

The Lewin Group
**Strategies for Improving Care Coordination for Individuals with Intellectual and
Developmental Disabilities (I/DD)**
August 9, 2022

Melanie Norris

Thank you. Good afternoon, everybody.

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Today's session will include presentations and moderated discussions with three subject matter experts on I/DD. This session is being recorded and will be posted along with the recording and slides on resourcesforintegratedcare.com. You can also download a PDF of today's slides on the resource pod located on the left side of your screen.

We are pleased to inform you that Continuing Education credits are available at no additional cost to participants. The webinar is approved for one Continuing Education contract hour by the *National Association of Social Workers* and for one Continuing Nursing Education contract hour by the *California Board of Registered Nursing*. We strongly encourage you to check with your specific regulatory board or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.

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This webinar is supported through the Medicare Medicaid Coordination Office at the Center for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high quality health care that includes the full range of covered services in those programs. To learn more about current efforts and resources, please visit our website resourcesforintegratedcare.com. Or you can follow us on Twitter or LinkedIn for more details.

Today's session will include three, 20-minute presentations on strategies for delivering person centered care for individuals with I/DD. Each presentation will be followed by a brief question and answer portion. So, at any point during today's webinar, you can submit questions to the presenters via the Q&A pod located on the left side of your screen, and we will answer as many questions as time allows.

At this time, I'm very pleased to introduce our wonderful panel speakers. We are delighted to have **Dr. Emily Lauer**, who is the Director of the Center for Developmental Disabilities Evaluation and Research at the *Eunice Kennedy Shriver Center*, as well as an

Assistant Professor in the Department of Family Medicine and Community Health at the *UMass Chan Medical School*. Dr Lauer's work focuses on applied research, evaluation and policy efforts to improve the health and wellbeing of people with I/DD and other vulnerable populations. She conducts health surveillance and systemic quality improvement for these populations at the state, national and international levels.

Our next speaker will be **Dr. Joan Beasley**. Dr. Beasley is a Research Professor and Director of the National Research Consortium on I/DD and Mental Health at the *National Center for START Services* at the University of New Hampshire. Dr. Beasley is a licensed Mental Health counselor and is the author and co-founder of the START Model, which we will learn more about today. A service linkage crisis prevention and intervention program to improve capacity for effective services and support for children and adults with I/DD and mental health needs.

And finally, our webinar will conclude with a presentation by **Dr. Steven Deutsch**, who serves as the Chief Medical Officer for Partners Health Plan of New York. Dr. Deutsch is a board-certified orthopedic surgeon trained at Columbia and Harvard where he served as Chief Resident at the *Massachusetts General Hospital* and on the Faculty of Harvard University. I know that you're all going to enjoy hearing from this incredible lineup of speakers. Dr. Lauer, Dr. Beasley and Dr. Deutsch. Thank you so much for being with us today.

As I mentioned, my name is **Melanie Norris**, and I am with the Lewin Group, and I will be moderating today's event. I am also joined by my colleague, **John Jansa**, who will be facilitating the Q&A portion following each presentation.

This slide describes our learning objectives for today's session. By the end of today's webinar, participants should be able to describe the current gaps, gaps in care, for individuals with I/DD, provide strategies for delivering person centered care for individuals with I/DD through the use of innovative care coordination models and understand the impact of these strategies on outcomes of care.

Now, before I pass it over to our first speaker, we would like to launch two quick polls to get a sense of who is in the audience today.

As you could see on your screen, our first poll is which of the following best describes your professional area? Are you part of the health plan as a case manager, customer service representatives or administration and management? Or are you part of the medical fields through nursing, physician's assistants, pharmacy, social work or advocacy? Please take a minute to respond to the poll and we will push the results out in about 10 seconds.

I see we have about 45% of attendees who have responded so far. So, I'm going to give it about five more seconds. And then so are the results.

Okay, it looks like most of the people on the webinar today are health plan case managers, or care coordinators, and we have some representatives from management and administration as well as medicine, nursing, and social work.

Okay, next, I'm going to ask in which care setting do you work? Are you working in a health plan? Do you work for in an ambulatory care setting, long term care facility, homecare agency, community-based organization, consumer organization, academic research organization or other?

We'll give it a few, about 10 seconds for people to respond. So far, we have about 40% of the votes and so I'll give it another five minutes, sorry 5 seconds. Okay, not surprised it looks like most of our audiences are from the health plans. We also have representatives from community-based organizations and some long-term care facilities.

Thank you everyone for providing that feedback. I think based off these results, I'm sure that the folks on the call today will have a lot to learn from our speakers. So, without further ado, I am pleased to turn things over to our first speaker Dr. Emily Lauer to provide an overview of health outcomes and the current state of care for people with I/DD. Dr. Lauer, please take it away.

Emily Lauer

Thank you, Melanie. Next slide, please.

So, I'll talk today about what we know about health challenges for people with intellectual and developmental disabilities, as well as the current state of health care for them and particular clinical related conditions and challenges that they experience. So, we know worldwide that people with these disabilities experience a wide array of different health inequalities, and, unfortunately, violations to some of their basic human rights.

If we compare people with intellectual and developmental disabilities to people without these disabilities, you know that they're more likely to live with complex health conditions, many of which are chronic. These chronic conditions often are more poorly managed than people without these disabilities and may include less common conditions like epilepsy.

They also have more limited access to high quality health care and health promotion programs that are uniquely targeted to the needs of these individuals. We see that they receive preventive screenings at lower rates, particularly cancer screening and more likely to experience obesity, and many different projects who have conducted community-based evaluations of found undetected vision, hearing and dental problems. And people with I/DD are more likely to have mental health problems, as well as the overly prescribed on psychotropic medications. And we'll talk a little bit more about why that is in a moment. Next slide, please.

If we consider how people with I/DD access care and their experiences, we know that they face a large array of barriers of access. This includes providers who may not know or be comfortable with supporting their individualized needs, particularly related to things regarding their disability. There are a limited number of specialists who accept Medicaid and Medicare and people with I/DD have a greater need for specialists of different types and arrays that may be harder to find them in their communities. And they

need to navigate what we know to be a complex system of care. And so, if you consider some of the executive function challenges that are present in people with intellectual and developmental disabilities, it makes it even harder for them to navigate these systems of care which can be hard for any person, to find or receive services.

If you look at the history of inclusion of people with these disabilities and managed care, it really varies. Some early programs really struggled to adequately serve this population, in part because they tend to need a greater number of services, and more frequent services. They also need some really skilled case management and I think early programs may not have had those particular skills. There are however pockets of excellence in what we see in the community-based care system, including some interdisciplinary clinics that have done a really nice job of training up their clinicians and supporting each other in approaching person centered care model for these individuals.

