to innovate and rapidly scale promising care models, targeting those with the greatest need, experience the poorest care, and incur the highest cost.

The definition of disability we are using throughout this webinar is this slide. Disability is the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, developmental, or some combination thereof. A disability may be present from birth or occur during a person's life. It is not based on a diagnosis but an impairment of function, important this be noted. This is a critical component to understand for the model addresses the functional limitation not just the medical condition.

Operator: Excuse me, Mr. Duff, I would like to note it's breaking up there at your location.

Chris Duff: Okay, let me see if I can move a little closer. Thank you very much. Living with a disability is a great deal more common than we may think, for many of the disabilities are hidden and many experience limited access to the community. As this slide represents, they commonly face other challenges beyond functional limitations. In terms of accessing healthcare, persons

with disabilities are more likely to face significant barriers to getting the care and services they need. I think that's especially evident in physician care and so on.

As the next slide shows, Medicare and Medicaid enrollees have significantly more services from nearly twice the emergency visits, increased in-patient and outpatient hospital services, and triple the prescription drug utilization compared to Medicare-only enrollees. While this slide shows slightly increased physician visits, this in actuality represents primarily specialty visits. Studies have shown over and over that reduced access and utilization of primary care and services occurs for dual-eligible enrollees.

This slide -- the next slide here looks solely at Medicare and Medicaid enrollees and demonstrates that the most costly 5% of the population represents 41% of the expenditures. While the least costly 5% of the population utilize less than 1% of the expenditures. I think what that shows is the key is looking at the membership that you have and being able to identify who are those people who need a different level of touch and support and care.

So before I turn this over to Dr. Burrows, I would like to ask one additional polling question that will hopefully guide part of the presentation here. The polling question is what pillar of the DCC model are you most directly involved with? Care coordination, primary care, long-term care services and supports, equal or none? So if you could submit your answer, Dr. Burrows will review it shortly.

Now, Dr. Burrows, I will hand it over to you. Dr. Burrows?

Adam Burrows: Thank you, Chris. And good afternoon. As Chris mentioned, I am an internist and a geriatrician and I work in two integrated care models. I work in the PACE Model Program of All-Inclusive Care for the Elderly, which is a staff model and I also worked as the Senior Medical Director for the Commonwealth Care Alliance's Senior Care Options Program and my role there is primarily bridging our health plan and our clinicians with primary care sites to form a fully collaborative partnership.

Next slide, please. So what are the problems that we are trying to address through integrated care? Previous slide, please. Let's just go back one. Thanks. So what are the challenges and the problems with our healthcare system as it's structured in trying to meet the needs of persons with disability?

Well, first, care is commonly reactive. In other words, care is punctuated, it's episodic, it's problem-based rather than preventive, preemptive and continuous. And when I say preventive, I am not just talking about screening mammography or flu shots or primary prevention, I am really talking about ongoing prevention in terms of persons with established illness and disability while we talk about tertiary or quaternary prevention. And much of this is because of the limitations of office-based practice.

Persons with disability and I'd first say we define that quite broadly, individuals who are unable to meet their ADL and IADL needs independently, whether it be by virtue of physical disability, chronic mental illness, aging and frailty, multi-morbid medical conditions all compounded by the

financial and social barriers to health. Persons with disability live with that condition continuously, so there is a mismatch between their experience and the way that we have designed and organized care, we have designed and organized care around the provider, really not around the patient or the consumer. The challenge of fully integrated care is to match care to the individual.

Care is also fragmented and it's fragmented in many different ways. Typically, persons with complex medical situations have a different provider for every organ system, for every problem on their problem list and there is very little coordination among different providers. Furthermore, it's cumbersome and burdensome for individuals with disability to access the care in that way. There is also fragmentation along and across the continuum of care. We have hospitalists, we have SNF-ists, we now have transitionalists, we have palliative care consultants and as an individual moves along the continuum of care, there is a change in provider at each stop along the way.

