

**Event ID: 727159**

**Preparing for New Roles and Responsibilities – Participant and Provider Readiness**

Operator: Ladies and gentlemen, thank you for standing by and welcome to the Disability-Competent Care webinar. At this time all participants are in a listen-only mode. Later we will conduct a Question-and-Answer session. Instructions will be given at that time. If you should require assistance during the call please press \* then zero. As a reminder, this conference is being recorded.

I would now like to turn the conference over to our host, Chris Duff. Please go ahead.

Christopher Duff: Thank you, Marlo. On behalf of The Lewin Group, The Institute for Healthcare Improvement and the Disability Practice Institute I would like to thank you all for attending this ninth in our series on Disability-Competent care this fall. As Marlo stated my name is Chris Duff and I am the Executive Director of the Disability Practice Institute.

A few quick things about this webinar platform. If your slides are not advancing please push F5 on your computer keyboard and that should get the slides moving again. Please note the two icons circled at the bottom of the screen. The one on the right allows you to print a [PDF] of the slides for this presentation. The red one on the left is for questions. If your question is about the technology somebody behind the scenes will respond in real-time.

If it is a question for the presenters we will be compiling them throughout the webinar and will return to them during the Q&A. This is the last of our current webinar series. All of the webinars, including this one, are recorded and will be available along with a PDF of the slides at the link of the bottom of each of the slides.

Today we are focusing on readiness; specifically readiness related to providers and participants. We will reserve 15 minutes for Q&A at the end. You can submit questions in writing and we will additionally open up the phone lines at the end of the presentation for live questions.

I would like to step back just a moment to give you the genesis of this series and several other tools for integrating healthcare services for dual-eligible populations. The Lewin Group along with the Institute for Healthcare Improvement has a contract with the Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services to provide tools and technical assistance for providers that are seeking to integrate and better provide care for individuals who are dual-eligible for Medicare and Medicaid services.

We would like our future work and technical assistance to be as helpful as possible so we are asking everyone to fill out a short survey at the end of this webinar. Please also send us your ideas for future webinar topics or other content that you would like to receive either at the end of the survey or to the email address listed on one of the latter slides in the presentation.

Today's webinar will be presented by two clinical leaders at the Independence Care System of New York. ICS was founded in the late [90's] and has partnered with thousands of persons with

disabilities and their providers to manage long-term services and supports. In that time they have demonstrated national leadership in developing unique and creative services tailored to working age adults and seniors with disabilities.

Their experience combined with that of a few other pilot programs across the country serve as the model for the description of Disability-Competent care that we have been referencing throughout this series. Anna Fay is Vice President for Independent Living Services and Marilyn Saviola is Vice President for Advocacy and Women's Health Access services. They both have decades of experience in independent living services and support, initially working as advocates.

They have brought this advocacy knowledge and perspective to their work at ICS over the last 10 years. We have asked them to share their experience in this webinar series so others can learn and build upon their expertise. They will outline the work they do to prepare their staff to serve their members. Lynne Morishita, one of the co-authors of the Disability Competency Assessment Tool that I referenced earlier will be available during the Q&A session also.

Before turning the presentation over to Anna and Marilyn I wanted to provide some [context] regarding the need for this training. These new dual demonstration programs across the country are demanding to all stakeholders; plans, providers, participants change how they work. The healthcare system needs to evolve from a focus on illness to a focus on health and function. Meanwhile providers are challenged to expand their field of vision beyond their professional silos and operate as a multidiscipline team focusing on the needs and preferences of the participants.

In this webinar series we are specifically focusing on persons with disabilities who are eligible for Medicaid and/or Medicare services. This means that participants will be able to assume greater control over their care and supports. Care teams and providers will be expected to operate as a team jointly focusing on the participants goals and preferences as delineated in individualized plans of care. Health plans are being challenged to take on new populations, persons with disabilities in particular, and supporting their providers and reinforcing participant outcomes.

I will now hand it over to Anna for their presentation.

Anna Fay: Thank you, Chris. Independence Care System, or ICS, was actually started to operate in April of 2000. So we have about 13 years under our belt at the moment and we have learned a lot. The founder, Rick Surpin, created the Managed Long-term Care to serve people with physical disabilities and chronic conditions as he believed that managed care offered the greater flexibility for this group of people whose needs traditionally were kind of the square pegs always trying to fit into the round hole.