And we know that there are gaps in quality measurement. And I mentioned this because newer models like value-based care really focus on outcome measures. And so, where we don't have good relevant measures for this population to ensure their needs are included, particularly so they're more unique needs, they tend to not get emphasized and so that is an additional gap. Next slide, please.

So, when we look at how and why people with I/DD experience, have...sorry, access Health Services, we see that they are more likely to do the emergency department in a given year, for example, and also to be hospitalized. When we look at why they're using the services, we see more of what we would call sub optimal utilization. So, needing to go to the emergency room for conditions that could be treated if recognized early in the ambulatory care clinic or outpatient services, and also some utilization that's preventable.

We do see a big, what we would call a behavioral component to why people are visiting the emergency room. And this underscores a greater need for community based mental health care and crisis response. For these conditions that understand how to work with people with disabilities, including people with autism. Unfortunately, the emergency department can become the provider of last resort in the situation.

As I mentioned, people with I/DD are less likely to receive health screenings. We've done some work to try to figure out why that is. And we see fewer referrals for screenings by clinicians. There's been some feedback from clinicians that they might not want to try to put someone through preventive screening. But of course, if we think on the other side of the options when you detect a condition at a late stage, that is an undesirable experience as well. So, we're trying to work on education for clinicians and support to have a person-centered approach to considering screening options. We also see some hesitancy with people who are supporting people with I/DD. So, guardians and family members may be hesitant to put someone up for a recommendation for a screening that may be uncomfortable or a little bit scary for them.

You also see people who have special positioning needs, such as women who may not be able to access traditional mammography, experience challenges and getting the screenings they need. And we have seen some programs with some success that do what

we call desensitization. So, we think about a new screening experience and the equipment that's used and the whole experience to walk someone through that ahead of time to allow them to touch the equipment to get more comfortable in the environment and understand what will happen during the course of the screening can really help reduce anxiety during that process.

The advances in screening also give us some opportunity to create more individualized recommendations. So, there are numerous screening options. If we think about colorectal screening, for example, we now have more fecal occult blood testing options, which is stool sample instead of needing to go through an invasive procedure.

So, while not every one of these new screening options will be appropriate for every patient, there are some greater options and that might include ultrasounds for breast imaging instead of mammography. So, for some patients who may not have been screened at all in the past, these newer options may be a good frontline approach to see if further care is needed.

You also want to work with beneficiaries and their supporters to understand why the screenings are important, what will happen during the screenings, and how to make screening appointments that suit their needs. So, they may need appointments with extra time, or certain times of the day, or at locations that are more accessible to them. Next slide, please.

When we think about how to optimally support health for people with intellectual and developmental disabilities, we first want to listen to the beneficiary to understand their own strengths and needs. And if the beneficiary can't tell you that themselves, then ask the people that they choose to support them and are surrounding them. There are some really helpful models that have come out to emphasize some of the key components to making person centered care accessible for this population.

So, we can't assume a high degree of health literacy really in any of our patient populations. But we want to make sure people understand the conditions that they're diagnosed with and how to optimally support themselves. There's a model called communicate CARE that came out of Surrey Place that has a nice, broken-down component of how to communicate and interact with patients so that you really emphasize getting to know your patient, including their accommodation needs, creating a safe and comfortable space to support that person. Accommodating their needs, there are things like we talked about with appointment times or physical locations, and to establish a rapport.

And if you consider how to communicate here, you want to be really clear in your communication, to be listening attentively, to be really responsive to their concerns, and engaged with the patient. And if you think about the different components here, these work for many different types of beneficiaries and patients, not just people with intellectual and developmental disabilities.

I also want to make a note here about behavior. Behavior, in people with intellectual and developmental disabilities is often really misunderstood. It is communication, and it should start there. And when we train our medical students, for example, we use a HELP model, which is an acronym that really breaks down how to consider behavior first as communication and very last as either a psychiatric condition or just an undesirable behavior.

Often people with intellectual and developmental disabilities may act a little bit differently, when they have a medical condition when they're in pain, when they're experiencing some symptoms in a way that you or I might, like vocalize. We also want to consider its environment. So is there something stressful happening around the person or something and agonizing, thinking about lived experience, there's a much greater history of trauma in this population, including abuse and neglect. So sometimes behavior is related to past trauma.

And if it's no to all three of these things, it's kind of only then that we pursue the idea that their behavior, especially if undesirable, or adverse, might be a psychiatric disorder. The opposite of this order is what has happened, unfortunately, historically. And so, there are teams that are, are doing a better job of, of really working through this, but it's an important consideration.

As we'll talk about in just a moment, too, there is a number of specific risks and conditions that people with I/DD are more likely to experience. And we want to be sure to assess their various risks including the risk of trauma and to mitigate those throughout their relationship. Promoting advocacy is also really helpful because as you can see with the barriers that are experienced advocating for each person's needs is a key part of ensuring that they receive high quality health care. Next slide please.

So, in managing chronic conditions, we want to be thinking about how to make that person, that beneficiary and their supporters as skilled as possible in supporting themselves. And often, that means educating that person and the circle of support around them. As we think about trying to make lifestyle modifications like dietary changes and other things, it's a lot easier if people do this together and they're all on the same page as opposed to one person in the household. For example, trying to make a change, while everyone else there around does not. So, we want to include and engage the circle of support. And people with I/DD may need some additional assistance to help make these lifestyle changes like diet and exercise. To make sure that they are managing their chronic condition and that they know when to seek help if there's a sign or symptom that emerges from that condition.

There are unfortunately a limited number of chronic condition management programs that really apply to people with I/DD. So, there's evidence for example, that some of the individual diabetes management programs, for example, don't always do well. Extrapolated for this population, so there is a greater need for more patient centric approaches. We also know that from what we've assessed with claims data that physicians are not as likely to adhere to all of the quality components of clinical management for chronic diseases for people with I/DD as they are for other people that

they're treating. Diabetes is also a great example here. If you know the NCQA components of comprehensive diabetes care, for example, they're much less likely to receive all of the different components that make high quality care. So, there is place for education and for advocacy. Next slide, please.

As I mentioned, there are some conditions that people with I/DD are more likely to, to have and these include what we call the fatal five. Either viral obstructions, infections of various kinds, but predominantly, urinary tract infections, pneumonia, and cellulitis, aspiration, dehydration and seizures. And there are a whole number of reasons why people with I/DD are at higher risk for these conditions. That includes some of their comorbidities, the medications they're taking, particularly psychotropic medications, and the side effects. Some of the lifestyle factors and their need for support from other people. We want to make sure in preventing these that we take a couple of key steps.