There is also fragmentation between disciplines and not just between medicine and nursing or between medicine and behavioral health or between medicine and rehabilitation disciplines, but perhaps even important for individuals with disability, there is fragmentation between the direct care workers who are often doing most of the hands-on care and supported individual disability and the so-called professionals in our interdisciplinary teams.

Care tends to be standardized and uniform. We have a tendency to want to bucket patients into a bucket where you get this package of care. What we really want to be asking is how can we titrate care in small increments so it is individualized and fully person-centric. So, these problems, the reactivity and episodic nature of care, the fragmented nature of care, the difficulty with accessing care, our difficulty in titrating and individualizing all this results in preventable, avoidable costs, misaligned incentives and often failure to access primary care.

In terms of misaligned incentives, and as you are well aware in future service medicine, every one tends to benefit from the churn, the referrals to specialists, the referrals to tests, the follow-up appointments in perpetuity, everyone benefits except for the patient because the system of care is structured and organized around the providers often, rather than around the individual. And again, just to restate the challenge for us, the challenge really is with the opportunity of fully integrated care how do we restructure it so that it really focuses around the individual with the disability?

Next slide. So when we talk about Disability-Competent Care, what do we mean, it's a person-centric model delivered by an interdisciplinary team that focuses on achieving and supporting maximum function, independence; to maintain health, wellness and life in the community that recognizes and treats each individual as a whole person, not as a diagnosis or condition; and structured to respond to the physical and clinical needs while considering also emotional, social, intellectual, and spiritual needs. So a very broad-based holistic definition of health that very much aligns with the World Health Organization's definition of health, not just an absence of illness and infirmity but overall well-being.

Next slide. So here we have a contrast between the traditional medical model and the DCC model. Obviously, the medical model focuses on medical problems, often broken down by different problems where we are really focused on the individual and the person. In the DCC approach what we want to do is to move barriers that creates problems with access and grant the consumer control over services options and the care plan itself. One of the ways of changing our thinking about that is to really think of the individual as the consumer.

One of the reasons that we have embraced consumer-directed personal care both in our PACE program and in our Senior Care Options program is that it really reorients and changes the mindset of the providers, of the professionals on the team. If the direct care is consumer-directed, then why not the entire care plan? And it shifts us from what we want to achieve with outcomes and the care plan to what the consumer wants to achieve. What are his or her goals? And they may not be medically-focused or -oriented, they may be much more broadly defined. So it shifts our focus and orientation. And therefore there are a lot of control checks, when we have to relinquish control, but what we learn is by doing it we actually gain more authority even in the long term.

Next slide. So these are the core values of the Disability-Competent Care model. As we talk about participant-centered, person-centered it delegates autonomy to the primary ethical principal respecting participant choice and the degree of risk, we will have a whole session on the dignity of risk. But really Disability-Competent Care means shifting from us worrying about what risks we can live with to what risks the consumer wants to live with. We tried to change from the institutional paradigm to a person-centric paradigm removing medical and institutional bias. And as Chris said, the three pillars of competency are relational care coordination, responsive primary care and flexible long term supports and services.

Next slide. By relational care coordination, what we really mean is developing relationship and of course it's important to have a good working relationship with one's primary care providers, but that's usually insufficient for persons with disability because the valued interactions again are intermittent and punctuated. For someone living with a disability in an ongoing continuous manner, he needs an ongoing and continuous relationship. He needs someone with boots on the ground in the community where participants live, where consumers live and in their home and familiar with their environment developing a relationship with them.

Next slide. Primary care needs to sort of change its orientation to become more responsive and the most important example of that is the same day sick response. If someone has an issue, he can't necessarily wait until the next available appointment. There needs to be a multiplicity of ways to address that problem that day. There needs to be a capacity for home resident. There needs to be transportation available if necessary to transport an individual to access care. There must be urgent care capacity. And all of that must be done with a sensitivity and awareness of the disability that the individual is living with and the barriers to care that must be overcome. Next slide.

