Christopher Duff: Good afternoon, everyone. My name is Chris Duff, and I am a disability practice and policy consultant who has been working with The Lewin Group to develop the Disability-Competent Care model and related webinars and materials. I will be joined today by Karen Luken, a disability health consultant with 35 years in the field. Karen has a BS in therapeutic recreation from University of Illinois at Urbana and a MS in recreation and leisure studies. Karen is the Project Director for the Medical Health Homes for People with Developmental Disabilities Initiative in North Carolina. Additionally, she was the Director for the Center of Recreation and Disability Studies at the University of North Carolina, Chapel Hill responsible for teaching, research, and development of innovative services for people with significant disabilities living in the community. She has published articles and resources on cancer screenings for women with developmental disabilities, cardiovascular disease and adults with disabilities, community design and active living, retirement options for people with disabilities, and creating inclusive environments for people with disabilities. I am honored to have her provide this presentation today.

On behalf of The Lewin Group, I would like to welcome you to this series. The Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services has contracted with Lewin to develop technical assistance and actionable tools to support providers in their effort to deliver more integrated, coordinated care to Medicare and Medicaid enrollees. All of the webinars have been recorded and will be available, along with a PDF of the slides, at https://resourcesforintegratedcare.com/.

In 2013, we published a comprehensive Disability-Competent Care self-assessment tool, which we refer to as the DCCAT, describing disability-competent care and have since produced 25 webinars on the topic along with numerous supporting tools and documents. These are all available on the RIC website. The DCC material has recently been revised to be more accessible to users and reflect the further development of the field. It is now structured in seven pillars of disability competency as outlined in this series.

We introduced the seven pillars in previous webinars dedicating one webinar to each pillar. We allow at least 15 minutes at the end of the presentation for questions. Today's presentation is the last pillar, Disability-Competent Long-Term Services and Supports. We would like to solicit your opinion on this series as well past webinars and supplemental resources. Please take the time to complete our survey at the end of the webinar and send us your ideas for future content and topics.

Today's presentation will focus on long-term services and supports commonly referred to as LTSS. These are both formal or paid and informal or unpaid supports focusing on helping people function in the setting of their choice and participate in their community. There are three overarching domains of LTSS including resources and settings to facilitate inclusion, meaningful activity, and social connectedness and relationships. While these three domains are not mutually exclusive, they compose the breadth of services and programs necessary for people with disabilities to function in the community.

First, I would like to provide context for the DCC model and LTSS has a whole. Research has shown that the population of people living with disabilities have significant health disparities. This is due to a variety

of barriers to care. Access, in its many variations, is one that was discussed in the third webinar in this series as well as the availability of screening services and supports. This all results in poor outcomes including secondary or chronic conditions. All of these can be impacted to some degree by well-designed and supported LTSS.

A wide range of social factors also lead to poor outcomes. Many people with disabilities rely on Medicaid and/or Medicare for their healthcare. Medicaid, for example, is income and asset tested meaning that the recipients are living on a limited income and are financially challenged. Many of these programs are going through an extensive redesign moving from fee-for-service to value-based purchasing. As the payers are increasingly focusing on outcome measures, such as cancer screenings, vaccinations and diabetes management, the clinical interventions are straightforward but communications and service deliveries stretch the disability competence of many providers. Add to that the financial, transportation, and other challenges, it is no wonder they experience poorer outcomes. Thus, plans and providers are learning ways that they will better achieve outcomes if they attend to these challenges.

Addressing these challenges can significantly improve these outcomes and intern have a direct impact on revenue for providers and plans. At this point, I will turn the presentation over to Karen.

Karen Luken: Good afternoon, thank you for allowing me to take part in this presentation. I will be covering an array of information describing long-term services and supports, the domains, and some of the ways that you can utilize LTSS to support positive health outcomes and quality of life for persons with disabilities so they can live in an inclusive and integrated environment of their choice.