So, as I mentioned, first, we want to assess risk and to mitigate that risk. We also want to take some preventive approaches. So, ensuring hydration, good diet, bowel health, making sure we're not over prescribing sedating medications, or those that contribute to constipation. And making sure we're taking prevention approaches that can all help mitigate what we would call the fatal five.

Those are really essential to act on early signs of symptoms and to recognize these as we talked about, they may not always look like they would, for other people where they may be, have unique ways in which a person with intellectual or developmental disabilities expresses pain or discomfort that we want to recognize and pay attention to. Next slide, please.

The polypharmacy is a really big deal in this population. People with I/DD especially adults tend to be on a staggeringly high number of medications at the same time. And we particularly see polypharmacy in psychotropic use. So, some of the reasons for these are mistaking behaviors for mental health conditions. And so, there's overuse of things like antipsychotics in this population. We also see more meds being added, the more someone goes to the hospital or to ER trying to treat what's emerging at the time. But very often those meds aren't walked back if they're not needed. We also understand that sometimes people with varying conditions look like they have other conditions when they show up. And that's where provider education support is really critical to be able to help them distinguish what's actually going on. And we see also that some of the medications that are frequently used have side effects that are then managed with additional medication. So, you can see where we enter into a cycle of more and more medications as the person gets older. There are multiple downstream effects of that polypharmacy. It does include unfortunately, increased morbidity and mortality, but it points right back to the fatal five as well. So, more constipation, more bowel obstruction, more dehydration and things of that nature. Next slide, please.

So, in terms of improving accessing quality here, we want to think about hitting a number of different areas. So, we want to ensure a good provider capacity of specialists, not just I/DD specialists but specialists who accepts Medicaid & Medicare for all the populations. We can overcome provider reluctance by providing education, and support. There are

some innovative models looking at things like an echo model where there are clinicians who have experience with I/DD who can be a source of advice and referral for other conditions like primary care physicians who may be working out in the community that can aid the ability to treat this population. So really thinking deeply about how we scale up and build confidence in our providers about how to care for this population.

We also want to provide skilled care management here. Really understanding the needs of people with I/DD and making sure that they can navigate that complex system. And that may really involve a start to finish kind of approach where you're making sure that they're able to successfully not just get that appointment but get in the door and receive the services there.

We also understand that, as we talked about, with the diabetes care example, access is not necessarily sufficient to achieve quality. We want to make sure that our physicians are really supported to apply the evidence-based practices for this population. Really be thinking through those steps and ensure that they get all the different components they would think about for other populations, as well. Next, that's it. Thank you very much.

John Jansa

Great, thank you very much, Dr. Lauer. We have now entered the Q&A portion for Dr Lauer's presentation. And I want to first thank those that submitted questions during Dr Lauer's presentation. We will do our best to ask and get answers to the questions that were raised. And including for those questions that were submitted during registration, which we appreciate everyone's input. Dr. Lauer, we did have some questions come in during registration and so I'd like to begin.

You talked a little bit at the end of your presentation about ways to improve provider capacity. One question that came through was what do you recommend health plans prioritize if they would like to improve provider capacity for providing health care services for people with I/DD?

Emily Lauer

I would say two things. First is education. I think often you know, using the continuing medication for medical education credits is a helpful way. We have to keep in mind that many medical school curriculums did not include content on how to treat people with intellectual and developmental disabilities. That is changing, but it's slow and it's not universal. So, we can't assume that they've had a chance to really understand the unique needs or how to communicate with these patients. And, you know, sometimes it's intimidating, and we want to build that confidence. So, the education would be the first part. And then support would be the other.

So, if you're going to launch a program, for example, where you're enrolling a number of beneficiaries with I/DD, you want to make sure that skills support is a resource. Some of these providers have questions or they're feeling stuck or they're not sure what to do, that they have a skilled resource that another clinician they can reach out to coach them to guide them, provide them with advice.

John Jansa

Great, thank you for that. A question tied to that then, for many people in the community that are serving people with I/DD, as people with I/DD age through systems. One of the questions that came through during registration was how to best support individuals with I/DD as they age out of a pediatric system into more of an adult system, and how can families and caregivers and health plans support individuals with I/DD as they age through these systems?

Emily Lauer

Yeah, I think that's a great question, in part because there's substantial differences in the models of care currently between the pediatric and the adult system. So, we really want to be thinking about that transition early. Some of the stronger systems start having these conversations about what that person will need in their adult life as early as 14 or 15. So that there's multiple years to have that conversation and to be understanding for example,

how much support will that young adult need in making decisions, understanding that once they become an adult, there may be an opportunity for models like supported decision making, sometimes guardianship, but we want to, you know, support somebody to be as independent as possible.

And so, thinking about the right model to help them advocate for themselves, and then also making sure that there's a warm handoff with the adults provider. It can be challenging to, to find adult providers, that will take in young adults, so that will take some time sometimes. And we want to make sure that those clinicians have an opportunity to work with each, other talk with each other so that there's a continuum of care. And it doesn't feel like a hard switch from one system to the other. So those would be some of the tips I have, you know, depending on whether you're a family member, or even a care coordinator or provider, encouraging those conversations to start early is, is very beneficial.

John Jansa

Great, and we have some great questions coming on the Q&A. So, I'd like to raise one of those up Dr. Lauer, reflecting on the claims-based analysis that you noted in your presentation, are there any specific programs or initiatives that you can cite that are aimed at improving the quality of care?

Emily Lauer

Well, I mean, I think there's, there are a few out there, with the analysis we did involve multiple states across the US and just came out fairly recently. So, I think we're still working on the next steps to trying to work with local public health programs and others to build materials that are specifically designed for chronic condition management, advocacy. Encouraging people to inquire with their clinicians and advocate for the support they need. And then I think there is an opportunity to do more education and outreach, related to these conditions to ensure that people with I/DD are able to take

advantage of what we already know, constitute, you know, quality care, because diabetes care clinically for someone with I/DD doesn't necessarily look any differently than it does if you don't have I/DD.

The patient support may be the tests you need to run and, and things may be very similar. So, we want to make sure that we're not seeing inequalities in those components. And I think where we have an opportunity to chase for and monitor those things, health care plans have a good role in this. They can be an influencer to make sure that clinicians are providing the high-quality care to this population as well.