Finally, flexibility and long-term supports and services. Again, as I spoke about earlier, we need to move from sort of a bucket mentality to an individualized approach where services are titrated to meet the needs of the individual that where they can be modified with any change in status,

where they truly become flexible to meet the changing and ongoing needs of the individual. Next slide.

So, this diagram sort of illustrates this notion of titrating the intensity of care to the need of the individual and even though here we have bucketed into high-care, medium-care needs, and low-care needs, I like to think more of it as a continuous rather than a bucketed approach so that you can change the care and deliver, change the supports and services as one's needs changes. Next slide.

So at this time, I'd turn it back to Chris and I hope we will have time for the questions at the end.

Chris Duff: [Jesse] would you actually go back to the last slide? I really like Adam's point on that last slide with the inverted triangles. I think this slide does kind of imply that we put someone in a bucket and that's where they stay. And I think it is an -- however the model is applied there needs to be a flexibility of what's going on with Sally today. So today, she may have high needs because she is in a serious episode, so it's been through a UTI, but tomorrow she may be -- not tomorrow, next week she may be just fine, maybe under the low-care needs because she is totally on her own. So I think a clarification there is a really a good one -- a helpful one.

So just to add, you put up the third slide, I think it would be good third polling question. The last polling question, it was interesting because the majority of people were care coordinators and now this polling question is, when considering your organization, which is the pillars, that Dr. Burrows described, do you think presents the great opportunity for improvement? The participant-centric care coordination, the primary care, flexible LTF, all the above or none? I would be interested in participants' response.

I mentioned earlier on and there was a slide in this packet here that talked about the de-cap tool. There is a reference to that at the end. I don't know that we need to go over the slide again, but what that tool does is, it basically breaks down all that Dr. Burrows presented in far greater detail and asks you -- kind of takes you through a whole process of looking at your own organization, your own vision, capacity and capability. It then kind of kicks it out into where the opportunity is and then gets you kind of a strategy for how do you prioritize those opportunities, what are like low-hanging fruits and what are things that are going to be really important, but are going to take a year or two to be able to get to full implementation. And it's really kind of a whole QI process and I think the tool is a good starting point for really most any organization that is beginning serve this population in significant numbers.

So, at this point, I think we can open it up to questions, so if the operator could come back on, I'd appreciate it.

Operator: Thank you. Ladies and gentlemen, if you wish to ask a question, please press * followed by the 0 and an AT&T operator will assist you and give you further instructions. Once again, for questions, please press * 0 at this time.

Chris Duff: (Technical difficulty) we get some questions in, I have a question or two that I am going to ask Dr. Burrows. How does care coordination for a person with a disability vary from care coordination for other population?

Adam Burrows: Well, I think for other populations they may have episodic care coordination needs. They have episodic illness and they may need some support in addressing that issue. I think the most important concept is that persons with disability are living with that continuously. So the person charged with care coordination has to establish, as I talked about, a relationship with the individual, continuous over time. I would also argue that that care coordination really cannot be provided remotely, exclusively remotely, telephonic or office-based, it really needs to be based on an awareness of the individual's living environment, individual's social environment, the financial and social barriers to help that individual is living with on a day-to-day basis.

So I think really two things distinguish it perhaps, one is its ongoing continuous nature and building that relational care coordination and also the greater complexity which requires a better understanding and familiarity with what the living experience is of that individual.

Chris Duff: Thank you. I appreciate that. We received a call or a question from [Cathy Kaufman]. She said, I don't think anyone on the line disagrees with the strategy but tell me and this is what I hear from plans across the country. Tell me how to engage the physician practice model, episodic care coordination? In other words, how do plans get their providers especially on the primary care side to be able to implement this model without actually overwhelming them with the needs and expectations?

Adam Burrows: We're going to do about a whole session to primary care. I will say this at this point and this is a point I've made before and will continue to make is that plans have to start to think of themselves as providers if they are going to engage with these populations and these individuals and it needs to be the plans as providers that need to carry a lot of his competency to the primary care practice.