Long-term services and supports are design to prevent institutionalization. One of the eligibility criteria is if that person is at risk for placement in a nursing home, group home, or some type of community living environment typically that one would consider an institutional environment. LTSS, and that's the way I will refer to it as we go forward, is based on principles of self-determination and person-centered planning, which have been referenced in earlier parts of the Disability-Competent Care webinar series. There are a couple of core elements of self-determination that are important to emphasize as we talk more about LTSS. Self-determination means that the person is making their own choices and decisions based on personal preferences and their interests, so they can achieve their goals and their options of living in the community of their choice. It is important that they have the freedom to choose services and supports and not just be placed in a program. They should have the authority to make decisions and be supported in those decisions, have support that is formal and informal to build resources and personnel to build a community life, and have responsibility to manage resources well and be a contributing member of their community.

Person-centeredness has been referred to in previous webinars as a critical element of disability-competent care and is also essential in long-term services and supports. It is important to see the person first, not their diagnosis or label, and that we focus on the strength based approach for their interests, access and capacities and build long-term services and supports around that person-centered approach. Again, long-term services and supports are designed to enable an individual to live in the most integrated setting or environment with the appropriate and sufficient services and supports to meet their needs, while being cost-effective and culturally responsive.

So, let's take a look at some of the services. We will begin by looking at paid services that constitute long-term services and support. This list is in alphabetical order not in order of importance. Some of these are provided to an individual in a home, some are in the community, and some may be more group oriented services.

What is critical is that you understand the resources available; you may need to develop a community resource guide. There are examples of those available at https://resourcesforintegratedcare.com/. Anytime resources are pulled together, they must be continuously updated and relevant to the individual's situation, community, and geography.

Let's take a look at an individual's story that might illustrate some of how we think about long-term services and support. Calvin is a middle-aged male living in the community. He is divorced and has two sons and ran his own business. He was injured in a car accident that resulted in him acquiring a spinal cord injury with significant physical outcomes. He could only use one finger on one hand to manage some of his physical needs.

He had, what we might consider, a typical life comprised of work and community connections. His injury resulted in hospitalization and extensive rehabilitation, so there were physical challenges that he had to take on. It was the loss of independence and all of the major life changes that were overwhelming. The accident resulted in changes to his privacy, autonomy, a significant impact on his financial security, and concerns about his life, the burden on his sons and what would his life be like moving forward.

As part of his disability-competent care and working with his interdisciplinary team, there was an acknowledgment that he needed to look at community living options outside of the rehab and nursing home environment. The team hired a relocation specialist who could help Calvin begin to look at options and explore what his future choices might be. Again, what is important here is that long-term services and supports often involve a time of exploration and looking at options as the individual begins to build their person-centered plan.

We will go forward and begin to look at the specific domains of long-term services and supports as a way to think about how you would help the individual construct a person-centered plan to achieve improved health and quality of life. One way we think about long term services and supports is three specific domains. The first domain is resource and settings that facilitate inclusion, which you might think of as place. Where is the individual living? How will this place support integration and inclusion? Another domain is meaningful activity, which you might think of as purpose. What is the individual's purpose in life? Are they employed? Are they involved in education? Are they retired? Are they an active member of their community through volunteering and social activities? What is the purpose that grounds their day-to-day life? The third domain is social connectedness and relationships or we might think of it as people. Who are the people that are part of this individual's life and the important relationships that sustain them day in and day out?

Let's take a closer look at each of these domains and how it relates to requirements for long-term services and supports. We will begin by reminding you that long-term services and supports align with the pillars of Disability-Competent Care that were mentioned at the beginning of the webinar. Care coordination is a critical part of a successful LTSS plan and may require acknowledgement of more players, more

connections and the need for more coordination. Member assessment is critical, and LTSS may challenge you to think with the individual about more life domains than a traditional healthcare plan. This plan needs to be individualized and continuously updated as the individual's life circumstances change and hopefully improve overtime. Communication is critical across all parts of disability-competent care and can, at times, be challenging within LTSS because there may be more players and more connections that need to be involved in the communication network.