We ventured into this endeavor and as I said over the years have learned a lot. We created some programs that were specialized as wheelchair evaluations, for example, are related of course to what we found to be the needs of our members. Wound care program. An MS program. That is Multiple Sclerosis. Spinal cord injury specialized programs. We got really pretty good at managing assessments and checking boxes. We did that very well.

It became clear though for those of us with disabilities particularly in the organization, and there are quite a few of us staff. Marilyn and I are both in leadership positions. Our staff was doing well with checking the boxes but they were really dealing with grey areas, as what we call them, which required judgment. This was a whole new group of people that they didn't necessarily have any experience with.

We thought we really need to look at disability-competence from the point of view of the lived experience. Who are our members and what do they do all day when they are not on the phone with us or when we are not visiting them in their homes? What do they experience? What are their lives like? Next slide. Wait a minute, the next slide. Let me get it here. Great.

What is disability-competence? It is essentially looking at the person and that person's preference, understanding and supporting that person in their choices to the greatest degree we could. Why disability-competence training? There were several reasons for that. One of them certainly for the staff is enhancing their satisfaction with their work; being able to understand and have difficult conversations with members and actually for efficiency, for member satisfaction as well. So there were a lot of reasons why we believed that the kind of experiential training was important.

We organized a group of people that supported disciplines across the organization and we began to write the training. The core content we spent some time discussing and tried very hard to make it relevant to our members' experiences. So we dealt with issues like isolation, institutionalization, difference perhaps between a member or a person with a disability who incurred their disability as a child or were born with it versus somebody who acquired their disability as adults, and believe that all of these experiences are part of being more responsive to our members.

The training we use the tools of a lot of guided imagery; role play, stories, some exercises. For example we ask staff to think about what they have heard that people with disabilities cannot do, dot-dot-dot. So there is no judgment here. What do you think people with disabilities can't do or shouldn't do? Trying to get at what stereotypes and what attitudes and feelings people bring with them to their roles, whatever those roles are.

We ask people to, for example guided imagery, we ask them to imagine what it might be like to wake up one day after an accident or an illness and be told that they will need to be transferred to an institution indefinitely and ask them, "What is the first thing that comes to your mind with this?" It is a very, very intense training but I must say it has been well-received.

I think that we can go with the next slides. I want to just give you a story about the difficult conversations. We had a member who had multiple sclerosis, for example. This woman was ambulatory but she was falling a lot and her care manager was talking to her about using a wheelchair or a scooter for her safety and function as well. She resisted tremendously.

The conversations were not [going well]. We dealt with that in one of the trainings and role played the member and the care manager maybe two, three or four times. We looked at the

impact of language and approach to the point where she was the care manager actually managed to convince or the member that maybe this was something she could try. That is part of what the training is about as well.

Dignity with a risk. Risk is a very big issue for us. There are many ways in which our members or people with disabilities learn to function. Sometimes they don't look like they are the most safe way to do something but actually they are because they have been learned and practiced over a lifetime. Or there are people in our membership who come from a great spectrum of individuals. That is the other thing. People with disabilities are represented in every group.

Most of our members who are Medicaid eligible, have Medicaid, many of them have behavioral health issues. Some of them have drug issues. What we try to do obviously is inform. If somebody is diabetic and we obviously educate them about their illness and their disease but if they are not going to take their insulin or if they are going to eat the box of chocolate then they are informed but that is something they are taking the risk doing. As long as it isn't putting our staff or our provider staff at risk, and sometimes we make agreements to if you are going to engage in whatever it is then do it on your own without your aid or attendant in the house or in your apartment.

Dignity of risk is another example of that. There is a gentleman in our membership with cerebral palsy. During his assessment our nurse asked him to perform certain functions and one of them was to transfer to the tub and he did but he did so in a very awkward way she thought. Getting on his knees and lowering himself into the tub, and she said to him, "Do you do this all the time?" He said, "Yes." She said, "But this is dangerous." He said, "Well, not for me. I have been doing it a long time." She said, "Well, why don't you try a tub bench? You sit in it. You transfer in it. There is no danger of falling, etc." He said, "I don't need a tub bench. I really am able to do this. You asked me to show you and I did."