John Jansa

Thank you so much. A follow up question again, talking about some of the contracting initiatives around value-based care. Can you speak to a little bit how do you propose value-based systems can best serve adults with I/DD when considering from a contracting perspective, and considering adults with I/DD as they age into the senior or elderly realm?

Emily Lauer

Yeah, I think sometimes the targets that are chosen for a larger, more diverse value-based care program, don't always consider the specific needs of people with I/DD. So, I do think there's more work to be done to figure out what the right targets are. We've been engaged in some early work in that but thinking about what does this population really need? What does success look like and ensuring that you have the ability to measure it for this population? Sometimes they get a little bit lost in the larger population emphasis, but they are high utilizers. They have as we talked about complex care needs. So, when you're looking at the value-based outcomes, both in the design phase and the measurement phase, I think being able to carve out this population for specifically understanding do they get the value-based outcomes too is beneficial to see how your program is functioning.

John Jansa

Great. And we may have time for one or two more questions. One question that came in through the Q&A. Very often there's discussion about how providers can take additional steps to serve adults with I/DD, individuals with I/DD. How can providers best be supported to offer the time and expertise they need to effectively provide health care for individuals with I/DD?

Emily Lauer

That's a great question and I do think the providers need to have the resources, financial and otherwise, to be able to carve out the time to really thoughtfully provide care for this population. I think we often see that longer visit times are needed. But in addition to the visits, a longer amount of time to be able to connect with other clinicians that are supporting that individual, you know, to really work with a team-based approach to provide care, because that's where we see more optimal outcomes for this population.

And so, where there is a managed care environment, I think that presents a lot of opportunities to ensure that the providers have the space and time that they need as well as the skill support to be able to serve these individuals really well.

John Jansa

Great, thank you so much. And again, thank you, everyone. We will take Q&A sessions after each presentation. So as the presenter is providing their content, please feel free to add your questions and we'll do our best to ask as many as we can get to. At this point, I want to take us now to our next presenter, Dr. Joan Beasley, who will be presenting on the START Model. Dr. Beasley.

Joan Beasley

Hi, good afternoon. First of all, I want to just say what an excellent presentation Dr. Lauer just had, and a lot of what we're going to be talking about will have relevance based on what she just presented. So, it's a very nice segway. Next slide.

So, as Dr. Lauer described, my focus is on mental health needs and people with I/DD. And many people with I/DD experience numerous health disparities, including higher rates of mental health symptoms and behavioral challenges compared to their typically developing peers.

And I think what I would say to sort of add to what has already been described is that there is a social construct to this, that can't be ignored that people suffer from trauma and disparities associated with having I/DD almost from birth. People are underestimated. They're kind of robbed from their optimism when they're diagnosed. And this really contributes to especially mental health issues in the population and a high percentage of people that suffer from trauma.

People are often misdiagnosed, under diagnosed or undiagnosed, and even when it's detected few evidence-based treatments exist in mental health. This gap has translated into the very costly and ineffective care, and as described just a few minutes ago results in frequent emergency department and psychiatric hospital visits for people with I/DD and poor quality of life. An earlier age of mortality. Again, as described earlier, the way I describe the population as I refer to them as being having I/DD-MH not dual diagnosed or comorbid. But I/DD-MH which is to say that the population has mental health service experiences, whether or not they actually have a mental health condition is sort of ranges from they certainly do to they absolutely don't, but they receive these treatments anyway.

And there's little research and best practices for individuals with I/DD-MH. And the population is often misunderstood, underserved, and underestimated. Next slide.

So, START was developed in 1988. It stands for systemic therapeutic assessment, resources, and treatment. The term systemic applies to the therapeutic assessment and resources, as well as treatment modalities incorporated into START. We believe that things have to be linked, that there's a social context to it, that collaboration is key. Certainly, managed care is one of the avenues to get there. If people are well trained and

understand the population well. We first developed START in 1988. I'm the author of the model, my colleague, Dr. Robert Stogner, who was a psychiatrist, worked with me on the model back in the late 80s. And it was first cited by Dr. David Satcher, the Surgeon General in 2002 as a model to help overcome disparities in access to mental health care.

Many of the people served to START are dual eligible individuals and our national center trains local community providers in the START Model. We also have mechanisms for physicians, clinicians, people with lived experiences and others to collaborate across the country, to enhance their capacity and share knowledge. We have practice groups in all kinds of areas. As a result of the network that's been built. START teams provide cross systems crisis prevention, intervention, planning, networking, partnerships, as I just described now, health assessment and coaching and 24-hour crisis response, outreach and training.

There are START programs located currently in 12 states and we have 10 additional network partners that use START practices of one sort or another. In 2021, the START Program served 4000 people with I/DD-MH across the lifespan in that year. We have approximately, information for approximately 11,000 people in the START database currently, that we have used to evaluate how things are going next slide.

So, START is a public health tertiary care model that uses this approach to build capacity and reduce the use of emergency and crisis services for individuals with I/DD-MH, and also to increase their service experiences and their mental health. In stage one, we determine the level of acuity, we provide hands on training, share information and advice amongst beneficiaries, families and service providers and ensure there's a coordinated continuum of care in place to respond to their needs and wishes.

We also in stage two identify triggers that lead to crises, conduct ongoing assessment, engage in robust cross systems crisis prevention and intervention planning, and integrate health and wellness activities as part of the remedy.

In stage three, which is crisis management, there's proactive management of crises when they do occur through the use of after-hours crisis response in home emergency support. Therapeutic coaching is one of those devices that we use, crisis stabilization beds, and ongoing training development of newly identified interventions. Next slide.

So, START focuses on community linkages. It's a systems linkage model, and capacity building across a system of care rather than segregated siloed or duplicative services. It's key to build linkages across clinical teams, training and consultation providers, and therapeutic resources so that everyone works together and with other key stakeholders. And by bridging these linkages across the systems, we can break down those silos. And as a result of the linkages, both Medicare and Medicaid recipients can experience efficiencies and cost savings associated with that.

Acute care utilization is reduced and more cost effective. Long term Support Services can be identified, and this includes the reduction of the use of restrictive services. So, while

medication is certainly a big problem, polypharmacy so is restricted segregated services for this population. Next slide.

So here is our framework that is research based. We've been researching the model since 1988. And this is the most recent framework based on the analysis of data. There are four core components to the model intake, an assessment, consultation and mental health, mental health skills coaching for individuals and their caregivers, in their primary settings, 24-hour urgent response, and intervention and linkages, including referrals, outreach and training to the system of care.