People need access to information. In Calvin's example, he is going to need new information that perhaps had never been part of his life situation. How do we ensure ongoing access to current relevant information? There will be frequent life transitions, and they may be broader than the traditional transitions we think of such as emergency department to inpatient to rehabilitation. Life transitions can be frequent moves, family changes, aging and staff turnover. Transitions are a critical element to keep in mind as long-term services and supports are considered. Throughout this whole process, partnerships and collaborations are essential and will be changing overtime.

We will move in to looking more specifically at elements of resources and settings that facilitate inclusion. We are talking about place and how personal assistance services and the living environment are the tools that facilitate community integration and quality of life. We will look at some of the living options and settings that people may encounter. Supported living is one of the ways we talk about long-term services and supports as an alternative to institutional or facility-based care. In Calvin's situation, he may have been in a rehabilitation facility and then a nursing home facility, so supported living assists him at looking at community living options. We have a list of options on this slide in alphabetical order, but not in order of importance. They illustrate the variety of supported living options that someone could consider including adult foster care, assisted living, independent living in an apartment, and living in their own home. Each of these environments may require home modifications in order for them to be successful and achieve maximum independence. There are resources on home modifications also available on the resources for integrated care website.

As the individual is exploring living options, it is important that a functional assessment be conducted to determine what the individual's needs are at this point in time and be sure that their individualized plan of care reflects those needs, so that the appropriate services, paid services in particular, can be put together. This may involve hiring the personal care assistant. This would be the individual who comes into Calvin's home and assists him some of the activities of daily living such as bathing, toileting, and eating. It is critical that the personal care assistant or direct support worker is specifically trained and is able to provide the care required by each participant. Some individuals may be able to direct much of their PCA care, while others may need assistance in learning how to take on this role in terms of training and supervising someone who is a paid caregiver.

It is also important that we acknowledge that there are core competencies that personal care assistants need to have in terms of knowledge, skills and ability and that also needs to become individualized. In Calvin's case, he needs someone who is familiar with spinal cord injury and direct health risks. Another direct support professional may need to know about traumatic brain injury to provide care, so it is important to focus on the person and their environment and not just the diagnosis. Ensure that all of those elements are something that the personal care services are able to address. Remember that by providing the right choices for supporting lived, you are increasing the options that the individual has for how to

successfully achieving their life goals.

Another option available in long term services and supports is the self-directed option or consumer-directed option, which gives the individual more flexibility and responsibility to design and direct their services and support. Self-directed services are an alternative to a traditional agency managed service or agency-delivered model. Each Medicaid funding authority has different guidelines for their self-directed options, but they all share common characteristics such as an individualized budget, an individualized plan, and the importance of providing assistance and support. Although the individual is responsible for hiring, training and firing their staff, managing payroll taxes and conducting the business of their long-term services and supports, they receive support from a support broker or consultant who acts as an agent for the individual and takes direction from the individual. So, a self-directed option does not mean the individual is totally left alone; they are provided appropriate support. However, this may be a new consideration for many individuals particularly if they are dealing with an acquired injury.

It is important that the options are clearly explained, and the person has time to explore them. Perhaps, they talk with other people using the self-directed option. There are good resources on self-directed options available through the New York State Office of Disability Services. I would encourage you to check some of those out if this is a new approach to long term service and supports for your consideration. The reality is that many people may still choose the agency model to service delivery or at least begin with that approach. Within that, the agency takes responsibility for many human resource functions and responsibilities. There is also the shared living option that people should become aware of where an individual chooses to live with another person, couple or family in the community and services are provided to them in that environment.

In any living environment, the person needs to be offered the opportunity for dignity of risk, so they are making their own decisions with appropriate supports and learning, developing competencies and taking calculated risks as they learn how to live in the community of their choice. One of the ways Disability-Competent Care has an important role in this is role modeling the person is in charge of whatever living option or setting they have chosen for themselves.

Let's move on to looking at the second domain of meaningful activity or purpose. There is a wide range of services that facilitate meaningful activity in ones community. All of these should be age appropriate and desired by the individual. In Calvin's situation, he was an employee and a business owner, so vocational interests are likely to be a strong concern and interest to him. People may be at an age where they do not want to be involved in educational programs but lifelong learning is an opportunity. Special recreation programs and connections allow us to have meaningful activity in our lives as well as shared activities such as group meals or some individuals may need something structured such as an adult care program. What's important is that you always think about the person in their environment. How is it developmentally appropriate and culturally responsive in meeting their needs in terms of community and inclusion?