I don't really think that we can fully expect primary care practices to transform themselves overnight to be able to accommodate persons with disability the way that we would ideally like them to. They have constraints themselves, but if the plan is assuming responsible for the individual with disability, the plan themselves have to assume responsibility for that competency, but plenty of clinicians on the ground in their homes are carrying that to the practices.

In other words, the ownership of it really has to do with the plan thinking as a provider.

Chris Duff: And, you know there is a variety of strategy that has been used across the country. I think we've actually asked Adam in the future webinar here to talk about some of those approaches, because they really -- you need to assess your -- where your members are, what practices are working well. One question we have is, when I did a comparable program in Minnesota is -- could we find a physician champion in the practice. If we find a physician champion he or she was really able to kind of get that practice to begin thinking and functioning a little differently. So there is no textbook or answer to that question. I think this only need to work with and as Adam said, the plan needs to own that. And then, support that by providing the

plan obviously with data and adequate reimbursement, which is of course a whole another issue. Are there any questions online?

Operator: Those queued up on the phone lines I'll give another quick reminder. For questions, please press * 0.

Chris Duff: Okay. Jesse, can you put up the poll results from the last question? So it's interesting, a majority of people on this call, the pillar they most worked with was care coordination. But really everyone says, it's very interesting, but people are overwhelmingly saying that it's all the above that we looked at. And I think that I am really pleased to hear that, because working in isolation as we all know doesn't get the system changes that not only we know what is needed and our regulators are expecting, but that our members desperately need, because these are usually the people who are not getting the care they need, when they need it, and how they need it.

Another question I have heard is, I am still confused about what is considered a disability, for example, are those of us with poor eyesight disabled? Let me take a shot at that and then Dr. Burrows, I'd be interested in your response. I think I would encourage you to stop thinking about it as disability and an individual as disability and instead think about, are they functionally impaired. If they can't see, to be around in the community, they are disabled by poor eyesight. If they need to wear glasses, but with glasses they can read 12 point, they are probably aren't functionally impaired. So I think what this medicalization has done over the years is people tend to look at disability in terms of diagnoses and this whole model that I am looking disability in terms of function and how can we support these people to function in a community setting for lives that they want. Dr. Burrows, how would you answer that question?

Adam Burrows: Well, the way I think about it as a geriatrician, I think about one's ability to independently perform ADLs, activities of daily living, basic ADLs and IADLs, those instrumental activities daily living that one needs to do in addition to basic ADL to survive out in the world.

And then, through assessment determine how one is doing with each of those basic ADLs and each of those IADLs, and then determine what are the impairments, what are the obstacles and barriers that may cause one not to be able to function independently in a particular domain, what can we do to improve function so that one can be as independent as possible, when someone is unable to achieve independence, what long-term support and services could be put in place to make sure those ADL and IADLs needs are met. And my experience is in the population I serve, it's rarely one impairment contributing to an ADL or a IADL disability. It's usually multiple impairments across cognitive domains, physical domains, social and behavioral domains which is why in addressing them, you need to bring the inter-disciplinary team to bear on both including independents and supporting ADL needs when they cannot be met.

And as I talked about before, long-term supports and services need to be flexible. So, one's level of independence and one's need for support changes over time, so there needs to be both continuous assessment, continuous engagement with the individual to know if there's been a change in status and a change in needs as well as a flexibility to respond to it, so that one can

remain living in the least restricted site possible, at home and the community ideally having all ADL and IADL needs met.

Chris Duff: Is a question from (technical difficulty) who I happen to know is from Colorado and they have an interesting model of managed care. The Disability-Competent Care model still seems to imply medicalized care, done to persons of disability by professionals rather than a balanced approach to treating, empowering, supporting, self-care, breaking dependence and non-accessible and non- Disability-Competent Care providers. Adam, do you want to take a shot at that first and then I will go ahead it too.

