

**Strategies for the Implementation of Disability-Competent Care**  
**Approaches to Creating a Disability-Competent Primary Care Network**  
**May 27<sup>th</sup>, 2015 - Transcript**

Brad: Ladies and gentlemen, thank you for standing by, and welcome to the Strategies for the Implementation of 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. If you should require assistance on the call or if you'd like to ask a question, please press \* and then 0.

I'd now like to turn the call over to our host, Mr. Chris Duff. Please go ahead, sir.

Chris Duff: On behalf of the Lewin Group, I would like to welcome you to the fourth 2015 webinar roundtable session on approaches to creating a disability-competent primary care network. As Brad stated, my name is Chris Duff. I'm a disability practice and policy consultant working with the Lewin Group. The Medicare and Medicaid coordination offices at the Center 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/Medicaid enrollees.

First, I'd like to introduce you to our platform for this presentation. As Brad stated, if your slides are not advancing please push F5 on your computer keyboard. Also, 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. Feel free to enter any questions you may have regarding material, and we look forward to discussing them during the Q&A portion of the presentation.

Beyond the Q&A features to which you can submit questions and comments at any time, we will be using instant polling to ask specific questions to help guide our presentation. To demonstrate the process, here's the first question.

What working experience do you bring to this webinar? Please choose all that apply. After a minute or so, we'll go back and look at the -- review the results.

This series consists of eight webinars running on Wednesdays at this time to June 24th. All webinars will be recorded and are available along with a PDF of the slides at this link, [www.resourcesforintegratedcare.com](http://www.resourcesforintegratedcare.com).

In 2013, we published a comprehensive disability care self-assessment tool describing disability-competent care in three pillars, individualized care coordination provided by an interdisciplinary team, redesigned primary care delivery, and flexible long-term services and supports.

This is our third webinar series focused on components of disability-competent care. Resources from past webinar series and this one are available on the website I mentioned before.

Our previous webinar series were all more content-laden with little time available for questions and discussion. For this series, we're switching that around with only summary content being provided to allow for more discussion. We would like to solicit your opinion on this series as well as past webinars and supplemental resources. Please take the time to complete our survey at the end of this webinar and send us your ideas for future topics and content. Contact information is listed at the end of this presentation.

At this point, I'd like to go back and review the results of the first polling question. [Brendan], can you put the first polling question results up? So, I see the vast majority of you have worked within health plans. I am glad to see there's a handful of you who have been actually direct providers. And then, there's the coordinators. We have here a diversity of experiences. This presentation really is, if anything, tailored toward the health plan perspective. So, this kind of fits well with what we expected here.

Slide 4, here, Dr. Adam Burrows and June Kailes will return today as our presenters. Dr. Burrows is currently Medical Director of the Upham's Corner PACE program and Senior Medical Director at the Senior Care Organization of Commonwealth Care Alliance, both of which are in Boston. He's an internist specializing in geriatrics and is a national leader in the development of provider-centered primary care models focusing on adults with complex health needs.

June has been a presenter in all of our webinar series and is one of the authors of the disability competent care assessment tool. She brings over 30 years as a disability educator and policy advocate. She has consulted with health plans and health providers across the country helping them understand the needs of their members with disability and strategies to better communicate with them and meet their needs. Dr. Burrows will be the primary presenter of the content. June Kailes will bring her perspective to the discussion of disability competency.

Today's webinar is going to focus on primary care, specifically building and supporting a disability-competent primary care network. In previous webinars this year and previous years, we have presented information about the delivery of primary care. And we have heard it is one of the most challenging aspects of delivering disability-competent care.

The traditional model, which debatably works well for many of us, has not been prepared to adequately address the needs of persons living with disabilities or functional limitation. Today, Dr. Burrows will present different models for structuring and supporting primary care networks with required education, communication, information, and aligned incentives.

As you will hear, it is imperative that providers and plans look beyond just physical health of the participants to see that other needs are met in order to establish and maintain overall health.

To provide the presenters with additional context, I would like to ask an additional polling question. How well do you believe your participants, whether they're clients, patients, are served by primary care in your community? Do you believe it's very well served, adequately served, poorly, or not at all? Not at all can be due to availability, poor access, network limitations, and so on. So, if you would respond to that, I would appreciate it.