As we think about meaningful activities, it is always important to acknowledge the realities of transportation. Accessible transportation can be a cost effective option for some individuals to be able to access work, recreation and education. The reality is that public transportation options vary greatly across communities. It is important to learn about the community resources available to the individual

participant and to understand the functional skills that the individual needs to use the area's transportation resources. Going back to the individualized assessment and the individualized plan of care, they need to address transportation within a long term services and supports approach. What physical skills will the individual need to use a specific transportation system? Is it transfer skills or endurance for the length of the community ride? What communication skills are necessary to ask for directions? What cognitive skills are needed to do way finding within the community particularly if the individual is moving to a new community? The individual assessment and plan of care can document these needs. Long-term services and support provide a mechanism for the individual to utilize transportation to meet their goal of meaningful activity. As you think about transportation, always think about both sides of transportation, getting to some place and going from. Figure out the public transportation timing and consistency, and reliability. Some public transportation involves extensive time. Is that a good fit for the individual's health status and endurance? Should this be something that is worked towards in terms of setting up transportation that will be a success and not necessarily a significant barrier to the individual?

Let's look at types of transportation services that might be available to an individual and identified within LTSS. These are not listed in order of importance. Ambulance is specific to types of transportation needs. When you think about taxi, Uber, Lyft, and other shared economy transportation services, how might that be an option for the individual, and what skills do they need to be successful at that? Some communities have paratransit services and others have successful public transportation. Again, understand the realities of how these operate, when they operate, and how the individual can use them to be involved in meaningful activities of their choice. Urban communities are different from rural community. Rural communities have significant informal networks that may provide transportation services.

Now, we will move to a discussion about social connectedness and relationships for people. We know that interactions with others within our homes or communities are important to all of us. This is especially true for those who have significant disability or functional limitations who may be at risk for social isolation and the resulting depression and other significant problems. When we think about social connectedness and relationships with people, we want to, in this case, think about informal supports such as with people that might be considered care partners including family, peers, and community acquaintances such as employees or business partners. These are people who are part of someone's life and are not paid caregivers but are vital to the individual's community connectedness and sense of well-being. In the Disability-Competent Care model, the intent is not to treat these informal supports as caregivers, but to acknowledge the importance they have in the individual's life and that is a two-way relationship. This may be a new role for many individuals. There may be a need for the IDT to assist with some discussion, coaching, or training to learn how to assume a slightly different role as a care partner. In Calvin's life, the focus may initially be with his sons and then move on to employment connections and individuals that he is living with now in his new community location.

Social connectedness and relationships require a variety of different skills and some may also be linked to formal services. As we think about making new social connections or resuming social relationships following a significant injury or illness, there may be a need to focus on independent living skills such as money management, stress management, or communication skills.

We have talked about transportation, which has a critical role in social connectedness. If someone is accustomed to being an independent driver and that is no longer an option, focusing on that skill

acquisition and those resources will play a big part in if someone will be successful in those relationships. Exploring activities will be important particularly if the individual has moved to a new community or is needing to pursue different community interests. Some individuals, as we have said, may be at a significant risk of social isolation. What are the variety of ways that technology can help with maintaining connection? Examples may include telephone reassurance, texts, or e-mails. How do we help someone stay connected as they rebuild their social network? Individuals may also experience anxiety as they try new experiences or meet new people. What type of behavioral support might be helpful to them? This may involve blending paid long-term services with some of the informal supports.

We talked about mobility in a variety of ways throughout the presentation. It is important again to think about both mobility services and mobility equipment as one of the ways that an individual stays connected to people, has a sense of purpose, and is able to live independently in our community. One's health status is impacted by mobility such as the ability to get to appointments including healthcare appointments, and the ability to reduce the risk of falls and injuries from a safety perspective. Functional independence is important so that individual minimizes their reliance on informal care partners and paid care providers. Home modifications, accessible environments, adaptive equipment can enable the person to work and be engaged in their community and increase their sense of autonomy.

