

Flexible Long Term Services and Supports
Event ID: 701182

Operator: Thank you ladies and gentlemen for standing by. Welcome to the Disability-Competent Care Webinar Series Call. At this time all participants are in a listen-only mode. Later we will conduct a question-and-answer session. Instructions will be given at that time.

Should you require assistance during the call, please press star then zero. I will now turn to the conference over to our host, Chris Duff. Please go ahead.

Chris Duff: Thank you, Karen. On behalf of the Lewin Group, the Institute for Healthcare Improvement, and Disability Practice Institute, I would like to thank everyone for attending this seventh webinar in our series on disability-competent care.

As Karen stated, my name is Chris Duff, and I'm the executive director of the Disability Practice Institute. First, a few quick things about this webinar platform. If your slides are not advancing, please push F5 on your computer keyboard and that should get them moving again. Please note the two icons circled at the bottom of the screen, the one on the right allows you to print a PDF of the slides to this presentation. The red one on the left is for questions. If a question is about the technology, someone behind the scenes will respond in real time. If it is a question for the presenters, we will be compiling them throughout the webinar and will return to them at the end.

As I said, this is the seventh in our series of nine webinars being presented through the fall. All the webinars are recorded and available along with a PDF of the slides at the link on the bottom of this slide.

Today we are focusing on coordinating flexible long term services and support. We will continue the series in early December with presentations on building a disability competent provider network and participant and provider readiness.

These presentations will reserve 15 minutes for Q&A at the end.

I'd like to step back for just a moment to give you the genesis of this series and several other tools for integrating healthcare services for eligible populations. The Lewin Group, along with the Institute for Healthcare Improvement in Cambridge has a contract with the Medicare and Medicaid Coordination Office commonly called the dual office as the Centers for Medicare and Medicaid Services. They're contracted to provide tools and technical assistance to providers that are seeking to integrate and better provide care for individuals who are dually eligible.

We would like this webinar series to be as helpful as possible, so please submit questions in writing. We will additionally open up the phone lines at the end of the presentation for live questions.

We're also asking participants to fill out a short survey at the end of the webinar where we will be asking for feedback to make sure this series and our other efforts are meeting the mark in terms of what you need. Please also send us your ideas for future webinar topics and content

either at the end of the survey or to any of the email addresses listed at the end of the presentation.

Today's webinar will be presented by two clinical leaders at the Independent Care System of New York City. ICS was founded in the late 1990s and has been partnering with thousands of persons with disabilities and their providers to manage long term services and support. In that time they have been demonstrated national leadership in developing unique and creative services tailored to working with adults and seniors with significant disabilities.

Their experience, combined with that and a few other pilot programs across the country, served as the model for the description of disability competent care that we've been referencing throughout the series.

Jean Minkel, the senior vice president for rehabilitation services, and has created multiple programs to support the mobility and adapted the equipment needs of their participants.

Rachel Stacom is senior vice president for care management at ICS where among other things she created their multiple sclerosis program, which has been recognized by the National MS Society as a center for excellence in long term care. We've asked them to share their experience in this webinar series so others can learn and build upon their expertise.

Before turning this presentation over to them, I wanted to provide some context for integration of long term services and support with primary and acute care medical services.

In this webinar series we are specifically focusing on persons with disabilities who are eligible for Medicaid and/or Medicare. When we speak of integration in this series we are referencing the integration of the financing and the benefits of healthcare, Medicare and Medicaid in particular.

We're also referencing the delivery of healthcare services, specifically acute primary care and long term services and support.

While both programs provide for healthcare needs, there are significant differences in the origin and focus. Medicare is funded by the federal government and is an entitlement program for those 65 years of age and older. Persons under 65 generally become eligible for Medicare once they are deemed permanently disabled.

Meanwhile, Medicaid is funded by both the local state and the federal government, and is an entitlement program based on need and income, covers children, pregnant women, parents of eligible children, seniors, and individuals with disabilities.

Most importantly, though, in terms of benefits, Medicare covers primarily physicians and hospitals with their related tests and procedures. Medicaid, on the other hand, covers all that Medicare covers plus long term services and support. While this appears comprehensive in nature, the differing funding sources, populations, and priorities have resulted in highly fragmented care.