Dr. Burrows will review the results in a few minutes here. But at this point, I will turn it over to him and June for their presentations.

Adam Burrows: Thank you, Chris, and good afternoon. It's a pleasure to be with you today. As we discussed at the introductory webinar, there are barriers that we encounter all the time to effective primary care. In particular, for those with disabilities. Slide 6 outlines many of those barriers. Can you advance to the next slide, please?

This is the main message I want to communicate to you today that in delivering fully integrated care to vulnerable population, you, as health plans, need to think and act like providers, which may represent a shift in how you do things. But this statement is really grounded in my experience as a PACE physician and medical director for 19 years, and my experience with the Commonwealth Care Alliance as the medical director for its Senior Care Options program, and in the experience of Commonwealth Care Alliance in operating OneCare, its health plan for younger dually-eligible beneficiaries.

What I'm going to present to you is not abstract concepts. It's not something that was drawn up in a board room. It's really grounded in my experience and our experience through trial and error over the past one to two decades.

It's important for you to understand that as health plans assuming this responsibility, you are accountable for the totality of care delivery for its competency, in particular as we'll talk about today, disability competency, for its quality, for its costs. The important message here is there really is no such thing as care coordination without actual care delivery. That for this population, health plans need to assume the identity of providers, the mindset of providers, and truly contributing to the improvement and transformation of care delivery for populations that you'll be serving. Next slide, please.

I'm going to talk about three general approaches to primary care delivery. A staff model approach, a collaborative model, and a delegated model. And ideally as a health plan, you'll develop the capacity for all three so that you have a range of options to apply. At Commonwealth Care Alliance, both our Senior Care Options and OneCare program, we have developed the capacity for each of these. I'll spend the most time talking about the collaborative model, because I actually think that has the most relevance as you develop your own approaches. Next slide, please.

So, staff model is perhaps the simplest. In a staff model, the health plan itself employs the primary care providers and builds specialized practices for vulnerable populations. That population can be persons with significant physical disability, person with significant and persistent mental illness, or physically and cognitively disabled older adults. A health plan can develop a specialized practice for each or a practice that addresses all of them.

The plan constitutes a full interdisciplinary team, which typically would include the following -- primary care, nursing, occupational therapy and physical therapy, social work, behavioral health. But you may need to add other disciplines. This list is by no means exhaustive. You might need

to add wound care specialists, respiratory care therapists, DME specialists, pain specialists, palliative care consultants. Over time, you might identify more needs that you need to bring into the staff model. As we'll talk about in the collaborative model, these are the same capacities that you will need to develop in a collaborative model. Next slide, please.

As I said, I'm going to spend the most time talking about the collaborative model, in which you, as a health plan, develop clinical capacity, provider care coordination care management capacity and partner with primary care sites and primary care providers.

So, in this model, the plan develops specialized clinical groups. These groups do not include the primary care physician or provider. That would come from the primary care site, but it includes nurse practitioners and physicians assistants who can deliver home-based primary care in collaboration with office-based practices, registered nurses, LPNs, medical assistants, community health outreach workers, again, occupational therapy and physical therapy, social workers, and behavioral health workers. And as I mentioned earlier for the staff model, this list is not exhaustive, and you may find you need to add others. For example, respiratory therapists, DME specialists, palliative care consultants, and so forth.

The key element here is that this constituted clinical group develops a collaborative relationship with primary care practices so that you're working together collaboratively on behalf of the members that you're serving, the vulnerable patients and populations that you're serving. In that, you are capable of providing ongoing assessment information that I call the input or the (inaudible) limb of care.

And in collaboration with the primary care provider, you are then able to go out and implement the care plan, the output. You offer capacity for same-day sick encounters in the home as well as for triage functions. Identifying a problem, communicating with the primary care practice, determining what is the appropriate site of care, home, clinic, urgent care, emergency room. And importantly you are delivering not just care management and care coordination, but you are also offering care delivery. This is a critical value that you're able to bring to the primary care provider operating in isolation out of an office-based practice.