She came back to the office and talked to our rehab folks and said, "I really think he needs a tub bench. I know he says he is alright but I really think this is risky." So our rehab person who is a physical therapist scheduled a visit with the nurse to the member's home with the tub bench and they went and placed the tub bench and he sat in it. He went along with this and made it very clear he could not transfer with the tub bench. There were all kinds of issues that were really much less safe for him using the tub bench.

So what does that say? That says we have to be able to, as professionals, to not think that we are always the expert. Our members are the expert in terms of their own needs and how they do things. I'm not even sure to be honest with you what slide we are at right now. Let's see. Understanding the lived experience. That is kind of how we try to put people in touch with their own feelings.

There are things that we hear from them when they are finished with this is that they had never thought about certain actions that they have taken, decisions they have made with members, members calling all the time and very anxiously expressing need for whatever it is; whatever service, whatever piece of equipment. All of that is really related to the major reason that we are here and that is to provide them with services and supports to live in their community.

They know, as all of them do, without those services and supports the institutionalization is the option and that is really not an option. So we also talk about the Olmstead Decision which was the Supreme Court decision that actually brought about ICS in a very real sense since what it did was mandate, or require, that people with disabilities receive services in the most integrated setting. This was a decision, as I said, a Supreme Court decision of 1999, I believe.

It comes from the ADA, Americans with Disabilities Act, which that most-integrated setting is three words in the ADA that brought about the Olmstead Decision. The Olmstead Decision has taken off and I must say that all of the healthcare reforms have a lot of Olmstead in them. I remind our staff that every day they are fulfilling the promise of Olmstead in their work with our members.

I think it is a, how am I going to say it? On the one hand we have the staff to train and to support who provide services in the most integrated setting and respectful of our members. On the other hand is we have got of course our members. How do we support them? I am going to turn this over to Marilyn now for her to talk about.

Marilyn Saviola: Hi. I am going to kind of lay the foundation on how we approach people with disabilities as an organization, as a managed care plan. I think what is unique about people with disabilities is that it is the perception of people with disabilities as needing care, as being powerless. Many people come to us as staff with that kind of thinking. It may not be expressed but it is ingrained in who they are. I think the training we do tries to get at the core of that so that people can get beyond what their initial assumptions are about someone with a disability to look and move from there.

Our goal is to support people with physical disabilities, adults with disabilities and chronic illnesses to live in their community. Our responsibility is to coordinate their care so they can get the services and things that they need in order to achieve that goal. Most professionals come from a medical model as opposed to a social model of rehabilitation where the patient is the one who we are doing for rather than the person who we are helping to do what they want and we are in their lives and it is a long-term relationship.

I think one of the biggest challenges we had early on was getting professional staff; RNs and social workers who could step back and yes they had a body of knowledge and a body of expertise that could help people with disabilities and chronic illnesses. But they didn't always know how things fit and what was needed in an individual's life.

So to begin with this is our responsibility to provide these supports and communicate and to empower people. The whole movement of I guess the term is participant-directed care or client-centered care. At the core of that is that people with disabilities are the controlling force in their lives and rather than assuming that someone comes in and our assessments are done to see what they need and what they can't do we approach it from what can they do?

What can we do to support that in their lifestyle so that our care managers are then better able to dialogue and form a relationship with people rather than coming from the point of view of a

person who is disabled can't do anything. I am here to take care of them and I am here to make their lives better. So it is a real leap for many professionals to make because in any other health environment this balance doesn't exist.

Moving on from there, I think it is essential to have this trust depending on what the person wants, right? So we make assessments to determine the type of care someone needs, the level of care, their ability to make interventions on their own behalf, their ability to seek assistance when necessary and awareness of risks and abilities to monitor, intervene and intervene appropriately and the level of health literacy.

We have people who were born with their disability, people who grew up as children with their disabilities and a large number of people who became disabled later in life because of disease like MS, a car accident, we have a significant number of people who acquired spinal cord injuries because of gunshots or stabbing and then we also have a huge number of people who because of a chronic condition like diabetes now they are disabled because of peripheral neuropathy, amputations or a decrease in their ability to see.

