The Lewin Group
Disability-Competent Behavioral Health
March 15, 2017
2:00 p.m. EST

Christopher Duff: Good afternoon, everyone. Thank you for joining today's presentation. Please take a minute to orient yourself to our platform. If you would like to ask a question, please use the chat feature on the left lower hand side. Technical questions will be addressed as they come in, and content questions will be addressed at the end of the presentation. If you would like to download the slides from this presentation, use the icon on the top right. Additionally, live closed captioning is available at the bottom of the screen.

My name is Chris Duff, and I am a Disability Practice and Policy Consultant who has been working with The Lewin Group to develop the Disability-Competent Care model and related webinars and materials. I will be joined today by Dr. Andrew Jorgensen, Associate Medical Director at Outer Cape Health Services, and Dikke Hansen, their Director of Behavioral Health. Together, they bring years of experience in building integrated primary care and behavioral health teams. Outer Cape Health Services is a federally qualified health center serving the outer portions of Cape Cod. Dr. Jorgensen is board certified in pediatrics and internal medicine. He obtained his undergraduate degree with honors from the University of California, Davis with a B.S. in biochemistry and received his Doctor of Medicine degree from St. Louis University School of Medicine with a distinction in research. His internal medicine and pediatrics residency was completed at the University of Texas at Houston. Prior to joining Outer Cape, Dr. Jorgensen was a practicing physician and Regional Medical Director at the Cambridge Health Alliance.

Dikke Hansen is a licensed independent social worker at Outer Cape Health providing counseling for adults and children. After graduating from college with a bachelors in social work from Augustana University in Sioux Falls, South Dakota, Dikke received her master in social work from Michigan State University and a masters and certificate in global mental health from Harvard University in 2008. Before joining Outer Cape in 2014, she was the Clinical Director of the Family Counseling Center of the Massachusetts Society for the Prevention of Cruelty to Children. I am honored to have both Andrew and Dikke provide this presentation.

On behalf of The Lewin Group, I would like to welcome you to our Disability-Competent Care webinar series. The Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services has contracted with Lewin to develop technical assistance and actionable tools to support providers in their effort to deliver more integrated, coordinated care to Medicare and Medicaid enrollees. In this series, we are introducing the pillars with a webinar dedicated to each. This is the sixth of seven webinars running on Wednesdays through March 22nd. All of the webinars are recorded and will be available along with a PDF of the slides at the Resources for Integrated Care website.

In 2013, we published a comprehensive Disability-Competent Care self-assessment tool describing disability competence and have since produced 25 webinars on the topic along with numerous supporting tools and documents. These are also available on the RIC website. The DCC material has recently been revised to be more accessible to users and reflect the further development of the field. It is now structured

in seven pillars of disability competency.

We will be allowing at least 15 minutes for discussion and questions at the end of the presentation. As you can see on this slide, today's presentation is on the sixth pillar, behavioral health. We would like to elicit your opinion on this series as well as past webinars and supplemental materials. Please take the time to complete our survey and send us your ideas for future topics and content. At this point, I will turn this over to Dikke to start the presentation.

Dikke Hansen: Hello, everyone. It is nice to be with you this afternoon. Today, the agenda is going to be behavioral health within disability-competent care. We can talk about mental health, behavioral challenges, and substance abuse. What we are really looking at within Disability-Competent Care is making sure it is integrated with primary care and the interdisciplinary team. This is the best practice, and here at Outer Cape Health, we are working hard to make sure that happens.

Behavioral health is the term for what we used to call mental health; this also encompasses substance abuse and chemical dependency. With the other DCC pillars, the focus is on the functional limitations or barriers experienced by people with behavioral health issues. DCC organizations have learned that behavioral health care should be integrated with primary care and found this is most effective way to deliver services to individuals with disabilities.

People with disabilities are more likely to experience difficulties or delays in accessing physical and behavioral healthcare. They experience worse outcomes and are less likely to receive the recommended care. They are more likely to experience depression and chronic conditions and also more likely to experience disabling illnesses such as heart disease, high blood pressure, respiratory disease, etc. Also, they are less likely to receive comprehensive preventative care including common screenings such as mammograms and colonoscopies.