The last one we were just talking about, assessment and care planning, two of the key functions that we engage in. I just want to remind people that true interdisciplinary care plans are dependent upon comprehensive multidimensional assessments. It's through that assessment that we can develop person-centered individualized comprehensive individual -- interdisciplinary care plans. Care planning without comprehensive assessment is like one hand clapping. You really need both and you need to join them together. And by developing the clinical capacity in your clinical groups, you are able to do the assessment, work with the primary care provider in developing a care plan. Next slide.

So, the focus of this webinar series is really disability competency. And the question is, in this collaboration, where does that competency reside? And I would argue that you, as the health plans, need to own disability competency. You need to accept responsibility for that. Yes, ideally, primary care practices will become more disability competent. Often they come to the care of patients with that competency already. But we can never assume that. And it's very

difficult to actually reach all the primary care practices with which you collaborate to develop and nurture that competency.

But the best way to really bring to that collaboration that competency is for the health plan to own it and to bring that capacity to the primary care practice through examples. So, that can begin with appreciation and an understanding of the social disparities that dually-eligible beneficiaries confront. So, disability may be a consequence of a medical condition, chronic medical condition, a physical condition. It may be a result or a product of mental illness or behavioral health condition. But often, it's just a consequence of social circumstances. Remember, by definition, all that we serve are indigent. They're eligible for Medicaid. And they confront all the ravages of poverty.

Most commonly, our most vulnerable participants, the ones we struggle with most are disabled by a combination of all medical conditions, behavioral health conditions, and the social determinants of health. The social circumstances in which they live. And you're the ones who really need to develop specialized knowledge around these conditions and bring that specialized knowledge to the collaboration with the primary care provider. And our experience has been that over time, those primary care providers become more knowledgeable through your experience and through what you bring to the collaboration. You educate the PCP. Next slide, please.

So again, in this collaborative model, you as the health plan, through your clinical and care management and care coordination capacity develop specialized expertise and comfort in working with persons living with disability, whatever that disability may be. You develop specialized expertise in addressing the social determinants of health.

And again, you individualize care. There's a term that's popular these days, population health. I'm still not exactly sure what it means, but what we're doing in these integrated care models is providing highly individualized care. We may begin by stratifying into broad categories, but within those categories, within the individualized care based on unique circumstances of each individual. And we have the capacity, the ability to calibrate each care plan in very fine increments and adjust those as needed. And that's what you're able to bring to the collaborative care.

Through demonstrating -- if you can go back one slide. Just to the last point, it's through your ownership of disability competency that you prove your value to the primary care practice by delivering on concrete outcomes. What are some examples of that? Well, exterminating vermin from the house, reducing polypharmacy, and improving medication adherence, addressing housing needs, implementing environmental modifications and adaptive equipment, coordinating transportation and escorts, supporting consumer-directed personal care, perhaps finding a surrogate to help a consumer direct care or providing teaching to a consumer and PCA together. These are the added value, the value-add, that you bring at each interaction with primary care providers. Next slide, please.

So, what're the key elements in developing a collaborative model and engaging a primary care practice? Well, it always starts at the top that you need to align your vision and mission with that of the primary care practice with which you're collaborating. And you need to get buy-in from

them that they want to improve care for these populations and they see you as an asset to help them do that. It's always worth taking time to build that alignment of vision and mission.

You may need to provide financing to support specialized access. So, for example, you may want to pay for extended visits so that primary care physicians can spend the time that they need with particularly vulnerable and disabled patients. You may want to pay for them to have time to meet with your care coordinator and have a mini team meeting. These are valuable sessions in delivering care and building collaboration that you might need to create a financing arrangement to support it. And of course, you may also want to enter into risk sharing arrangements as well so that there's financial buy-in and financial reward for primary care practices that support your goals.

It's very critical that you establish what I would call the terms of engagements that are the mutual expectations of the primary care practice and of you. What can the primary care practice expect of you? What can you deliver? And in doing this, it's critical that you're able to describe in granular detail, all which you are able to offer. Care coordination, care management are abstract concepts and require definition so the primary care practice understands what you're doing and what you're able to bring to the collaboration.