Adam Burrows: Sure. I was hoping you would take the first crack, but I think our conception of Disability-Competent Care, the DCC model, is trying to move us away from an overly medicalized and overly professionalized model. I think there is a recognition that in the approach we're endorsing that we want to change the locus of controls to the individual, so the individual controls resources, controls direct care and hopefully by extension more aspects of their care. But there are also there is a recognition that that individual needs to engage with the larger healthcare delivery system in order to address medical problems and other issues. And so, how do we bridge those two, how do we bridge the experience of the individual granting control to the individual, creating a person-centered approach to care, how do we bridge that with the healthcare world around us. And how do we influence the healthcare delivery world and how it has been structured to be responsive to that and to accommodate that.

Chris Duff: I like that approach. Your comments make total sense to me. We are transitioning the -- and it's not just the care and service and supports for the disability that is kind of across the healthcare continuum. And I think in this world in particular, the problem that we are dealing with now is the dollars have come out of medical dollars. And so, now we're trying to use medical dollars and we are throwing in and Colorado especially is an interesting model, like just throwing in a lot of social dollars and community support dollars and so on. But historically, it's been medical dollars. So we are trying to -- you need to use some of the language in the medical world in order to access some of those dollars and to get those providers involved, but we need to kind of translate that to more independence. And I think your language was self-care breaking down dependence.

One approach I know that we talked about with you in particular, Gary, is training. The training that could be done for providers around disability competency and it's not so much about how to deliver this that we count, it's really more about mindset and how do you look at it and how do you elicit from the individual what is important for them. And that's clearly something that needs to be done. But the question is I don't know that we can start there. We need to keep our eyes on it, but it will take some time to get there. So push back -- your question, if you have anything more you want to say on that?

Then there is another question from [Mary Martin] who I believe is in Minnesota. Her question is, health plans don't usually fund LTSS and that varies across the country. I think some -- there's some dual plans that do incorporate long-term services and support; some dual plans don't and it really boils down to the state. But I think the majority of them don't incorporate it or they do incorporate, they will incorporate in portion, like the Massachusetts, they do not -- the under 65

do not incorporate PCA. So the question then becomes to help plan, don't fund LTSS. How do we suggest that they better utilize them? How do they influence the support that is needed for the person to maximize their function and maximize their life that they want to live it and minimize their avoidable episodes of illness, such as breakdown and so on? And I think that that's a tough thing. I think ultimately that boils down to the relationship issue.

And so, I would suggest with any plan, you need to partner with whoever is responsible for that. I know in Massachusetts they contract with centers for independent living to do that. But then the issue becomes and maybe Adam you can talk about this in Massachusetts a little in a minute, but -- in some states, local counties do it. And in which case, the plan needs to develop good relationships with the counties, so they can call county A and say, I got Sally here, she is coming out of the hospital, she can go right back home, but she would need to increase your PCA services from 4 hours a day to 12 hours a day for two weeks or else she is going to end up in a nursing home.

Well, that needs to be done, obviously pretty quickly and that can only happen with a relationship with the entity who is responsible for that service. So I think all I can do is suggest to keep to build -- and keep those relationships with those entities who do have the capacity to respond and respond to LTSS services.

Adam Burrows: Yes. I agree, I mean, as we acknowledge that the most critical element in the health and well being of an individual with disability is his or her long-term supports and services. And that health outcomes and healthy utilizations and health costs are dependent most upon the success of those long-term supports and services. We cannot disengage with them whether we are responsible for their costs or not. We are obliged to engage with it. We're obliged to engage with it in a way that recognizes consumer direction and control if that exists. But nonetheless, we must engage with it. Otherwise, we will never be able to address the social and functional determinants of health. Ideally it's fully integrated and when I think about integrated care, I am thinking about fully integrated care with long-term supports and services included. But if there are situations where that doesn't exist, it just imposes up on the health plan an additional responsibility to develop those relationships and become fully engaged with that world.

Chris Duff: Again, it's back to the question from Gary, it's about process. I mean, we are in an evolution that's in process. Dr. Burrows, can you -- I don't know how familiar you are with the One Care Programs in Massachusetts, but how are they bridging that gap between the external entities who are doing LTSS and the care team that are within these plans?