Dr. Andrew Jorgensen: I'm going to take over from here. Chris, thank you for having us today. What Dikke was mentioning is thinking about integration from an individual level, but what are the reasons we want to focus on integration and behavioral health and primary care from a population level? We know that disability status and health disparities are often associated with poor performance on measures that are linked to payment in value-based purchasing programs. For example, they are less likelihood to complete recommended cancer screening programs.

On many measures of focus (e.g., cancer screenings, vaccinations, diabetes management), the clinical interventions are straightforward but communications and service delivery for people with disabilities stretch the disability competence of most providers. What strategies can we use to encourage people to do things that will help improve their health overall? Person of disabilities have over twice the incidents of mental health problems due to the interference of their other disabilities and, on top of that, socioeconomic factors. Addressing the health disparities and social factors can significantly improve outcomes for people with disabilities, having a direct impact on revenue for many providers and plans. We know that when you compare, for example, a patient with heart failure, and on top of that, they also have mental illness or substance use, it can dramatically increase the cost to the payer.

So, why integrate behavioral health and primary care or how do you do that? Behavioral health and

primary care services are typically delivered in different settings often with little coordination and integration. This leads to a lot of miscommunication and a lot of opportunities missed. The fragmented delivery of care can be particularly problematic for individuals requiring a wide variety of services to address physical, emotional and behavioral challenges. At Outer Cape Health, we had a great opportunity to work in a co-located manner. Instead of referring our patients outside of our organization for behavioral health services, the services are integrated with much better outcomes for the patients and the community as a whole. Increasingly, behavioral health is integrated into primary care settings. Some integrated health plans are starting to embed primary care into behavioral health clinics. There are movements for integration. For example, for patients whose primary problem is schizophrenia, it might be better for them to have an established behavioral health clinic for which an internist, family medicine, or mid-level takes care of that patient in that behavioral health setting. Here at Outer Cape Health, we have integrated the behavioral health into the primary care center.

There are a lot of behavioral health concerns amongst dual eligible Medicare and Medicaid enrollees. 40% of Medicare and Medicaid enrollees who are under 65 have a mental health diagnosis, which often creates that availability for Medicaid. Medicare-Medicaid spending is twice as high for individuals with a serious mental illness, which we alluded to earlier. Healthcare utilization and costs are twice as high in diabetes and heart disease patients with depression. We know that nationally, there were 217 million days of work lost annually to related substance use disorders costing employers an estimated $17 billion a year. Another study showed effective depression treatment in primary care lowered total healthcare costs by $3,300 per patient over 48 months. Not only is this the right thing to do, but it is effective from an outcomes standpoint for the patient along with cost savings.

We are going to transition to talking more specifically how mental health is addressed in the primary care setting. DCC defines mental health from a functional perspective, where it is viewed as a state of well-being in which participants realize their own potential, can cope with the stresses of life, can work productively and fruitfully, and are able to make contributions to their community. Restoration of functionality is the focus. We screen patients for depression in the primary care setting as many different primary care health centers are doing. We know that incidents of depression and anxiety are higher among adults living with functional limitations or disabilities. We also know that depression and anxiety can be a primary disability or secondary to the direct result of a patient's life as a disabled individual.

In the end though, the important thing is to identify the people who have behavioral health issues and be able to institute treatment. It's important that the integrated delivery team assess each participant and discuss and develop plans accordingly. There are several tools that allow us to do that. The ones being used at Outer Cape Health and at health centers across the country are the PHQ-9 for the assessment for depression and the GAD-7 for the assessment for anxiety. These screening tools use the established definitions for depression and anxiety to help identify those with those conditions.

We have found it incredibly beneficial to include mental health professionals in the interdisciplinary team. That is a key value of the DCC model because each participant with a mental health concern needs is able to rapidly have the input and involvement of a mental health professional or specialist. Not all persons with disabilities present with mental health concern, but by screenings these individuals, you are able to identify those who do have an issue and identify early on when an issue presents itself. A person with a disability may not initially have anxiety or depression or substance abuse problem, but it may

become apparent later in their involvement with the interdisciplinary team. That is why it is important to have the mental health professional readily available and accessible to the patient.

We are going to talk a little bit about having specialists within the behavioral health network. Although primary care providers have significant training in these issues, they often feel uncomfortable dealing with patients with more complex problems. For example, as an internal medicine physician, I feel comfortable treating an individual with depression using standard therapies, but when a patient may require more than one medication or a complex treatment plan, it becomes important to have a mental health professional involved.