So, for example, you may need to outline a menu of options and roles and responsibilities for each member of your care team. For example, we are able to do point of contact INR testing in the home. We are able to obtain urine samples and start antibiotics empirically. We can adjust insulin. And all of the other care coordination responsibilities that you assume. So, in building these terms of engagement, building the collaboration, it's important that you outline, again, in granular detail, what you're able to offer.

And it may be that one primary care site may choose to accept certain things that you offer where others may want to hold that responsibility themselves. So, you have to be flexible enough to adapt your capacity to each primary care site.

The next piece is communication. How will you communicate? How will you communicate on an urgent basis? So, you identify an urgent problem. You need the primary care practice to know. They identify a problem. They want your assistance in addressing it. How will you communicate on an urgent basis? How will you communicate on a routine basis? How will you provide them with ongoing support assessment information so that they can factor that in to their primary care management and medical care out of the clinic? Will you use electronic health records? Will you have access to that electronic health record? What other mechanisms do they prefer? And again, you may need to adapt each primary care site.

Another key element is what I'll call an account manager, your basic business representative with that practice. The lead point of contact with leadership there. But you also need what I call an operational contact. This is often a nurse-to-nurse relationship. Most primary care practices have some nurse coordinator, nurse manager, and it's important to establish that day-to-day operational contact and collaboration with that individual in that practice. Next slide, please.

So, you've established the terms of engagement. You've established the collaboration. You've established the means of communication. But it's important that you also provide ongoing oversight, support and guidance. As medical director, my key responsibility is bridging our health plan and our commissions with that primary care site so that they're working as one, as one collaborative partnership on behalf of the individual. Even though it's two organizations, they need to come to see themselves as working together and aligned. And that's a key role of the medical director in bridging the two.

You're going to want to share with primary care sites quality data. You're going to want to help engage them in quality improvement efforts. You're going to want to be transparent in sharing with them cost and utilization data and discussing what might be the root causes of over-utilization or high cost as well as identifying reasons for cost savings and favorable utilization. So, this again is a key role of the health plan and its medical director in engaging with the primary care site.

We set up quarterly site meetings with all of our main primary care sites, where we review quality data, review utilization and cost data, discuss day-to-day operations, communications, and collaborations. And you're also going to want to offer technical training to primary care sites. Maybe around issues relating to disability competency. But perhaps also around other issues like how to code and document appropriately, how to conduct end of life discussions, and complete a POLST. So, that's something you can offer to improve the competency, and again, enlist the support of the primary care site in your goals and your vision. Next slide, please.

And the third model is the delegated model. And here's where you identify a site that really wants to take it on themselves, that has your complete buy-in for the vision and mission of what you're trying to do, and they want to assume care delivery and care coordination responsibilities. You still have a responsibility to define the expectations for the care model, team composition, staffing ratios, basic elements of care. And then, you continue to provide the same support and oversight that you might in a collaborative relationship. Quality programs, utilization management, the quarterly site meetings, and the sharing of data. Next slide, please.

So, I'd like to illustrate some of this with reference to a patient. This happens to be my primary care patient. I saw her as recently as yesterday. And everything here is true except her name. So, she's a 66-year-old woman, and here's her medical problem list. She has end-stage renal disease on hemodialysis, diabetes with neuropathy, peripheral arterial disease, she's had a below-knee amputation in the past, history of a minor stroke, coronary disease with a heart attack in the past, chronic heart failure, sleep apnea, she smokes. She's been labeled or had been labeled as non-compliant because of her difficulty adhering to diet, medications, and to dialysis, which she would skip frequently. And she's also been described as depressed. Next slide.

So, you could draw up a wonderful medical care plan to address each of Anne's significant chronic medical conditions, identifying the problem, identifying the intervention, and the goal. And this is a very pretty care plan and could be very appropriate for all her medical conditions. But I'll tell you, you will never ever get a handle on Anne's medical problem. You will never get a handle on her utilization, her emergency room visits, her hospitalizations, the cost of her care. You will never get a handle on those if you stopped there.

But this is often where a primary care site might stop, because they don't have access to other information through that comprehensive multidimensional assessment. Nor do they necessarily have the means to address any of those issues. That's when you have to have the competency.