The research outcomes include increased capacity in the system of care, decreased use of crisis services, and increased satisfaction with services received and increased mental health stability overall. The thing that I think is really important about this is the use of research and fidelity-based models allows for increased ability to be able to have remedies work sooner than just sort of kind of trying to work it out on your own as an independent service provider. So, while it took the first iterations of the START Model, it took about three years to gain stability for individual service users. It now takes about eight months before we reach stability, and we find increased service capacity and understanding of how to go forward and this is very, very important. I need to mention, however, that we have not discussed the role of race and ethnicity, and bias about the population. That where you live matters, there are differences in access to care between urban and rural settings, your severity of your intellectual disability matters.

Your health, primary health conditions absolutely undermine emotional wellbeing and mental health, and poor mental health undermines your health. So, there's an intersection there that needs to be addressed. And what we do know is for this population, when people are employed, they do better. Next slide.

So, I'm going to do a quick care study. This is a deidentified case, there is no Mr. D. but we'll call him Mr. D. for the purposes of this quick overview. He's a 30-year-old male diagnosed with I/DD since the age of two and schizophrenia since the age of 17.

Mr. D has periods when he's unable to sleep followed by dysregulation and aggression. 85% of the people who end up in the emergency department for mental health issues who have I/DD are referred due to aggression. And the police are often the ones who bring them to the emergency department, which was the case with Mr. D. So, what usually happens, the intervention strategies include determining the level of acuity and to address their immediate needs, refer them to the providers that need to address those needs, and work with linkage partners. If the person is hospitalized, the START team will go and work with the inpatient unit and help as a liaison, a translator of how to treat Mr. D, how to understand how he's communicating and how Mr. D can contribute to his own care. And conduct crisis evaluation review historical patient records. Very comprehensive look, we want to know when Mr. D did his best and what happened since then, determine any further assessments that are needed and survey the individual and his family and his caregivers and himself about his service experiences.

So, the START team provides care, provides surveys of caregivers, but also surveys of people with lived experiences are being developed now with a current grant that we have. We really feel like people with developmental disabilities and intellectual disabilities should have greater opportunity to describe their own experiences and their own needs with regard to mental health services.

We supply research, and coaching and throughout the process engage in our practices are humanistic and focus, we focus on positive psychology, as well as other avenues in including expressive therapy and OT services. We strand spot via gratitude, exercise, health practices, etc. So, Mr. D was never readmitted to a psychiatric inpatient unit. Although he did use crisis beds at times. One of the things that ended up happening was during the process of getting to know Mr. D, we learned that he had temporal lobe epilepsy and suffered from partial complex seizures. All his medications, his polypharmacy to treat his mental health actually lowered his seizure threshold and his aggressive episodes increased with as a result of the mental health treatment that he had. And he ended up back in the hospital with more medications.

So, as we learned more about what was going on with him, we realized that his episodes were much more likely triggered by seizures and postictal activity than psychosis. Mr. D actually learned to recognize when he was having an aura, he actually would tell you, your shoulders were shrinking. He's noticed things in terms of his experience with seizure activity. And this helped guide this his system of support. So, his words, his experience helped guide our learning. Next slide.

So, health plans should actively engage in data collection and outcomes to ensure best practices for individuals with I/DD. Data, data data, it's what you're looking for, that matters and how you use the data. But if you collect demographic, clinical and service outcomes for every person that receives care, you will learn how to improve care. Over time identifying best practices based on beneficiaries experiencing positive outcomes is key. And not assuming that because you have I/DD, you can't tell people what you're experiencing. Those people with intellectual and developmental disabilities do have something to say and it's our job to be able to hear them and listen. Working in partnership to improve research practices is key. We have developed with our colleagues across the country, the National Research Consortium on mental health and intellectual and developmental disabilities, you can find it on our website, and it aims to advance research on best practices and policy toward positive outcomes amongst people with ID D/-MH. Emotional wellbeing and mental health, not just the treatment of illness. Consider funding research about wellbeing, the promotion of health and including individuals with I/DD-MH is needed. Next slide.

So, here are a couple of resources that you might find useful. We are now embarking on a study with Dartmouth Medical School, utilizing the integrated mental health treatment guidelines for prescribers, that you can find on the website link here. It's free. And we are training residents and interns in prescribing practices, and you cannot just focus on psychiatrists because 85% of medications are prescribed by people who are not psychiatrists. Evaluation of telehealth services is also going on in order to ensure that when people receive telehealth services, they can gain maximum benefit. Next slide.

You have to attend to the three A's of service effectiveness. This is a key takeaway. Access to Care, care must be inclusive, timely and community based. It has to be appropriate. Outreach, training and collaboration are key to improving appropriateness of services. And we all need to be accountable, we have to have outcome measures that clearly define that are clearly defined and review of data must be frequent and ongoing.

There is evidence of great improvement when we work together to improve capacity, strengths-based approaches and integrated health cross systems collaboration are key. And a solutions focused approach builds capacity through primary interventions, include secondary interventions with expertise for specialized approaches, and a safety net for emergency interventions. Next slide. Thank you.

John Jansa

Thank you very much Dr. Beasley. So, we will move into the questions and based on your presentation, thank you so much. There was a lot of great information there and we did get some great questions coming in. The first, this is actually there's two questions from the registration that we'd like to start with. One question that came in, how do you recommend striking that balance between meeting the needs of the patient and the requests of caregivers.

Joan Beasley

So, the first thing you need to do in striking that balance is acknowledge that those are two different perspectives. I think in the past, what we tried to do, was have the caregivers represent the voice of the person or the patient. And the balance will come from actually listening to and attending to both. And understanding that there's a context to which health can be promoted at a context in which health can be undermined. So that would be the first thing I would do would be to find mechanisms to have separate conversations and engagement with the patient and with their caregiver.

John Jansa

So, piggybacking off of that question, there was a follow up, what were, what are some of the lessons learned in working with caregivers, if there's a need to have a more in-depth conversation on best managing the needs of the individual?

Joan Beasley

So, one of the things that happened in an early study that I conducted several years ago, was I, I tried to evaluate what drives the crises. Why do caregivers call for help? What are the issues with people with I/DD-MH that result in emergency service use. And I tried to control for several variables including aggression diagnoses, polypharmacy, health conditions, etc. The most significant predictor of somebody having difficulty was whether or not the caregiver had support. So, people, caregivers who, especially in families, primary caregivers, who were sole source caregivers, without additional support in the home, were far more likely to use emergency services and far less likely to use plan

services. So, I think what we don't really pay enough attention to is the caregiving context. And really shoring that up will really help get better outcomes.