Adam Burrows: I can state more about the Senior Care Options program than about One Care because I am more integrally involved with that.

Chris Duff: Yes.

Adam Burrows: In Senior Care Options sort of the vehicle for bridging that is someone that we call a geriatric support service coordinator who is our link to the aging service access points the area agency on aging world. So that individual functions as a linchpin between our world and theirs. Similar way in the One Care Program whether it's -- with whatever agency we are doing

that, we are establishing that relationship. And that's one of the interfaces that we have to address where we have to have a mutually respectful relationship to understand that the orientation maybe slightly different between them and us, but nonetheless we'll have to work together to develop engagement collaboration and work together on behalf of the individual, serving the individuals' needs and goals.

Chris Duff: Great. Other questions that we've gotten online here is and I think this is probably [inaudible]. When working with a person with disability, what's expected of the care team, however it's formulated in terms of accommodations? I mean, there is two answers to that. One is a legal answer, which is obviously to meet the ADA and other requirements. But really what I would encourage to step back and encourage you to not so much look at the legal implications, even though they are certainly very important, but to say what does this person need and how can we get it accomplished?

If the barrier to getting the person back home is a ramp, then you have to figure how to get the ramp. If there isn't funds to pay for the ramp, then you need to step back and think, oh, is this person involved in a church, could some volunteers from the church build the ramp for the house. I mean that's the kind of mindset that I think all of these programs are being challenged to kind of step back to is what does this person need and how can we meet that need? How can we accommodate that need and respond to it based upon the prioritization of the individuals? And so, I think what's happened in the past is we look at, well, what are they qualified for, what are the benefits that they -- we could know with this diagnosis and with ADL dependencies, they are qualified for this. Someone with an ADL dependency of 7 may qualify for 6.3 hours of PCA, but a very functional home living situation may only need 3 hours.

But another person with the identical score may have a very problematical situation unreliable care giving and so on, in which case they may need more. And I think what this population and all populations, the bit that they are asking for is the engagement to discuss what I need and how I can get that need in that. And I think that's why the first step is getting to know the individual and the context in which they function. And in terms of who they are, that will then get you to looking at how can we best accommodate their needs.

Tom, were there any questions before I begin to wrap this up?

Operator: We do have one queued up and it's from the line of [Victoria Haltom]. Please go ahead.

Victoria Haltom: Hi. This is Victoria Haltom, I'm from Michigan and I am a social worker. In Michigan, we are linking Medicare and Medicaid together under a program called Michigan Health Link, very similar to PACE. But if you were in PACE, you can't be in Michigan Health Link, obviously. My concern is, is that each person is going to be assigned a case coordinator and right now we don't have any outlets for an ombudsman or any way to straighten out problems with the program. And the other thing is we have not been told how many people will be on a case. But if it's like our Department of Human Services, they have an average of 400 people. And I am very concerned about that it's so comprehensive that it sounds like a miracle of all the things that they are going to be able to do under this new program. And I have worked

with PACE too. So I think it's a great idea coordinating all this. I just really am concerned about how it actually comes off in practice.

Chris Duff: That, ultimately, is the key question. Adam, do you want to take a shot at some of your experiences and I can talk a bit about some of the things I think.

Adam Burrows: Well, since you referenced PACE, I will start with my PACE experience. As you probably know, the unit of care management, the unit of care coordination in PACE is the team itself. There is no individual charged with that particular function. So, in this model you describe where, I guess, a care coordinator I think you have mentioned might have a very large case law, if I understand your question correctly.

The question then becomes with whom is that case coordinator working, what is the team that the health plan is assembling to actually deliver care. And the hope is that individual won't be working in isolation. You really have to build teams to do the multidimensional continuous assessment and to deliver the interdisciplinary care and, as you are talking about a model where primary care is remote, then bridging to the primary care site and carrying some of that disability competency, owning it and bringing it to the primary care site. So yes, I would be concerned if the model is expecting a lone care coordinator to carry a caseload of 400 and manage everything. There has to be a team behind that and interdisciplinary and team care.