So, let me tell you a little more about Anne. Next slide. So, she was born in rural Tennessee. She moved to Massachusetts when she was 17. She raised two children as a single mother. They currently live in the Carolinas with their own children and grandchildren. She sees them very infrequently. She worked as a home health aide until her stroke. She identifies as Pentecostal and relies on her spiritual belief during difficult times. Her closest relationship was with her sister, who lived in Boston as well, but who died last year. She rents a small room in substandard housing from a niece, but finances are tight and there's constant stress in the household. Next slide.

She had food stamps, but lost them when she relocated. She spends most of her time alone in her room, missing her sister and worrying about food and housing. She feels that her nephrologist and dialysis nurse don't communicate with her respectfully and her temporary dialysis catheter is causing her pain. She is exceedingly frustrated by her dependence on others for getting about and for meeting her basic needs. And she readily admits to feeling discouraged and hopeless about her situation.

So, it could be that these issues are identified by a primary care provider in a primary care practice. It could be that these issues are identified by her nephrology team at the dialysis center. But it's often the case that they are not, because those sites are so limited in the time that they have with the patient, in their ability to probe and to identify the social barriers to help. But again, you as the health plan, out there in the home, in the communities, getting to know individuals, developing those human relationships, that's what you can bring to the collaboration. Next slide.

So, this is what the care plans ends up looking like. Those medical problems fall to the bottom. What rises to the top? All those psychosocial issues and those social determinants of health. So, bereavement, social isolation, food anxiety, inadequate housing, mobility limitations. These are the things that Anne struggles with every day. And until you address those, neither you, nor her primary care providers, nor her specialists will ever get a handle on the chronic medical conditions that are contributing to poor health outcomes, high utilization, and high cost.

But again, this is what you are able to bring to the relationship, to the collaboration as you develop that specialized expertise in disability. Disability conceived broadly. Disability conceived to include all that the individuals you care for are wrestling with in their homes and in their communities. Which is why it's not sufficient to just engage in her medical care coordination. Care coordination has to be practiced on site, as a product of a relationship. In the homes, in the communities where your vulnerable members live. Next slide.

So, here're just some questions for you to consider. How can you impact care delivery for the vulnerable populations that you're serving? What approach to primary care is right for your environment? Staff model? Collaborative model? Delegated model? Can you develop multiple



approaches? So, you have a multiplicity of options. How do you engage primary care practices with which you will work? How do you establish terms of engagement? What is the value-add that you can bring to the relationship to prove your value? And most importantly, how can you assure competent care for vulnerable and disabled populations? How can you own that specialized knowledge? Next slide.

And as we have outlined in the disability-competent care self-assessment, these are some of the features of disability-competent primary care. We haven't talked about the structural elements for access. These are critical for disabled individuals. But that's a key piece. Once again, that the health plan needs to own responsibility for the specialized competencies. You must engage with providers and hire providers comfortable with specialized care issues. You must constitute interdisciplinary teams capable of sharing decision making. You must integrate behavioral health into the model.

You must develop different approaches to same-day access for episodic care. The same-day sick situation. How can you address that in the home? How can you provide transportation to the clinics? How do you provide same-day access to address an urgent care need before it becomes a bigger problem? You have to assure access to appropriate subspecialists. Subspecialists who are comfortable and competent with the issues that person with disabilities face. And as we'll talk about next week, when we talk about (inaudible) of risks, you have to own the ethical framework for care as well.

So, I'll stop there, and at this point, turn it back to Chris and to June.

Chris Duff: Thank you very much, Adam. I appreciate that presentation and it actually left me with lots of questions, but I'll hold off my questions. But really, as you can see in this next slide here, the key components to interdisciplinary care team, community outreach and integration, person-centered approach to the partnership, integration of hospital care and primary care. We didn't really get into that too much, but we talked about that before. But how people go from hospital, how they manage that, how they get back into the community. I think that's certainly an issue that needs to be incorporated as well as emphasis on long-term services and supports. It's only through looking at all of those, either directly by the health plan doing it or through one of those models he outlined that you're going to be successful in helping the participant achieve their goals.