John Jansa

Great if we can shift gears one of the live questions that came in had to do with building linkages across clinical teams, can you share how linkages can be built across teams and the mechanisms that can strengthen those linkages? For example, regular team meetings among the care teams? Are there other examples you can cite?

Joan Beasley

So, one of the reasons why I started on this path toward linkages is when somebody has mental health needs and I/DD. The clarity with regard to roles and responsibility, it just doesn't exist. So, one of the biggest goals in developing linkages is for everybody to sort of come together and say, what they have to offer to the person, what their system can provide, and what they need from their partners. And so, the linkage agreements really start out with a discussion about roles and responsibilities. In order for that to happen, there needs to be a primary element, a primary resource, for example, what I believe Dr. Deutsch will be talking about, a care manager, for example, to help foster those linkages and bring people together and be a translator between systems because the systems do not often speak the same language and that's what undermines the ability to link.

John Jansa

All right, we do have time for perhaps one or maybe two more questions. One question that's come in certainly, I think people were interested in learning more about the START program. If someone is interested in learning more about the program or perhaps investigate how to bring a model, like the START programs for their community, how do you suggest they begin to explore bringing a START Model to where someone lives.

Joan Beasley

So, you can look at the centerforstartservices.com. We have a website, just type in center for START services, it should pop up. We have lots of resources there. And if you have any questions after looking around, feel free to email me and I will connect you to the right people to talk about it.

John Jansa

Fantastic, thank you so much Dr. Beasley and as a reminder for everyone. We do appreciate all the questions being asked, we will do our best following the webinar to provide a supplemental material to answer some questions that perhaps we couldn't get to today. So please, if we did not get to your question, please refer back to the resources following the webinar. And with that, I'm happy to take us to our final presenter, Dr. Steve Deutsch will be presenting a managed care approach to improve the quality of care for persons with I/DD. Dr. Deutsch.

Steve Deutsch

Good afternoon, everyone. I'm Steve Deutsch. I'm the Chief Medical Officer with Partners Health Plan. And I'm going to be talking about managed care and its value in dealing with the health and social issues incurred by the I/DD population. Next slide, please.

Partners Health Plan, just to give you a little background, is a managed care plan that's exclusively dedicated to serving persons with I/DD. It went live in April of 2016. And it's the only program nationally that exclusively serves dually eligible individuals with I/DD. We have about 1650 members. Next slide please.

Managed Care, really, really is the platform that's necessary, I think, for dealing with the I/DD population. It provides the appropriate setting to gather data, key elements regarding health issues, utilization and costs related to the I/DD population. And it's this data that helps to identify sub optimal health care outcomes among the I/DD population.

And then identifying these outcomes. This data is used, and we used it to build new programs that we thought could in fact, improve the outcomes for our members and improve the quality of care, and at the same time, provide the baseline to, in fact, measure these outcomes. As we were putting these programs together, it became very apparent that no one discipline had all the skill sets to implement these programs and that we needed an integrated clinical approach a collaborative approach among multiple disciplines.

So, I'm going to be talking for the remainder of my talk about these four programs that we put together, I'm going to give you some outcomes and some key takeaways. Can I have the next slide, please?

In managing people are members that are inpatients in hospital and skilled nursing facilities, our main tool is our clinical rounds. We do this every Thursday. It's based on the Census which comes out on Monday or Tuesday. And we review all of our members that are in these facilities. It's a multidisciplinary team that participate in this process. It is really, really critically important. Next slide please.

We look at various things that you can look at this slide and you'll see we look at the medical status. We look at management approaches dealing with various issues. But rather than talk about this, I want to give you some observations after doing this for a significant period of time that we deal with on a daily basis and that we're trying to improve constantly. First of all, with regard to admissions, somewhere between 20 and 30% of all hospital admissions for patients with the I/DD population are inappropriate. There are multiple reasons for these inappropriate admissions ranging from the inability of a member to communicate, a complex medical history without a lot of records to go with it. Inappropriate admissions for postnatal depression after seizures and also on things like a G-tube falls out. Why are we so intent on and resolving this excessive admission process? Because we've experienced with these clinical rounds, spirals of members who deteriorate both medically and physically after they've been hospitalized.

And it's really amazing to see what happens to some of these people, and it starts a vicious cycle of rehospitalizations, etc. As far as concurrent care issues go, the hospital staff, we've worked hard to educate them because there's often a lack of understanding or ability to meet the needs of the I/DD population. And this can be related to time constraints in the hospital communication, or, quite frankly, some of the behavior issues from our members. Some of the behavioral issues that that our members exhibited in the hospital are outbursts, or misinterpreted outbursts trying to communicate, or outbursts related to fear. They also failed to eat and then that raises the issue of G-tubes, or they fail to participate in physical therapy. And that raises the issue of deconditioning and continually increased number of people that need to go on to a skilled nursing facility program. Staff oftentimes because of functional disabilities, fails to mobilize our members as much as they do non-I/DD people. And as a result, again, they get deconditioning, and we see skin breakdown. As far as medical regimens go, you've heard my predecessor say that the complicated medical regimens, regimen, and that's putting it mildly, often compounded by psychotropic drugs, and a lack of understanding of these drugs, even on the hospital staff in the hospital, and also a lack of information to reconcile drugs from outpatient inpatient.

We deal with lack of advanced directives, and a number of our people are over the age of 55. We deal with social issues related to identification of a guardian or bureaucratic processes. If there is no guardian, we've had to deal with social issues related to caregiver capabilities, even to the point of wondering if the admission was related to deteriorating caregivers. Many of our people who are older have even older parents, who again, are becoming incapacitated.

Also, in discharge planning, we have issues related to people going back to the group home, the residence that they were in, was either a lack of staff or training for that staff because of a new condition that the member has incurred. There are physical barriers related to getting somebody back who was an independent ambulator and now needs a walker. And there's evacuation criteria on a time basis that's set up by the state. Also, we deal with rapidly procuring durable medical equipment. And then last but not least, safety issues related to the patient's previous environment, is it safe for them to go back or then do they need a different level of care? Next slide, please.

The next program I want to talk about is our clinical pharmacy medication management program. This is a program that we developed. We started late in 2017 and have expanded since and it's a program that is done by the clinical pharmacists on our team. And they do what we call a comprehensive medication therapy review. And after this, I'm going to refer to it as a CMTR.