There are times at health centers where behavioral health specialists are not embedded within the team and within the clinic. At those times, having great communication and relationships with external behavioral health providers becomes important. That's what this point is all about. It is about having designated communication pathways from the interdisciplinary team in the clinic with specialists who are in the network but not co-located physically with the primary care team. It is important that primary care team keeps the external specialists up to date with their observations and impact of behavioral health interventions and progress towards goals. So, that communication point is important.

We are going to tell a story adapted from one of the patients we cared for here to illustrate the point of the success of integration. This is Nancy's story. She is in early 60's and lives with her partner in a small town in the Midwest. She recently moved to a new rural community in the Northeast of the country. She was on hormone replacement medications, and prior to moving, her doctor wanted to stop her hormone replacement medications and a goal of reducing her anti-depressant medications. Unfortunately, due to the stress of the move and changes in her medications, she developed extensive diarrhea and panic attacks so disabling that she was unable to leave her home or participate in the community, or as she was moving to new community, she was unable to develop new relationships. When she came to the Northeast, she decided she wanted a new primary care provider. She was able to establish a relationship with that individual, and that provider in the clinic was supporting an integrated behavioral health model. She agreed to a quick referral to a therapist who is working in the clinic and agreed to see a social worker in the clinic. Dikke will tell you what happened when she saw the social worker.

Dikke Hansen: She came to see me, and she was very perplexed why she was as anxious and what was going on with her. She thought it had to do with her medications. She thought coming off of her medications made her anxious and depressed.

As she and I started to work together, it was evident that she had just retired. She used to be active in her work and got a lot of out of work. All of a sudden, she has retired and does not know anybody in this new town. There were a lot of social factors that had to do with her depression and anxiety.

It helped to be able to discuss this with Andy and also that she was willing to see our clinic psychiatrist for the medication and consultation. She had spent so much time wondering if this was physical or emotional. We were able to let her know that it was a little bit of both. Her primary care provider, psychiatrist, and myself worked together to help her accept the physical and emotional struggles.

She was willing to go back to try another anti-depressant and new anxiety medication. She was also

willing to return to hormone replacement at a very different dosage, and it was much more effective for her. She is doing really well. She sees me weekly, but she is able to put structure in her life. She is doing more art, which she always wanted to do when she was working. She needs the structure in her life that work used to provide her; that is taking care of her anxiety. She's also making new friends and her relationship with her wife is much better. They have been to couple's therapy along with Nancy's individual therapy.

So, that was Nancy and that has worked really well. I know if I had worked with Nancy in a traditional outpatient mental health clinic, we wouldn't have been able to look at the issues of the hormone replacement that was an integral part of her problems. It was helpful for me to have Dr. Jorgensen to consult with all of that.

Moving on here, we want to look at behavioral challenges. These are those that impede the participant's ability to function in their home and community and within their family, peer relationships, and their work.

It is important that behavioral health challenges are incorporated in the initial and following assessments. It is important to look at where are their struggles? In their home? From their family or peers? What kinds of things get in the way for them to function well? What are their behavioral issues that are barriers for them? If we identify some of the challenges, then it is important to work with them and their care partners to identify the behavior and their triggers for that. From there, a plan can be developed to reduce barriers and develop alternative responses or behaviors. Often the interdisciplinary team involves a behavior specialist from the community to address these concerns.

At Outer Cape Health, we are in a rural community. We do not have behaviorist specialists available to us. Several of our social workers have experiences in behavioral changes, so we use their resources. I am guessing for many of you having a behaviorist specialist is not available as much as we would like to. Behavioral challenges can be complex. They require an understanding of the costs and the participant's ability to control and adopt more functional behaviors.

It is also important, as we set up a behavioral challenge treatment plan, that we include the primary care physician and the individual treatment plan, so that everybody is on the same page with this.

It is not common to have a behaviorist specialist attend the IDT meeting, but coordination is really important.

Dr. Andrew Jorgensen: The other aspect of behavioral health is substance abuse. From the DCC perspective, this becomes an issue to be addressed when it interferes with the participant's ability to function, their family and peer relationships, and work; that is part of definition of dependency. Just like depression and anxiety, we are not screening for substance use in the primary care setting.