So, before we go on, let's review the results of the last instant polling, if we could. It was a question about how well you all believe that your participants, clients or patients, are served by primary care and communities. Very few of you interestingly say very well. 66%, one-third of you say -- two-thirds of you say adequately and almost a third of you say poorly. That, I think, is probably pretty close to what many people with disabilities would say.

My experience is in a program we had is that people with disabilities who we worked with, when they just started working with us, were scared to leave their existing primary care providers, because that's what they knew. But when we encouraged them to check out somebody else or whatever, once they checked out one who really had clear competency, they were just amazed and were much happier. It's like they didn't know what they didn't know. They had trouble

understanding what was missing. And that's, I think, one of the roles the health plan and the care coordinators within the plan and others really are responsible to help with.

At this point, I would like to open the phone lines to questions. So, Brad, can you give directions please?

Moderator: Certainly. Ladies and gentlemen, if you'd like to ask a question, please press star and then zero. You'll hear a tone. And then after, it will then take your name and further instruct you. If you're using a speakerphone, please pick up the handset before pressing the numbers. Again, it's \* 0.

Chris Duff: Thank you. While we're queuing up questions, June, do you have any comments you wish to offer based on your personal and professional experience?

June Kailes: Well, Chris, maybe I can just start the discussion by commenting that with the diversity of health plans and models out there, there remains the question of bridging these readiness and competency gaps. And really what it takes to successfully make the transition to the models and levels of ideal competency practices that Adam discussed.

What do things like look in the interim for members or participants? What happens to members in the interim of making this big leap? And one of the things, even the most motivated and knowledgeable clinical groups out there, there's still a need for really just in time technical support from subject matter experts like, how do we do this? Does the plan offer access and the support needed on a daily basis for those in the trenches who're confronted with issues at the moment?

So really, it's while we're in process of building these competencies, and capacities, and making these heavy lifts to great models of competency, what're the interim steps and what are the interim supports? Because it just doesn't happen overnight. Back to you, Chris.

Chris Duff: That makes total sense. I think one thing that we experienced, plans, and Adam kind of spoke to this, plans have a lot of information about the members. That actually relates to a couple of the questions that've begun to come in. Have a lot of information about the members. The issue is how do you get that to the clinics and the clinicians within the center?

An example out of managing Part D, plans have not only the information about what prescriptions that they are on, but information about when it was last filled. How many of us have gone into doctor's appointments and not had really good information about medication? So, that is vitally important and extremely well-received by the physician to have something that is concrete to help figure out what's going on with what they see today.

So, that's just kind of one example of the partnership that the health plan can bring to the clinic. I think a question similar to this, along the lines of what came in from Mary Martin, she said it was an excellent first-person story. And I think many of the care coordinators within plans would totally get the content of your second, the more comprehensive plan of care. The question she

has is, how do you share -- what mode do you use to share that information with the primary care physician?

Adam Burrows: (Multiple speakers) I think as I laid out, what's important is to do the advance work. So, in establishing a relationship with a primary care site, the primary care providers, again, establishing the terms of engagement, the terms of the collaboration, and the means of communication. How're you going to share your vital assessment information so that you can develop together with the primary care provider a fully comprehensive, meaningful care plan that addresses all the social determinants of health as well as the medical issues?

How will you then share information on an ongoing basis? How will you meet and communicate? Will that be virtually? Will that be through periodic meetings at the clinic? Will that mean accompanying periodically a patient to an appointment where you can do some of the care planning? So again, it's critical that you establish the means of collaboration and communication so you can impart that specialized knowledge that you hold. And so you can bring that to the attention of the primary care provider in the clinic.

But often, you're just going to do these things. You're just going to identify the issues, address them, and as one of my nurse practitioner colleagues working in the OneCare program puts it, you're going to loop the doc in. You're going to let the doc know, "We've identified these issues and this is how we're addressing them. We think that this will contribute greatly to better control for the chronic medical problems, improved outcomes, decreased utilization." You just do it, and you use the communication to loop them in.

Chris Duff: That makes good sense. So, it's not as if the plan is going to do the doctor kind of to get the sign off as you often do for a more medical approach, intervention. It's more you're deciding what needs to be done, and implementing it, and keeping the doctor in the loop. In practice, that's far more functional obviously.