Think back to the webinar on accessible environments because that environmental approach and accessibility needs to be woven across all domains of long-term services and support. As we think about social and recreational support, we know that research has shown that community participation is a key factor in the health and well-being of people with disabilities. For the individual, this may involve a significant rethinking of what they are currently involved in. What is it they want to do? What is they used to do? Who are the people they want to spend time with? How do long-term services and supports make this happen? Who do they want to be with? Where can this take place? When can this get started? How do we make this happen? The initial plan may have an emphasis on formal supports, and over time, informal supports and care partners may become a more significant part of that. It is always important to acknowledge for someone that there may be a need for personal care assistance as they explore new community options and require assistance with transportation, transfers, toileting, and eating in different environments.

Let's go back to Calvin's story and think about how quality, individualized long-term services and supports would make the difference in what Calvin is able to achieve for himself. He worked with a relocation specialist who was able to help him explore different community options. It is not easy to always find accessible, economical living options. The person may need to work with IDT team overtime. Calvin was able to secure a two-bedroom apartment, which meant he had private space and could make plans for his sons to visit. Even though it was designated as an accessible apartment, there was still a need to do some home modifications to meet his particular needs. That required negotiating with the landlord and apartment manager and exploring other things such as power doors, hand controls, voice activated telephones, and appropriate kitchen equipment so he can be as independent as possible in his day to day activities. His social connections and relationships required significant focus. Following his injury, he was no longer able to work full time, so it meant that he had more unobligated time. He wanted to move from the nursing facility to his own place so that his friends could be in contact and his sons could come and visit. All of that happened when he had his own apartment. Having your own space enables you to be defined as an individual living in a community rather than an individual placed in a care facility.

He was able to resume part-time work, which helped with his finances and allowed him to re-establish that role of businessman and worker. All of these successes for Calvin required significant long-term services and supports and evolving needs over time. What enabled him to succeed was moving from the nursing facility, avoiding frequent re-hospitalization, decreasing his stress and family stress, and limiting his costs over time. By providing those best long-term services and supports that met his needs, he is now in the right place, has purpose, and is connected to the people that he wants and is able to maintain his quality of life over time.

As we move into the conclusion, we can see that for an individual to maintain their health, positive health outcomes and their well-being, it means that a truly person- centered plan that is individualized and thinks about their long-term services and support needs can make a critical difference in what the individual achieves and the role of the interdisciplinary team.

Some of the key takeaways from today include the fact that long-term services and supports are not static; they change over time. The individualized plan needs to be viewed as a living document. Independent achievement are goals, but not a destination that is achieved and checked off. As Calvin ages, there may be different concerns. He may be able to expand his employment hours. At some point, he may choose to explore different living options. Life goals change over time. All parties including the individual, their family, and the professionals involved generally benefit from education, coaching and mentoring. Throughout the process, advocacy is key because there are many new challenges that the individual is taking on, and their care partners may also be asked to become an advocate in this process. Creating and linking community resources to the participant is extremely important because it decreases the risk of social isolation, which can improve life and quality of life. I will stop here.

Christopher Duff: Karen, thank you very much. That was a great presentation. I have one or two comments. I am familiar with Calvin's situation, and what I wanted to emphasize is that Calvin was a guy in his mid to late 40s who went from having his own business and employees to being able to move only one finger. He was in the hospital and rehab for a long time. He was very depressed and saw no way that there was any way out of where he was. So we could not start with him by suggesting to look for an apartment because he was not able to see that. What I want to express is that it took several conversations with him over a couple months. The process takes time to get through. When the process started, he never would have imagined that in around six months he would be able to have the life that he has now. I want to re-emphasize that. That is what a relocation specialist can do. On top of that, they have all the contacts. They know housing settings that may have openings sooner than the ones in the paper or on the lists. It is worthwhile to use and experience relocation specialists.