It is highly recommended that screening for substance abuse be included in all assessments. It normalizes the issue with participants and gives them an opportunity to discuss it openly. Every physical in the primary care setting, we screen for alcohol dependency. Similarly, every initial or subsequent assessment from a DCC perspective, there should be a screening. In practice, the participant may not be comfortable

divulging their use until they have higher level of trust with the interdisciplinary team or a specific member of the interdisciplinary team.

Over time, you may see signs of use that do not come out on screenings that you may want to address anyways. I will talk about the screening method shortly, but we are going to talk about how you address the substance abuse once it has been identified. The point of screening is to determine if a patient is not at risk, at risk, or at addiction. When a patient is not at risk that is a good time for education and promoting healthy norms. For example, I might ask a patient, would you like to talk about safe drinking, and from there, give further information. For patients at risk but maybe not with addiction or dependency, you can educate the patient on the risks, but then help the patient create a plan to moderate risks. For example, instead of having two glasses of wine every night, have a plan to drink two or three times a week or maybe only one time per night. Within the integrated model, we have the ability to refer to the interdisciplinary team or refer the patient to specialty addiction treatment.

So, what are the methods we use to screen for substance abuse? We use a two phase screening technique. There is one question in NIAAA-1 for alcohol, and then one question in NIDA-1 for drug abuse. Basically, if the initial screening is positive, this allows you to screen lots of people in a pretty effective and quick manner. To normalize it, there is the audit in the DAST-10 tool used to explore in more depth. The basic idea is that the initial screening does not provide degree of risk, but it allows you to know if the patient is at risk or not. The more formal screening helps you better define the degree of risk. On this slide here, you can see the screening protocol summarized nicely here where if either of those initial screenings are negative, you reinforce the healthy behavior; if either are positive, it goes on to either/or both more advanced screening tools, and that leads to the ability to use motivational interviewing and change techniques to set up a plan. Throughout primary care, there is a focus on training the primary care team to do these brief interventions saving the behaviorists and behavioral health specialists for the more complicated situations.

I am going to have Dikke speak a little bit to the stages of change and how we help participates recognize and deal with their substance abuse.

Dikke Hansen: To start helping people recognize their substance abuse, you have to develop relationships. No substance abuse person will admit to having a problem unless they feel they can trust the person. This is where it is so important that the primary care physicians are doing some of the initial screening. We are talking a little bit here about motivational interviewing and the establish rapport, and then also starting to increase the participant's perception of the risks of their current behavior.

That is the pre-contemplation stage. Then, we go in to contemplation and elicit reasons for change, risks of not changing, and elicit self-motivational statements. It is important that this is not something we are telling them, but they are able to come up with some of these on these their own. As they are moving more or thinking about maybe wanting to stop, then we also need to prepare them and offer a menu of options for change or treatment. So many have a limited view of what treatments are available and by offering many different options, it will help them step closer to taking action.

When the action stage is there, then we need to support a realistic view of change through small steps. It is not just about preventing relapse but about being able to help them identify new strategies to prevent

relapse or explore the reality of relapse as a learning opportunity. One thing we know is that relapse happens, and one can expect that. That is usually where we learn to move on forward.

It needs to be a stepped care approach. If people are drinking a little bit too many drinks now and then, we will use a different approach than if they are deeply involved in their abuse. In the early stages, simple education and discussion is possibly all that is needed. In later stages, they may benefit from self-monitored reductions in their usage and having someone to discuss their ability to self-control. If they are not successful in their ability to self-control, they may benefit from stronger interventions such as a formal treatment approach. So, what is the model that we are using to promote recovery?

This recovery model that they want to talk to you about has shown through research to be helpful and has been helpful for us as well. The ten guiding principles of the model include instilling hope. Lack of hope is often an issue for all mental health difficulties. We want to make sure that the recovery model and treatment model is person-driven. We should not be telling them how they should succeed, but rather help them come up with ways that work for them.

This occurs through multiple pathways. Recovery helps with primary care, mental health, AA, neighbor support, and family support. There are numerous pathways that can be helpful. We talked about relationships with social workers and professionals, but it is important that we build a stronger foundation of support from their community and from their peers and families. This needs to be culturally-based and influenced, and again, needs to be holistic. It needs to be part of looking at the whole person; the whole emotional, physical, and spiritual person. The recovery model needs to be trauma-informed and needs to be based on respect. This recovery model is an approach to address behavioral health needs based on four major dimensions: health, home, purpose and community.