A comparable question is from [Rachel Robison] is, is the comprehensive plan, the one that's developed by the plan, includes the much broader picture, is that shared with the participant or is it merely used as an internal document?

Adam Burrows: Well, it's informed by the member or the participant. Any individualized care plan, any person-centered care plan should be grounded and informed by the individual. What are the goals that he or she want to achieve? What's important to him or to her? And that's why in that care plan, that's what was most important to Anne rose to the top of the care plan. So, she was involved in generating that care plan.

And then, obviously, at the conclusion of creating this document, you'd want her sign off on it. Yes, you did represent what's important to me appropriately. Yes, I share those goals. Or perhaps not. You missed out on something. Or, that's not important to me. So, the individual should always inform the person-centered individualized care plan as well as having sign off opportunities at the back end. And it's a living document ideally that guides the care team, that collaborative partnership between your team and the primary care site in providing care. But it

needs to be reviewed and modified periodically. And as new issues come up, it needs to be adjusted.

Chris Duff: Thank you. Do we have any questions waiting, Brad, on the phone line?

Moderator: Currently no questions in queue. I'll remind everybody it is \* and then 0.

Chris Duff: Thank you. I will go to some of the written questions. Here's someone, We have a very open network for primary care, kind of a traditional model it sounds like, although I certainly know some providers are more disability competent than others. How do I make that known to our members and attempt to influence their choice? And I'd like to hear from both Adam and June on that.

Adam Burrows: I'll let June start with that one.

June Kailes: Well, there's all kind of competencies, including being able to get in the door, knowing that the provider has what people need. Making the right referrals needs to be weighed using a sensible scale or exam equipment, that that's document so that the right referrals can be made.

And then, there's a whole level of other competencies that somehow need to be utilized. So, if I make somebody, for example, lives with multiple sclerosis, and there are two out of the four or eight neurologists in the network are -- really have that kind of expertise, where do I access that information so that I can help that member, that participant, find those providers?

Chris Duff: Adam, your thoughts?

Adam Burrows: Yeah, I think if a member expresses dissatisfaction with a provider, we have an obligation to suggest alternatives. I also like to think that with the right support and the right collaborative partnership, primary care providers who are otherwise overwhelmed, who otherwise really don't have the opportunity to look beyond the medical issue to the issues that persons with disability, persons confronting poverty or contending with, that while you bring that to the collaboration, he or she could become a better primary provider.

Chris Duff: That's a really nice perspective, because I know our tendency is to kind of have our favorites the community that we work in. And then, we burden those small number of providers who we at least perceive are the most disability-competent versus trying to figure out how can we make others -- help others become more disability competent. So, I really appreciate that support.

The only other thing I've heard of is just to encourage people to go and visit another one and interview them. And another thing we often say is, talk to some people who you know, some friends of yours who have disabilities. See who they're going to. See how happy they are. Because word of mouth is, I think, especially important in this kind of situation.

Adam Burrows: Chris, the one thing I'll also add is that sometimes though there are such specialized needs out there and specialized access requirements, that primary care practices may not be able to provide the level of care required, which is why in addition to the collaborative model and the delegated model, we also have developed a staff model capacity for specialized limited situations where really patients/members cannot access care in the community.

Chris Duff: By that, are you talking about a practice that basically provides care -- that goes to your participants? To their home?

Adam Burrows: It could be or it's a primary care site that is developed specifically to meet needs of individuals with severe disability. So, from the get go, building in appropriate access and specialized knowledge.

Chris Duff: That makes sense.

June Kailes: And Adam, I would just add that that also means in a large geographically expansive community with many networks, that may mean really working through repeated access to good transportation and knowing that the commute time will be longer than usual. But the payoff can be great.

Chris Duff: To kind of expand on that, one of the questions here, let's say there is a person that's new to your community, moved to Southern California, knows you and says, "Hey, I need a primary care physician," what would you advise them in helping them choose a primary care physician in any area? What criteria, credentials, other things would you encourage them to look for? Obviously physical access is a piece.

Adam Burrows: June?