Victoria Haltom: Thank you.

Chris Duff: I was just talking with a plan this morning, they were saying that in that state, they are expected to do an assessment with the physician for every member in their group plan every six months. That works when you have -- they have 300 members at this point -- this low enrollment. But when you get to large numbers, that's not going to work.

In California, I know that the plan has a tool, they use a tool to begin screening who do we need to call first. If you are getting enrollment of 500, 1,000, 5,000 in a month, you just don't have the staff. So you got to fix some help to figure out whoever is going to connect with first. Ultimately, it becomes a question of -- and I like this thing of another plan that I have heard, it becomes a question of what does this member need and how can you be responsive. What this one plan came up with, though it's been a little problematic to implement, is that at the end of the initial assessment, they engage with the person. So what do you want? How do you want -- what do you want of us and how much interaction do you want with us? They have found that the members are often among the best indicators of what they want. Some people with very complex needs that are maybe even on a ventilator, they just want you to get out of their way and they will call you if they need something. And they may be doing just fine. Whereas someone may be a para, living with paraplegia and have some other problems going on, they may need a lot to handle in coaching.

So you need to be able to, a, have that discussion and then, b, have a way to link Sally with the level of care coordination that she needs up to the staffing that's available. This organization I am thinking of basically found that 40% of their members were in the what they called you call us when you need us category and that worked very well. Then there is a high need category who

just needs regular phone contact and maybe a monthly visit. And then there is in between and then there is an urgent need, that's what Dr. Burrows was talking about earlier. There is episode of illness coming up. You need to make sure that you have staff available that day to respond to that episode or else the person is going to in hospital or have significant issues.

So I think some plans are hoping to do just medication reviews or history of hospitalizations and that kind of thing. Those really -- diagnoses, those are fairly uni-dimensional and don't really get at to the kind of care coordination, Sally, the individual -- that's my euphemism for an individual -- that Sally may need. And so I think the real art is the organization setting up the capacity to engage with the member and to be flexible enough to respond to episodes that may occur in that member's life.

So, with that, I think there's no other questions that were submitted online. So I am going to begin moving this -- and closing this. We'd very much like to thank you and appreciate your taking this hour to participate in the webinar here. As I said, the webinar will be posted online shortly. We hope you will consider the other webinars that are coming up in future weeks.

I did want to point out that we've had a schedule chain, so those of you who have signed up for the entire webinar series, the session titled Integrating Behavioral Health Competency within Disability-Competent Care team will be in week three, so that will be held on Wednesday, May 20 and the Dignity of Risk webinar will be -- we are still trying to finalize that day that will be in either June 3 or June 10. So if you are particularly interested in Behavioral Health and Primary Care Integration, please note that that will be two weeks from today.

Next week we are going to be focusing on Understanding the Lived Experience of Disability and the presenters will be June Isaacson Kailes who has done a lot of training for 20-plus years and a gentleman by the name of Dennis Heaphy who is one of the leaders in the Disability Advocacy Community in Massachusetts that's really guided the development of the One Care Program, which was the first demo that got up and running in the country for those under 65. So the two of them will present and they will talk about their own experiences and go from there.

So appreciate your time at the end of this for taking a minute to complete the survey that, if it is not up now, there will be a link to it shortly, there it is. And I also want to thank Dr. Burrows for his presentation today. You will be hearing from him two further times. I think his on-the-street experience both through PACE as well as Commonwealth Care Alliance is phenomenal. And I think he brings a breadth of way to step back and really look at how you would begin going at this because we are talking systems change and you know with the best ideas and the best intentions it evolves.

So, thank you, Dr. Burrows, and thanks everyone else and we look forward to future weeks.

Operator: Ladies and gentlemen, that does conclude our conference for today. We thank you for your participation and using the AT&T Executive TeleConference. You may now disconnect.