For everyone in behavioral health recovery, making informed healthy choices that support physical and emotional well-being is the first step towards recovery. The health component of the recovery model focuses on managing and overcoming one's behavioral health disability, substance abuse, or symptoms that interfere with their overall health. For example, abstaining from the use of alcohol, illicit drugs or non-prescribed medications if one has an addiction problem or attending Overeaters Anonymous.

Home needs to be a safe, stable, and comfortable place to live. Addressing the home environment includes dealings with relationships with others in the home and whether these relationships will be conducive to continued recovery. The interdisciplinary team needs to assess and address challenges within the home environment such as physical access, ability to pay rent and utilities, and access to adequate food. We need to look at the whole picture for this person who is wanting to move towards recovery.

Probably one of the most important pieces of recovery is for a person to have purpose. Every individual needs purpose in their life. Nancy, who we talked about earlier, all of a sudden quit her job and had no purpose. This contributed to her anxiety. Purpose can be a job but it can also be family caretaking or being creative. I talked about Nancy starting her art that she loved to do.

Another purpose is giving or supporting others. I have a patient who goes to AA meetings mostly because he feels that what he has to contribute helps others, and that has become his purpose.

Lastly, we have community. Every individual, regardless of ability, needs a community in their life beyond their family. Often we see people with disabilities are isolated. It is important to encourage support of a community and encourage people to access either church, community centers, sports, or whatever interests the patient. Get them involved in the community, then these relationships and social networks will provide support, friendship, love and hope. This is certainly one of the more important pillars again to recovery.

Dr. Andrew Jorgensen: We have one more patient or individual to talk about to illustrate these important aspects of the recovery model. Kevon is a primary care patient whose mental illness and chemical abuse evolved over decades. Through his 20's and 30's, he worked a variety of jobs where drugs and alcohol were part of the culture. In his early 40s, he got married and started a family, motivating him to get a professional job to help provide for his family and raise his kids. While his overall life stabilized, he continued to struggle with depression and was getting high or drunk nearly every day. Over the next decade into his 50's, he was in and out of rehabilitation, lost the job he loved, and ended up getting divorced losing important pillars of life. This coexisted with his chemical dependency, and he was increasingly depressed and struggled with an anxiety disorder.

He had a long-term relationship with his primary care physician who continued to talk with him about his depression and the importance of sobriety. At that point, Kevon was not ready to address that. As primary care and behavioral health became more integrated and his therapist was on site, he agreed to see that person. By having integrated behavioral health, you can bring patients to the exam room just for introductions. The behavioral health provider then becomes a familiar face, and the patient is more likely to engage with them.

Finally, it took several different therapists before Kevon settled on one that he felt a connection with. Once he found a therapist for him, he was able to see the impact of his usage and maintain his sobriety. Kevon's path to wellness was difficult. He lived in a halfway house, but with the help of his therapist, he kept focused and is finally living on his own and learning to move forward acknowledging his addiction and mental illness.

Today, he has a steady job and a good relationship with his kids and their mother and is living independently. His self-management strategies include support groups (AA and others) and developing a gratitude list to help him focus on the positives in his life. Acknowledging the strengths that he had helped him to maintain his strategy. We are going to end today with a few remarks from Dikke. I thank you for listening to me. After Dikke speaks, I will be available for questions as well.

Dikke Hansen: I wanted to end this session with saying, I have spent 30 years working in social service agencies. I have been a therapist and an administrator. The last two years I have spent in our behavioral health clinic that is integrated into primary care, and what I have seen of effective outcomes have been astounding.

I highly recommend for all of you to work closely with your primary care physicians and have an interdisciplinary team to serve the patients you are working with. If you have any questions on how to do that, please ask us. Working at Outer Cape Health has taught me more about primary care than I ever knew before. I just wanted to conclude with that. Thank you for listening.

Christopher Duff: Thank you very much, Dikke. I appreciate your comments. I also like the stories that you gave. One was about the interfacing of primary care and behavioral health and the other showed how sometimes it can take decades to get on top of the concern that was identified early on. I appreciate it very much.

Your last comments, Dikke, are pertinent to one of the questions we received in this presentation, which is in my experience behaviorists are not a covered benefit. Can you talk more about role of the behaviorist?