June Kailes: Well, I think it really depends on the member and what they're looking for in a provider. Sometimes it's a provider that's very easy to get to and you're geographically close. I've heard from many people that it's a provider that will facilitate communication by email. So, if it's only a renewal of a prescription or a question about a referral, it can easily be handled quickly rather than having to go through a time-consuming laborious commute to get there. So, it's that kind of access to getting easy questions answered quickly rather than having to go through painful commutes. So, it's all that kind of thing.

Is the practitioner a good problem solver? If they don't know it, are they willing to seek out information? You want a partner, then you want to be able to problem solve together. Is that provider comfortable with partnership instead of just kind of recommending what needs to get done? Not every provider is comfortable with that kind of partnership. So, those kind of things I think are important to know ahead of time what you need, what you're looking for, what's negotiable, and what's non-negotiable.

Adam Burrows: I'll add --

Chris Duff: Adam, you want to add to that?

Adam Burrows: Sure. Thanks, June. The only thing I would add to that is that individuals should know that as they sample potential primary care providers, they're not locked in. They can change. And what I think is really important is that they feel the provider treats them like a person. I think there has to be a basic starting place for a relationship between a primary care provider and a patient. That the primary care provider sees a person across from them in the exam room, in the office, and that the individual feels like that provider is treating them like a person.

June Kailes: And Adam, I would just add to that that referring back to particularly the second webinar of the lived experience and honoring that person's expertise regarding having lived with disability and what they know in terms of what works.

Chris Duff: Great. Well, we're near the end of our time. I want to get in one more polling question to give us some direction for the future. And that is, are you interested in additional webinars on the topic of primary care? And I've listed four topics here, but feel free in the Q&A to list others. If you're interested in learning more about the delegated model, we could do a whole webinar on that and have a physician or two who actually works in a delegated model talk with Adam about it. What we really need to do is hear from you about what are some of the things that you're interested in learning more about from us.

So, one last question I'd like to ask that came forward is, "Our members, it's obviously from a health plan, "commonly rely on their specialists for their medical care, which means there's coming out much attention to prevention. When I try to suggest establishment of a primary care relationship, I get some resistance." What're your thoughts on that, Adam?

Adam Burrows: So, I think the question's about individuals who get their care from specialists primarily without the primary care provider providing that person-centered care. Well, unfortunately in our highly fragmented, highly specialized healthcare system, that's often the case. And for individuals who have multiple chronic conditions are often seeing multiple specialists without anyone serving as the coordinator and as the person really addressing the individual.

Unfortunately, we do have a crisis in primary care in this country. And it's not always possible to access good primary care. A lot of primary care practices are closed. And there's a shortage of primary care providers. But I will say this that health plans have an opportunity here as well to establish that relationship with the individual and to assume some of that role as well. And it could be over time that there's a reduction in the dependence on specialists. It could be over time, the identification of the primary care partner to work with as well. But often, we as the health plans, we, with having that specialized expertise, have to fill that void ourselves.

Chris Duff: Thank you very much. Before I close this up, I'd like to look at the results of that last polling question, if I may. Interesting, care deliveries, but you're mostly interested in management of avoidable conditions. Yeah, that's been something we've been kind of talking about doing for quite some time, but we just haven't spent much time on that. Augmenting primary care with use of mid-levels. We have lots of examples across the country. And then,

obviously -- thank you for that feedback. It looks like there's a lot of interest in a lot of subjects. That's quite helpful.

I'm going to indeed wrap this up for now. We've reached the end of our time. There were a few questions received that we were unable to answer, and we will make sure they're answered offline by the presenters.

Next week at this time, as Adam referenced, we will explore the concept of dignity of risk and how it is inevitably linked to the application of self-determination and self-direction. Everyone who has signed up for this webinar will receive notice of all future webinars, tools, and other resources we are able to provide.

I would like to again thank all of our speakers for their presentation today and look forward to continuing our work this year to support the demonstration and the delivery of healthcare for persons with disabilities across the country. Thank you all for participating this morning -- this afternoon. Bye-bye.

Moderator: And that does conclude the call for today. Thanks for your participation using AT&T Executive Teleconference service. You may now disconnect.