It's based on current outpatient and or inpatient medications. It is based on a review on a weekly basis of the PDE files that we get from CMS, which shows fields refills and drugs and also whether or not somebody has been taking their medication, whether they've been adhering. It's based on a review of a clinical medical records. And one of the things we did early on, is we built a patient profile from claims data. Traditionally, in managed care claims data is used more for utilization numbers, it's used for financial issues. We were able to take that claims data and build a whole medical record for the patient including

diagnosis, costs, hospitalizations, office visits, medication fills, numerous things, DME, what programs there have been so that we have a great picture of that, that member which the clinical pharmacist can look at and puts together with the other pharmacokinetic issues that they deal with.

We use this program for transitions of care from the hospital or from the nursing home. We use it sometimes; we ask for the medication regimen from the hospitals. We're doing rounds because the pharmacist suspects that the medications may have been the cause of the admission. We do it for polypharmacy. And we define polypharmacy as more than eight medications. We do it for the management of chronic conditions. And if a staff or provider requests a CMTR. Now, once the CMTR was done, it's graded. We have a grading system based on the reasons we put down as high, medium, and low. All of the CMTRs, regardless of how they're graded, are, in fact, sent to the providers.

However, when it's high, or when it is medium, we expect a response from the provider. They may agree with the pharmacist, they may say I'll follow up with the patient. They may say I didn't prescribe this. But we have found lots of issues with people either over prescribing being nice because they thought they were filling prescriptions, etc. Gratifyingly about 85 to 87% of the providers send back their responses. So that is really very, very helpful. But the CMTRs find all kinds of things. The most common one about 22% is medication interactions. 22% is what we do in effective medication. About 17% is unnecessary medication, and it goes from there. The next one is needing additional medication. So, it's not only taking it away, but sometimes it needs to be added or the doses need to be adjusted.

And we have found multiple admissions related to medications. psychotropic drugs, for instance, causing hyperthermia misinterpreted as sepsis, syncope and dizziness, bleeding, arrhythmias, I can go on and on. Drug interactions which cause psychiatric admissions because of aggressiveness. So, it's really a very worthwhile program. Next slide, please.

The next program is a more traditional one. That isn't a lot of plans in the secure management program, but ours is pretty unique. Because each person has a two-member team, the clinical team leader, which is a nurse or MSW, who also was the one that participates in clinical rounds, has under her or she, four care managers at a bachelor's level. The team itself does an initial assessment of the patient when they first come in and creates a life plan. And then every six months reassess that patient. At the same time, they do a dynamic risk stratification, and this determines how many how often they will do interventions to catch up with a patient, whether it's monthly, whether it's weekly, it depends on the situation.

But the key in this model is in fact, the collaboration between the care management team which really deals for instance, clinical rounds, with discharges, whose social issues and actually gathering data, even lab data in collaborating with the healthcare members on the team. It really works well, and they really work as a team and it's critically important. Next slide, please.

Last but not least, I want to talk about telemedicine. Now, I want to give you some background and just because I think it's really an interesting process. We started telemedicine long before the pandemic, which has popularized it. We looked at our data in 2016 and 17. And we realized that 53% of our patients who went to the emergency room were admitted, we then reviewed spark data from 2015, and that's a database from New York State Department of Health. You know, in New York, and what we saw there was that if you were non-I/DD patient and hit the emergency room, your chances of getting admitted were somewhere between 10 and 16% compared to 40 to 45% for patients with I/DD.

So, a huge difference. We decided we needed to do something about that, and we decided the best way was to do a pilot program with telemedicine. We put out criteria for a company we wanted to work with, and we came up with a company called StationMD. It's a company that specializes in this process. They are board certified emergency room physicians who have also had additional training and caring for individuals with I/DD.

They had developed kiosks that go into residences, so they can do with the equipment in those kiosks and training, the DSP staff and the residences. They can do virtual physical exams. And for the community, we have an app. And for people who have multiple comorbidities, we can put it in equipment so a virtual physical exam can also be done. In addition, the StationMD physicians have immediate access to the medical records of patient profiles that I described for the clinical pharmacist.

So, when they're beginning to talk to a patient, they know that patient's history, they know their medications, they know their admissions, they know all kinds of information. So, this isn't a cold call whatsoever. Next slide, please.

The pilot program was so successful in 2018, in the sense that out of all of the phone calls, only 11% were sent to the emergency room. 89% were treated in place. It was so successful that in 2019, we offered the program to the entire have members. And what happens is this, if medically appropriate, the StationMD will treat somebody in place and this includes prescribing medications following up in two hours or the next morning, etc.

If that person needs to go to the emergency room, as deemed so by the StationMD physician, they will call ahead of time notify the emergency room, give them the history, tell them why they're sending them in. After the workup is done, they will talk with the emergency room physician. And they will in fact together, decide if the patient needs to be admitted. Just a little point in time. What I was told is a lot of emergency room physicians will admit somebody with I/DD because they don't know who's going to care for them on the outside if they let him go even if they could. So, it's been very successful. And we have, we also built a financial model. And since 2020, the estimated ER and admission cost avoidance from the StationMD program is greater than \$5.7 million. Next slide.

So let me give you some key takeaways. And both of my colleagues who gave great talks previously, have basically said the same thing. Number one, data is key to understanding and managing the health care and social needs of people with I/DD on a population but

also on a member centric basis. And I'll elaborate that in a minute. Managed Care is the ideal platform to collect this data.

How successful has this been integrating this whole process using a multidisciplinary team? For instance, since 2018, we've reduced hospital admissions by 42%, down from 413 per 1000, down to 239 per 1000. And another number, 30 Day readmissions have been reduced by 30%. Again, I want to emphasize that, that possible admissions for people with I/DD oftentimes are inappropriate and have devastating and lasting physical and behavioral effects.

Medication management is a critical component of dealing with the I/DD population. The pharmacist when it comes to pharmacokinetics, and drug interactions, really know best. I give you an example, out of 500 medical regimens that we reviewed in 2021, 60%, that's significant findings that could affect the members health. We're accountable for admissions, or we felt would potentially result in a hospital admission if not changed.

And last but not least, telemedicine has been highly effective reactive, I'm going to emphasize reactive tool for outpatient management of the I/DD population. As we gather data, we are now in the process of looking at proactive programs. We've analyzed data from emergency room visits and on key individuals. And what we found, that we can deal with urinary tract infections, head injuries, diabetes, diabetes and constipation on a proactive basis.