For example, Medicare only covers a problem once it occurs, resulting in lack of attention to prevention. This in turn resulted in the occurrence of avoidable conditions. For many persons with severe disabilities, over 50% of their hospitalizations are for preventable conditions, such as skin breakdowns, urinary tract infections, and [respiratory] infections as will be addressed by our speakers.

The dual demonstrations going on across the country are being designed to fully integrate the financing and benefits and consumer protections of both programs, focusing on the triple aim of improved health, improved healthcare, and controlling costs. They are designed to enable plans and providers to focus on these goals by removing the silos of care and financing that has created the dysfunction these days.

Now, I'll hand it over to Rachel for the presentation.

Rachel Stacom: Thank you very much. And thank you, Chris, for asking us to be here today. I always think it's better to start with a real-life story to kind of exemplify why we think the model of integration between long term care and home and community resources with the acute care is important. So, I'm going to share a story about a gentleman named Peter that is cared for in our program.

Peter is a 48-year-old man who has multiple sclerosis and due to his condition he has lost the ability to move his lower extremities. Despite this, Peter is very active and he uses a wheelchair to get around in his community. Unfortunately, recently Peter was hospitalized for 10 days because he has what we call neurogenic bladder, which leaves him prone to urinary tract infections. And unfortunately his urinary tract infection was detected very late and he had urosepsis.

So, he was in the hospital for 10 days and during this hospitalization he developed a pressure ulcer which very commonly can happen, especially in people who do not have sensation and don't really – their bodies don't, we talk about bio feedback, they don't have the ability to tell them when they shouldn't change positions. So, Peter has the pressure ulcer now. And during this they picked up that he had hypertension. Peter's ready to go home and they put him on a diuretic to treat his hypertension twice a day.

I think it's important for us to think about people with physical disabilities when we're creating treatment plans for them. And when we start and we're looking at someone like Peter we need to remember that although his baseline is already being physically disabled, there are different levels to that disability. And that it can still progress, especially someone like Peter who has multiple sclerosis that it can be a progressive neurologic disease.

Peter is ready for discharge, but his abilities that he had beforehand are now different now that he's ready for discharge due to what happened in his hospitalization. And as healthcare providers we need to begin to look at the impact of his motor status, what services he has in place, or he had existing in place before he came in, and what recommendations are going to be made for his treatment plan.

And for people with physical disabilities that rely on the community supports, we need to determine if the current treatment plan is feasible with Peter's existing services. So, if you look at Peter, and we know that he has had a decrease in function due to his recent hospitalization, he's weaker – he was weaker than he was going in. Does he need more help? And he's now being put on a diuretic to treat his hypertension. And he's going to have to go on the toilet and get off the toilet more often.

The other thing is that we need to heal that wound. And moving to different pressure, you know, moving to different surfaces can also impair that, and also just the moving itself. So, it's really important that we take this all into context when we create a plan for people. And we're going to touch on those specific factors a little more down the line in our conversation.

The next slide talks about how we view integrated care at ICS. And for those of you who have been introduced to Maslow's hierarchy before, this may look familiar to you, although it would be – certainly it's a little bit different. In Maslow's hierarchy it starts with talking about basic needs, which is on the bottom where we have Health here and that's where we're talking about really necessities to live, such as air, the ability to have food to eat, and water to drink.

And at the top of the pyramid in Maslow's hierarchy is self-actualization where someone is fulfilling their potential. Here at ICS we view that similarly meaning if someone doesn't have their health, if they are ultimately sick, we're not going to get them anywhere. We're going to have to address that illness and we're going to have to support them through that before we can do anything else. As we move up the pyramid, once we have them stable or healthy, we need to get them moving. And so as Chris said we are a disability – our foundation is in serving the physically disabled – without the right equipment people, again, are going to be confined to home. And Jean is going to talk about that a little bit more.

And then, finally, once we can get people healthy and moving, then they can get into their community. And that is our ultimate goal at ICS is to keep people at home and in the community however they like to define it. Some people like to participate in social activities and some people are more introverts and like to hang at home and watch Jeopardy! And whatever it is for them we want to make sure that they have the opportunity to do so.