The other thing that I wanted to point out with Calvin is that privacy was a big deal for him. He did not want people on the couch looking at him or in and out of his place. He wanted to have time with his sons and time alone. What quickly became clear after working with him was that he did not want that level of personal care service. He did not want people sitting around his place until he needed to be transferred somewhere. That allowed the plan to invest in modifications in his home, so he did not have to have someone sitting there to open the door when needs to go out or whatever it may be. That kind of judgment call that is an individual discussion process. Even though some of these up-front costs, like a door opener, are not cheap, they can be paid for within a month or two by reducing personal care on a daily basis. If the participant is going to have family over during the weekend, he may want his PCA services during the

week. It is that kind of thing that needs to be worked through with each individual participant.

I just wanted to share that. There is also one other story I wanted to share before I get into questions that we've had. This story relates to a storage shed. There is a plant in the Midwest that bought a storage shed for a participant. That's not on any Medicare or Medicaid benefit set, but they had a member that lived in an inaccessible apartment within a house, and she needed a scooter to build access to the community. She couldn't park the scooter in the yard because it was not a safe neighborhood and it would not last long there. She could not get it into her apartment and building a ramp and doing modifications to the entrance into her unit was quite expensive. It would have been close to ten thousand dollars. So, they came up with a plan for a shed, which they kept in the front yard; the landlord was okay with that. She would put that scooter in the shed and was able to walk with her own power into the apartment. A little investment in a good shed saved a lot of added work to make her apartment accessible. Again, this is just an example of creative thinking with the individual to see what you can work around.

So with that said, I wanted to go to questions that people put forward. Let me start with Marcia. You said that you have some members who are not dual eligible. I am guessing that they are probably on Medicare but maybe not Medicaid because Medicaid is asset based. They may have some private assets or whatever it may be, so they do not qualify for Medicaid, and all of the services we have been talking about today are traditionally paid for by Medicaid. So, the question is how can you get these services to people who are not on Medicaid or dually eligible? Karen, why don't you take a shot at that first?

Karen Luken: Okay. I think this is a reality that many individuals are faced with in terms of what eligibility criteria they need to meet for different insurance coverages or services. This is where community connections become critically important. For an individual such as Calvin, a center for independent living may be a valuable resource where it is consumer run, they know their community, and they may have connections that they can leverage to help with acquiring or purchasing supplies. They may be able to connect him to peers who have similar experiences; often, people have loaner equipment. If someone has a different health issue, such as multiple sclerosis or a brain injury, there are often advocacy organizations that have a strong focus on helping to address unmet needs. I would begin by tapping into community resources that are oriented to individual, family and peer support. In our state, we have something called First and Families which is designed to meet needs that the formal system may not cover. Each state may have a different way to access services, supports and leverage from the community assets that might meet an individual's needs. I will turn it over to Chris.

Christopher Duff: Karen, you came up with resources that didn't occur to me. Those are absolutely the right first steps. The other thing I was going to add, and this goes back to the role of a care coordinator, you need to be the role of the problem-solver with your participant. It's kind of the care coordination role. What we are trying to say through the entire DCC model is that this is focused on health and wellness. Even if all you manage is the Medicare side, if you can keep them involved in the community and engaged, they are going to have less healthcare utilization. Some of social factors I talked about in the beginning will also become less of an issue. I think that's the creativity that the Disability-Competent Care team needs to bring to the table.

This is a question that came in from Lindsey. I actually had the same struggle, and I am going to paraphrase. I am sensing she is a plan based coordinator. She has a problem staying connected to plan-

based long-term services and support providers. I think she senses that they are not necessarily well-linked and coordinated. She and the participant probably are, but the LTSS provider may not be. What do you have to make sure that all key participants remain engaged and working as a team?

Karen Luken: I think this is one of the big challenges because it is likely that there are more players and dots that need to stay connected. One strategy is to map out who are the entities and the lead people that are a part of the individual's world of care right now. As much as possible, depending on the individual's capabilities, the individual should be at the center of helping to identify and sharing in that communication, so that it is not viewed as intrusive or taking over for the person.

I think a true person-centered plan that is well developed and updated regularly will hopefully always ask about long-term services and supports and document challenges. By acknowledging it up front and deciding as an individual, health plan and providers, what are our strategies to ensure that we maintain communication between all of us is how the team works together. I will turn it over to Chris.