In conjunction with StationMD, we've developed treatment regimens. We are training people in the residences of people that have these issues, and we have identified on the centric basis who these people are. And we have programs where for instance, for urinary tract infection, they get a weekly dipstick. If it changes then nitrates come up, StationMD is called, and they will intercede. This is a very proactive process now to prevent things escalating to a point where it needs somebody needs to go to the emergency room or getting admitted. And we are using this with I/DD providers to share savings. So, there's a value-based component now going forward with this proactive process. So, I want to thank you for your time. I think all of the speakers have reflected a common theme with I/DD. But PHP represents a working model that continues to go on and I think emphasizes the value of managed care and dealing with and coordinating care for the I/DD The population. Thank you.

John Jansa

Thank you so much, Dr. Deutsch. We'll move right into questions. And one of the registration questions that came in Dr. Deutsch is when your care management team are serving members with I/DD. Very often those members may have other care managers or care coordinators that have been part of that individual's network. How do you ensure coordinated communication for members if they have other parties or managers that are involved in their service delivery?

Steve Deutsch

Great question. First of all, when we get somebody in the program, we pretty much conscript them and we do most of the care coordination. But if they have people in other programs that care, the care managers, the clinical team leaders will reach out to them, and they will coordinate with them so that we're not taking anything away, but we make sure there's coordination in the process.

John Jansa

Great. One question that also came through during the registration period. Through your work, and through the work of your teams engaging and working with the providers in the community, have you noticed any impact that your services have been able to provide that have perhaps addressed or aided community organizations in dealing with staff turnover or burnout? Do you have any recommendations for community providers on ways to address staff turnover and burnout at more long-term care facilities or community-based locations where some of your members may reside?

Steve Deutsch

That's a difficult problem. And a good question. And we really don't have a lot of control over things, such as burnout in the residences, or in the clinics that we've worked with the article, what will be called in New York, the article 28, the article 16, are they federally qualified health care centers? What's happening in New York at this point is one of the things that's come up is a new budget to more fairly pay the DSP population, and hopefully attract more people into this profession, by paying them better, and training them better. But we don't have direct effect on that other than the fact that we help support them as a, as we facilitate the care of our members, you know, in this process.

John Jansa

Great, thank you. For that we, we got a question that came in on the Q&A. And it's very straightforward. How does PHP track participants satisfaction with your care coordination approach?

Steve Deutsch

That's a great question. And I'm going to expand upon that, number one. In order to do that we do satisfaction surveys, okay. So, on an annual basis, we do patient satisfaction surveys. A large percentage of them are filled out by the caregivers, but we do this. But I want to make a point that I didn't before because it's a managed care plan, because we adhere to a HEDIS we meet certain standards for preventative care. And that's critically important. And we've met and exceeded federal standards for things like colonoscopies for Breast Imaging, or other preventative care. And because it's managed care, our people are not losing out on the preventative care that they should be getting.

And by the way, somebody had mentioned the fact about imaging, and we went to battle and explained, and we got the fact that we would cover. A lot about people couldn't tolerate mammograms, so they get breast ultrasounds with dental care. We have places

where we can do desensitization and anesthesia and we have a high percentage of people who get annual dental care. So, I just wanted to bring that up as part of that question.

John Jansa

Great, thank you for that. We want, we still have a couple of minutes left and we wanted to give you the opportunity. Dr. Beasley if or I'm sorry, Dr. Deutsch if there are if there are other outcomes, you'd like to highlight, through the plans work, any opportunities where the plan has really made an impact.

Steve Deutsch

As I said, I think it's we've lowered emergency room visits. So, there's been a little bit of a cost shift because a lot of admissions that people that would have been admitted and the emergency room would have been incorporated in the prospective payment system. Now city's emergency room visits, but we've lowered emergency room visits, we have lowered readmissions, we I believe that our admission rate now is in the realm of almost commercial insurance. And please understand that our members range, both in the community and residences from 21, up until the 80s, and 90s. So, we have a significant older population that we deal with at the same time. So, I think we have great outcome numbers. And, again, I've tried to share numbers on our clinical pharmacy program, utilization and again our numbers, we get a withhold on quality-of-care issues, such as dental visits, eye visits, and all of the above, either through HEDIS or through the state of New York through Medicaid. And we have exceeded those numbers that are given out to ordinary plans where the majority of people are non-I/DD.

John Jansa

Great. And we have time for one last question. Dr. Deutsch, how can people I think there are many people on the call that want to learn more about StationMD? How can they learn more information about StationMD and the benefits from that program?

Steve Deutsch

Yeah, they can. StationMD has a website, they can go ahead and look that up. But I just want to warn you, it's not just getting the telemedicine program. It's integrating it as they said, it's a really key, we set up a lot of criteria before we chose somebody. Again, they have that medical record they look at so it's not a blind, call back to somebody that you know, that has to get history from a DSP. And a member who might not be communicative. They have that medical history that that's one thing. We also, they have now, they're developing some behavioral health services for frequent users, which we've identified that go to the emergency room for attention seeking or other issues. But you can look them up on the website, and realize that you need to coordinate with them, you just can't let them go by themselves. And set criteria such as making sure they share their encounters in an encrypted basis with a PCP. I didn't get into a lot of detail. But that's all very important. But if anybody wants to reach out to me, I'll be happy to help them with that. But they do have a website. It should be under StationMD.

John Jansa

Thank you so much. Thank you so much, Dr. Deutsch. And all the presenters and all the participants today who asks great questions and our presenters who provided great answers. At this point, I will kick it over to Melanie Norris, who will take us through the final few slides, Melanie.

Melanie Norris

Thank you, John. I echo your sentiments. Thank you to all our presenters. We are coming to the close of our webinar. So, we've gotten through all the questions that we have time for today. If you have additional questions or comments, please email us at RIC@Lewin.com. As a reminder, this webinar was recorded and there will be a video replay and the slides will be available at resourcesforintegratedcare.com.

Additionally, if you're applying for NASW CE credit, or CNE contact hours, just a friendly reminder that you must complete the post test, which is linked in this slide and will also be pushing out the link through the Q&A pod in order to receive credit with that 80% or higher passing rate.

We want to thank you so much for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high quality presentations to all. Your feedback is important to us. The link is on the slide as well as being pushed out via the Q&A pod. For more information on I/DD we have provided a list of resources. On this slide there was plenty of really great resources as well mentioned throughout the duration of the presentations today.

We are developing two informative briefs on polypharmacy that was touched on today as well as telehealth for the I/DD population. So please be sure to check out our website for these resources. They will be coming out soon. And again, I want to extend our sincerest thanks and gratitude to our speakers from today. We appreciate you taking the time out of your busy schedules to share your expertise. And thank you to our audience for your participation and engagement. We hope all of you have a wonderful afternoon. Thank you.