People are at different stages in their lives. Younger people are more likely to have incorporated a sense of being a person with a disability into their identity as opposed to people who come in and feel that they are sick and they are here because they are sick. It is a whole process of helping people depending on the type of care you do and the amount of care coordination you do is based on a lot about where that person is in their life. What I want to say when they become disabled is how do they see themselves? Do they understand there is a difference between being physically dependent and in being totally dependent? Or not independent?

So we talk a lot with members and care managers about doing that to support people to make their decisions and it is not always easy. We work really hard with trying to get people to talk about what they want, what their life is like, how the decisions we make with them impact their life? Not just is he ever going to talk about the hours of personal care someone receives? Well what happens to people then? What is different? What do we need to do to build up someone's ability to take risks and make choices?

I think we should go to the next slide, please. One of the biggest challenges is access to healthcare for people with physical disabilities. Because of that many of the people we work with wind up being sicker because they don't get preventative care. They don't get good primary care. And they certainly don't if you are a woman with a disability it is extremely hard to access women's healthcare like mammography and routine pelvic exams. So how do we help people to maximize their access to healthcare to be able to know what to do?

What we have been doing a lot is trying to work with not only healthcare providers and talking about the legal requirement of providing accessible healthcare to people with disabilities but also to the person with a disability what do you need to do? What do you need to know about yourself? What do you need to know about what your rights are in accessing health? [MLTCs] and other dual-eligible programs are going to be really evaluated in part on emergency room visits, repeated hospitalizations so the more we can do to improve the access that people with disabilities receive in healthcare the more likely we are to be favorably reviewed.

It has a huge impact on people. One of the programs we do is an accessible mammography program. We partnered with several sites. One year one of our members who became disabled later in life as a result of diabetes, morbid obesity, high blood pressure and a lot of neuropathy was morbidly obese and weighed close to 500 pounds and uses a motorized wheelchair. She had to have a mammogram.

So in the program we offer we were able to send one of our nurse educators with the member to a partner site who would be able to work with the staff there to provide the disability-competency. How does the wheelchair work? Can the armrest come up? How can you better position someone? Because of that for the first time as a wheelchair user she was able to have a mammogram. When she had to go back the following year for her annual mammogram the nurse wasn't able to go with her. She went into the mammography facility, they looked at her and they said, "Oh, wow. Someone like you can't, we can't accommodate you," and she was able to say, "Oh yes you can. You did last year and I can tell you how to do it."

So a lot about what we try to do is work to empower our members as to what they want and how to get there. When we started we had all of these preconceived conceptions. One idea of improving healthcare was that most of our members were receiving healthcare from hospital-based Medicaid patients where they had no continuity of care. They saw the resident, the medical student and the intern and if lucky the resident some time.

So we said we would refer them to physicians in private practices so that they wouldn't have this, they would have better care. No one jumped at this. We couldn't figure out why someone wouldn't rather than spending hours at a clinic go to a place where they could be seen by a fully-trained professional in a better environment. What we learned was that it was a social outlet. Some people only got out when they had medical transportation. So what they would do is they would go to the clinic and they had met other people and become friends with them.

So they would go early in the morning, stay there the whole day, have lunch with their friends, probably go shopping and then come home. By our assumption that we would give them better care they would rather have their social authority and social event and experience. Coming from a living background Anna and I have talked a lot about integration and inclusion and not something that is separate but equal.

What we thought about was why don't we just send them to social day programs or things like that? Well that didn't work because these are usually designed for the frail elderly with some cognitive issues. Then we started working with some of the YMCAs and YWCAs and clubs in the area so that we were paying membership for our members to go and they weren't really taking us up on it. When we held focus groups to find out they said, "Gee, I really like the program but I am the only one with a disability and I'm taking a writing course and we are supposed to be writing about our experience but I don't feel comfortable," or, "I go there and then I have to wait two hours for transportation to come and get me."

What this generated was our members coming up with their idea of social programs. Now we run a several days' per week program in two of our offices where we run various groups. We have

done things like Weight Watchers. We have done a writing group, a movie night. We do sewing. We do art and they are led by members. The members are the leaders. It is all driven by a need that the members had.

What we try to do is support, be there as a safety net. Many of our people need a lot of care management and a lot of care coordination. Other people just need us as a safety net when something is going wrong. We have one gentleman who actually worked here for a while. He was very independent, very involved in a local disability rights movement and was living what is called [now a PCA] in his home. He came back. He was in Long Island. He fell off a curb when he was getting ready to go back and he was an amputee and hurt his back and his other leg, his one remaining leg. So he wasn't able to stand and do [trances] anymore.