Behaviorist is hard to define and get at. In Medicaid, it is a state option in the terms of a formal and separate service. What I would like you to do is step back from thinking of it as separate and focus on what this whole presentation is about. It is about the functional ability of the participant to live their life in their community. Even if you do not have access to the behaviorist, it goes back to people like Andy and Dikke to partner with to meet the needs of the participant. Andy or Dikke, can you add to that at all?

Dr. Andrew Jorgensen: Our description of the integrated model is foundational. We serve as the safety net. Part of what we have done is focus on trying to end the distinction between what is mental health and what is primary care. It becomes more of a fluid relationship, so we are less concerned about piece-mealing the resources. Everyone in the health center is helping patients however we do that. The funding is important, but within our integrated model, we have flexibility in how that happens.

Christopher Duff: Thank you, I appreciate that. I know Jennifer Valentine mentioned in the chat about a program at the University of Massachusetts, Amherst. There are also a lot of resources on the SAMHSA website. I encourage you to look there also.

This relates to the next question that came in. Does this present itself in a multidisciplinary team with behavioral health, primary care, and community resources? How do you get those providers to work as a team? Many times the providers are not within your clinic.

Dikke Hansen: So, how do we communicate with other service providers? One of the ways we do it here is through encrypted e-mails that they are able to use so that it is HIPPA compliant. We also invite service providers sometimes to staff meetings. We tried case conferencing by phone. It isn't big and fancy because everybody is busy. Anything else you want to add to that, Andy?

Dr. Andrew Jorgensen: It is all about relationships, and you have to stay within HIPPA regulations. We get informed consent for patients who are integrated into care teams, so they give us permission to communicate with external providers.

Christopher Duff: Thank you, I have another question that came in. I actually have been experiencing this myself. I hear from some of our clinics that some patients with mental illness are too difficult to manage. They can be disruptive and challenge our support staff and resistant to treatment. What can be done to better support these clinics?

Dr. Andrew Jorgensen: One thing we are in the middle of doing is de-escalation training for all of our staff members. In the past, you might have said these patients are mental health patients we will send

them to the mental health clinic. Now, there is this training process that has to happen for everybody from the patient service representative to people doing referrals. Everybody has to be educated on how to deal with patients with these conditions.

The fact of the matter is, when you are in primary care, there is nobody you say no to. You have to care for everybody. It becomes an important thing to deal with. With that said, sometimes you have to have behavior contracts and other sorts of interventions with patients. Since now you are integrated, the mental health person can help the patient moderate their behavior within the health center.

Christopher Duff: I think we have time for at least one more question. A great question came in from Dr. James Rohde, who is someone I know and has decades of experience as a primary care physician working with people with disabilities. He brings up the issue of people with severe mental illness and addiction to tobacco. He perceives, and I think this is shown by stats, that this group has significantly reduced life expectancy directly related to tobacco use. Do either of you have experience dealing with addiction related to tobacco or have any ideas?

Dr. Andrew Jorgensen: I do. The way we approach people, their readiness for change, developing where they are and developing strategies for behavior change works for anybody whether it is related to not using heroin or to avoiding drinking full calorie sodas. These techniques can be used; you just have to be where the patient is.

Christopher Duff: Dikke, any thoughts?

Dikke Hansen: I agree, but I think this is a difficult patient to do this kind of work with. Often, they may not get what they are trying to do. Tobacco or cigarettes may be their only friend. It becomes very complicated, and so, I agree with Andrew, but it is important that we recognize how difficult this would be for their recovery and sobriety.

Christopher Duff: I would add what I experienced with many people, that's their coping strategy. In some ways, it is harder for them to address that than other issues. Then, it becomes about moderating. I think you hit on a significant issue.

Our time is up. I appreciate all your questions today. We actually had more questions than we had in previous webinars. Please send any feedback you have to RIC@Lewin.com, and take the time to answer the survey that will appear on the screen at the end of the webinar. I would like to call your attention to the resources we have at https://resourcesforintegratedcare.com/ including the Disability-Competent Care Self-Assessment tool.

Please join us one week from today for our last webinar, Disability-Competent Care Long-Term Services and Supports. The presenter will be Karen Luken who has years of experience working with the State of North Carolina in the field of community integration. I would like to thank you and the Medicare-Medicaid Coordination Office for sponsoring this webinar and the entirety of the Disability-Competent Care work. Thank you for attending.