Christopher Duff: We have a couple of pieces in the Disability-Competent Care Self-Assessment tool. One suggests that this actually be a discussion held in the initial and subsequent assessments so that they engage with the person, arrange for PCA services and what else may be needed. How do you want us to interface with your provider? Engage them in a proactive way; that is always helpful.

Another question that we would regularly ask people in their assessments is how do you want to interface with us as your care coordination team? Do you want us to call you once a month? Maybe the person says they will let you know when they need something. Some people want a lot more contact. I think that is something that you can get ahead of it. You can agree on once a month phone calls, or if there is a lack of coordination, you can bring it up. For example, saying, "I hear there is frustration that you are having with your transportation provider or your shared living associate. Do you want me to get involved to help you with that?" You are asking them what they want, and how they want you to be involved. That is often a good way to proceed.

Karen, this may be simple. This person gets confused between home and community-based services and LTSS. Can you explain what the difference is?

Karen Luken: LTSS can be thought of as the broad umbrella term that is relevant to a variety of different payer systems. It is something that helps people with a variety of medical and community living needs. Home and community-based services are actually regulations that ensure individuals receiving Medicaid-funded services are receiving care in integrated community inclusive settings. So, it is an example of LTSS, and it is a definition that comes from Medicaid. Home and community-based services have undergone recent changes to emphasize the importance of community connection and integrated environments. Home and community-based services utilize the services and support approach, but LTSS can be thought of as an approach utilized by individuals in Medicare or in other payer systems as well.

Christopher Duff: That's great. Thank you. Mary Jo, you mentioned that there is a nursing home area agency that serves the area of record. Sometimes it is AAA or sometimes there are a variety of places that do that. Are they required to check the records of any potential staff? I would be shocked if there is not a requirement because most states are on top of that. Anyone that is involved with people of disabilities

mostly likely have background checks. Those are state-based laws and regulations, so I would refer back to your state.

Another question that came in states while people prefer one of the community settings, you mention LTSS should include disability-competent, age appropriate, quality long-term care facilities that promote community engagement and self-determination.

There is a stigma in long-term care. Some people think that these are horrible places where people are dumped at the end of their life. However, there is a place for them. Some people prefer them and some of them are doing creative things. I think there are great models. Some of the places I can think pertaining to working with people with MS are ones outside of Boston and there is a great one in Philadelphia.

So, I think you need to learn about your community and learn what is available. I am going to go to another question here.

If my member chooses the self-directed model, where can I send them to get support in developing the self-directed model? I will turn that to Karen.

Karen Luken: There are agencies that specialize in the support brokers who then are linked to individual selecting self-directed option. The intent is not that the individual is thrown out on their own to manage all of these complexities but that they are clearly seen as in charge. There are agencies and state Medicaid offices that should be able to provide you with a list of what agencies are linked to self-directed options. This is where advocacy and peer groups are essential. They can identify other individuals with spinal cord injuries or MS if you have opted for that. They can share their experience. That is where individuals share and ask these questions; this is what I learned and wish I knew ahead of time. It takes more exploration so that individual feels prepared to make the right choice for themselves.

I will turn it back to Chris.

Christopher Duff: Thank you, Karen. I am afraid we have run out of time. Thank you for all of your questions. We are going to have to wrap up. Please send any feedback you have to the RIC@Lewin.com and answer the survey that will be appearing on your screen shortly.

I would like to call your attention to the resources that we have at the RIC website and the Disability-Competent Care Self-Assessment tool. This concludes the seven pillars. They have all been recorded and will be up on the RIC website shortly along with the webinars from previous years. We have been very pleased with the level of interest in this series and the feedback we received. We have begun to go through all of your suggestions for future webinars or training materials. Your feedback will guide us into the future. All of you who are registered for any of these webinars will receive notification of future training opportunity.

I would like to, again, thank Karen for the presentation today and thanks to The Medicare and Medicaid Coordination Office for sponsoring this webinar and entirety of the Disability-Competent Care work.