When he was hospitalized they were going to send him to a nursing home and not to rehab and why? Because there was no goal. So no place would take him because he didn't have what they considered an achievable rehab goal which usually would have been walking but this man hadn't walked for 30 years and he wasn't about to be able to walk. So what happened was we intervened and talked it out. We have to look at someone what their normal level of function is and someone loses that because of an accident then the goal is to make them go back to their former level of functioning or as close to it as they want to be.

Their plan was to send him to a nursing home which he would have killed himself if he went to. So knowing what our membership consists of and knowing what they need is real helpful. We talk about the need for stable home care. Well, how can anybody live independently and pursue their interests if they have to worry will the homecare worker come? What if I have a replacement? Will they know how to transfer me?

So the importance to stabilize the home care is crucial. I guess I have been rambling quite a bit but I just want to really focus in on what we need to do, what plans need to do when they talk about the way they approach people with disabilities. Our population is not frail elderly or have cognitive issues. So how do we provide that model of care at the same time? How do we bring our members to that point where they take more and more responsibility for their lives and move away from being a patient to being a person with a disability?

I think that is about it. Chris?

Christopher Duff: Thank you, Marilyn. As you talked what you really reflected was that care coordination is just as much an art as it is a science. I am reflecting upon I think traditionally health plans tend to look at utilization to identify those who need a higher level of touch. That is a starting point but that is really just the science and that really won't get you to more of the art of it. That last situation you talked about, that gentleman sounded like who fell in Long Island he was very independent and did fine for a very long time and didn't need much. He was one of those people I refer to as you kind of run behind them to make sure they get what they need.

But then something happened to him and he needed for a short period of time a level of higher care coordination support to get him back to where he was and then we could back off again. That is situational. That all speaks to the care coordinators need to ultimately bring their own



judgment based upon the relationship they have with each of the participants about what they need today.

The takeaway, you gave some great examples and towards the end there are some tools that you referenced about helping them prepare for appointments and so on, but the takeaways I get from your presentation, yours and Anna's presentation, are threefold. First is that participants bring their own experiences, fears, hopes and expectations. It is the responsibility of the plan and their providers to listen and understand these. So the first step is definitely listen which again is new for many providers.

Secondly, support and coordinating a person's care requires a trusting, respectful relationship. The person is not going to talk and really share what they need if they don't have a level of trust. Without the trust communication can become challenging and the care less responsive to the participant's individual needs.

Thirdly, the coordinators need to take their lead from the participants, providing a level and nature of coordination that each of them expect. I think it is a consistent story all the way through we need to listen; listen individually to the participants as well as look at what they are doing. The fact that they weren't going to those community primary care providers. Instead of putting more pressure on them to try and do so you stepped back and said why not?

I think that is a theme all the way through Disability-Competent care and I think it would be relevant to other populations too that you need to look at what their experiences are and then model the support around that.

With that summary I think what I would like to do is call your attention to the survey link at the end here. We will be going to questions and answers in a few minutes. When you have a chance if you could make sure that you fill out the survey we would very much appreciate it. Marlo, could you now open up the phone lines for phone-in questions?

Operator: Thank you. Ladies and gentlemen if you wish to ask a question please depress \* then zero. You will hear an acknowledgement tone. If you are using a speaker phone please pick up the handset before depressing the numbers. Once again please depress \* then zero if you do have a question. One moment please as we get those that queue up.

Christopher Duff: Okay. I think I will take some of the questions that we received online. I think it was Anna you mentioned situations about not putting that at risk. Could you give me an example of a situation that your staff felt was putting them at risk? Then how did you handle that?

Anna Fay: One thing that comes to mind is we had a member who had a boa constrictor and a pit bull. Obviously it was kind of hard to convince the PCA to go into and visit him in his apartment and meet his needs. So what we did was simply say either put the snake in a cage to keep the staff, the people who were going to be coming into his apartment to assist him, to keep them safe. Of course it worked out. But there are many examples like that where there are members who engage in dangerous kinds of activities like selling drugs.

We learn about this because the direct care workers are there and they see it and they know what is going on and they are uncomfortable. So we just make a pact with them that if you are going to do this it is none of our business it is your life but you can't expect people to just do it when your aid is not there. So that is the kind of thing that goes on all the time, Chris.

Christopher Duff: Thank you, Anna. That is a great example. I have a question actually directly for Marilyn. Marilyn I know that your department at ICS in particular handles appeals and grievances whether they are formal or whether they are more informal. Can you talk about a situation where the participant, your member, was not getting -- there was a conflict arising with their care coordinator or care coordination team? Could you just talk to how you guys handle that and give me an example?

Marilyn Saviola: I can give you an example. We have one member who was going to college and she had been assessed for let's say receiving six hours of PCA services three days a week. Right? She said to her care coordinators that work with her, "I don't want that. I would rather have eight hours two days a week. I don't want it." They kept saying, "But rather 12 hours twice a week and they kept saying no you have to do it three days a week."

What we did in resolving it is bringing them together and having the member explain I am at class. I don't need someone there when I am at class, but I do need someone on the weekend because that is when I do my errands. That is when I do my shower. That is when I do my shopping. So you know she needs this care but how to give it to the member in a way that addressed her needs.

I think what happens a lot in the grievance and appeals is that if someone is dissatisfied with their relationship with the care manager part of what my staff does is say, "Why? What is wrong? What is not working?" Then trying to facilitate it. I think in a situation in an appeal when it is someone who let's say is getting 12 hours of PCA service five days a week and the assessing nurse says, "Well, you could do with less. You only need 10 hours," or whatever. I think what we work with the member to do is say, "Explain why you need it. If we reduce your hours what would happen? What would be the difference?"

The care manager or the assessing nurse is saying, "Look at this situation. She can explain to you why this would mean [that]." I think it is going a step beyond and to get really very specific in trying to figure out how our behavior or our decision to change something impacts on somebody's life because when someone does an assessment or even a regular care coordination especially with the assessment stuff you are encountering someone in a moment in time and what you see may not be reflective of what their everyday life is like.

Christopher Duff: Thank you. I think kind of related to this one of the participants emailed in an interesting comment. This is Linda [Thrower] of Blue Cross/Blue Shield of New Mexico, I believe. She talked about working with a care giver who smokes and she is on oxygen. What she said here is that basically what they did is they engaged the client in a discussion and basically came up with a strategy to tell her, to ask her and teach her to turn off the oxygen while she smokes and then she smokes and then turns it back on again.

So again I think that is another great example of it is a discussion process.

Marilyn Saviola: Right.

Christopher Duff: Another question that has come in is, let me just see one second, what tips do you have for developing relationships with individuals who are just really hesitant and distrustful?

Marilyn Saviola: I think you try to look for the one person on your team or your support staff who maybe the member would relate to. It may not always be the nurse. It may not always be the care manager. It could be someone in the rehab department. It could be someone in Member Services, someone in the Advocacy department. But trying to find out who has made a connection and then using that.

Christopher Duff: That is a great tip. What we found in Minnesota is often it was the Member Services person, the person they call for transportation who they trusted. That person was the one who had the most sense of what was going on in that individual's life. So then we would try and set up ways to reinforce that dialogue.

Another example that comes to my mind is someone we work with who was agoraphobic. We would send a staff member out but they would never be allowed in repeatedly and the person was really scared. That person watched once as one of her care givers came in. The way that person got into that person's apartment was they came in through the window. So our staff member actually went to the window the next time, knocked on it and was let in through the window. After doing that a few times there was some confidence and some trust there to the point where the member was willing to open up that door.

So again those are examples of working with the person.

Marilyn Saviola: I could give you a similar example early on. We had gotten all kinds of complaints from the healthcare provider that the member was dirty because she had a dog and she kept insisting on feeding the dog liverwurst and then the dog would have diarrhea and she wouldn't clean up and she wouldn't let the PCA. So we sent one of our nurses in who was really good with pets, right? She went in and she said, "Oh, I want to see your pet." I want to see your relationship. I just love dogs. Then she says, "Well, why do you feed the dog liverwurst?"

The member, who was delusional, said, "Because God told me that was the best food for dogs." They said, "Really?" They said, "Yeah." They said, "Well God told me that wasn't a good idea, that some dogs actually get diarrhea. Why don't you try doing this instead?" It worked. We couldn't keep a home care worker in the house but you get into the craziness sometimes.

Christopher Duff: That is great. I think one takeaway from all of this is somehow you need to step back from engaging in the power struggle because you are never going to win a power struggle. So the issue is kind of how do you step back. That last example you sent someone else

in who established a new engagement and came up with a different approach that at that time seemed to work.

Another question that we have and this goes back to Anna, you speak of the training you provide for all of your staff. How do you provide additional physician-specific training for your staff?

Anna Fay: I am assuming that means discipline-specific?

Christopher Duff: Yes.

Anna Fay: Right. We just do. We really have a very robust training program. For example, with Disability-Competent training is a 12-hour training and we do this in two days and it is mandatory for all staff because it is not discipline-specific. We have a four-week orientation for new staff at the end of which there is discipline-specific training that is provided. The training is ongoing. We have training in [something] called the Coach Approach and the Coach Approach really is communication training.

So it is robust. We have an affiliation with PHI which used to be Paraprofessional Healthcare Institute and they are just incredible with writing curricula for these programs. It is commitment. It is a commitment that the organization has made.

Marilyn Saviola: Anna mentioned earlier that we have some very specific teams. Like we have a team that specializes in MS. The staff in that team has been trained. The nurses have gotten their certificates for being proficient in MS in nursing. Social workers do a similar training. With a spinal cord injury team they spend time in rehab facilities learning it. The same thing with our rehab department. So we do that very specifically. Our wound care department all of our nurses are certified in that unit are certified wound care nurses. We pay for their training to get the expertise.

Christopher Duff: Thank you. I would like to at this point point people's attention to the survey at the end of the presentation. If you could take a few minutes and fill out the survey. Then also feel free to email any of the names on the slide if you have any questions regarding this webinar or have any ideas for future training.

One last question that I think is really a follow-up question to the previous question here and is for you, Anna, or Marilyn really. Have you found it necessary or beneficial to provide any ongoing or annual training for your staff? If so, what is the focus?

Anna Fay: Beyond the trainings that take place from the regulatory compliance issue we really are now developing actually a follow-up training for the Disability-Competent training which of course would be a lot shorter than the 12 hours. We have looked at the Coach Approach and kind of brushed, part of [this] training includes a revisiting the Coach Approach training. We try to integrate the training so that they come together and it is not something that is isolated. Do you have anything, Marilyn?

Marilyn Saviola: The grievance and appeals training is required annually. We do that.

Christopher Duff: Beyond just simply orienting your staff about the rights and responsibilities of --

Marilyn Saviola: We have them do some role playing.

Christopher Duff: That is what I was going to ask. Talk a bit about, give us a role play that you have --

Marilyn Saviola: What we start with is we do a role play of someone going to Best Buy or a place like that and trying to return an iPhone that doesn't work. Dealing with a nonresponsive person there. So we talk about the importance of customer service. Everyone has had a grievance. It is not just that you are somebody who complains. A grievance is just some kind of dissatisfaction. Then we will role play things where someone will call in and complain about a personal care worker. It could be a very serious complaint about neglect or it could be something as basic as they don't understand my culture. They won't cook African food or whatever and how you deal with that. Then to get their feelings about what happens when you do that or when you are multitasking and not really listening.

What happens then? It is kind of to kind of put that into the place of what you are doing that day and when someone calls with a grievance you may think it is not big but to that person it is a huge deal.

Christopher Duff: Thank you. That is what I was hoping you would say. It is very concrete and it is participatory. It is not simply a regulatory training you go through. You really try and bring it to life for them and those examples are great.

I am going to need to wrap it up at this point. We have reached the end of our time. Any questions that we receive after this we will get back to people after offline here. We are in the process of developing specific plans for the coming year based upon the input you have provided. Everyone who is signed up for any of the 2013 webinars that we are just now completing will receive notice of all future webinars, tools or resources that we are able to provide.

I would like to thank you again for participating and to thank our speakers, Marilyn and Anna in particular for your presentation today. We look forward to working with you all in the coming year. Thank you very much.

Operator: That does conclude our webinar for today. Thank you for your participation and for using AT&T Teleconference service. You may now disconnect.