So, what is long term care supports at ICS? And for us, the biggest service we provide is personal assistance. It's also known as home care, aides, personal care aides, personal assistance is listed there. So, that is the biggest service we provide and what we frequently hear from our membership or the participant is that they are their arms and legs for them when their body is not able to do it for themselves. So, using the home care worker really helps these people stay at home. Also, skilled nursing, some people have needs that create a need for that service on an ongoing basis. We have adult day health programs for people who prefer to go out and get those needs met in the community. Home delivered meals is also an option for people would prefer to use that service instead of a personal care aide being there. A lot of times we use that in combination here at ICS.

Rehab therapies are really important. Jean is going to talk a little bit about that, but I think in the acute care world we look at rehab as restorative. I think in long term care we very much focus on

maintenance and how can we get those experts in the home to help get the people either the equipment or learning the tools that they need so that they can maintain their current level.

And as we move onto medical equipment, again, we spoke to that before in mobility and we'll touch on that in a little bit. The rehab technology touches on that as well.

Without transportation we can't get people anywhere. And so we're using that – we use that often to get people to medical appointments here at ICS. And we are very lucky in the New York City area to have a power transit system which we call Access A Ride to get people to and from any social activities they want to participate in.

Home adaptation is really important. Jean has a great example that she's going to show you guys where I can personally say before I started at ICS many years ago I didn't realize how one single step could really be a barrier to welcoming someone with a disability into a facility. And making sure you're connecting people to the right social programs because we all need social support in our daily life. And sometimes we come into this world with it and sometimes we have to create our own social supports out there in the community.

Some additional services that in our Medicaid system is covered is podiatry, optometry, nutrition, audiology, and dental. And that's not always considered in long term care services. Here in New York it is. So, we want to make sure that our members have access to that.

Talking again about the gap in integrated healthcare, it is a very interesting world we currently live in in regards to long term care and the traditional medical model. And this first bullet that says "How does a doctor in an MS clinic deal with the person who is accumulating disability" comes from my own personal experience. I have a specialty in multiple sclerosis and I was speaking to a very dear friend of mine who is a neurologist and a very caring one. And I said to him, when do you bring up long term care services? When do you offer – when do you see how they're managing at home?

And he said to me, "I don't. Because I don't know what to do if they say they can't manage at home."

I'm a physical therapist and worked in acute rehab. And in that setting the patient along with the therapist, physicians, nurses, and family all worked really hard to create an opportunity for someone to be discharged home. The goal of acute rehab was to give somebody the functional skills to be able to compensate when there was a lack of physical ability. The experience that we had – the gold standard was discharge to home. And in my experience here at ICS starting back 10 years ago, a real awareness struck me that getting home is where the real world started. And that it's an opportunity to really take stock of what environment is the person trying to function in. Often acute rehab is in fact idealized. It's the best situation. When someone gets home it's the real situation.

I want to move to the next slide because one of the things we noticed is as professionals work in different environments, it's important to identify if there are gaps in communication. And Chris

mentioned early on the silos that get impacted – that get created depending on the environment people are working in.

Through our experience here at ICS, we've identified that talking to other professionals who are functioning in other environments, it's really critical to ask a very important question which is what is the best way to communicate with you. We find when we reach out to physician's offices is it voicemail that works, is it facts, who uses the text versus email. When you ask that question right upfront it takes a whole level of frustration away when one party is using email but another party is using voicemail and the interpretation is nobody gets back to me.

So, upfront identifying what is the preferred method of communication is so important. And the critical nature is each of us are working in our own environment. In the process of integration we're trying to break down the walls of those silos and to do that we really have to have a mutual understanding of what it is each person's role in the coordination of care.

The home care worker has a certain set of roles. How does that work with a therapist that comes in from the certified home health agency? How does that therapist interact with the nurse practitioner from the doctor's office? If there is a discussion of an understanding, what comes and is created is a mutual respect. How can each person work from their strength to provide the support that persons with disabilities need to in fact be successful in living in the community?

We can tell you after 12 years of service provision is not one person can do all of this. And supporting our participants is really based on mutual understanding which leads to mutual respect. Next slide.

Here at ICS, that process begins with actually a requirement of our program as a managed long term care program that there's a comprehensive, individualized assessment that's conducted in the home of the client by an RN. That initial assessment is done as part of the intake into the program and then is repeated every 180 days thereafter.

Our experience in focusing on people with disabilities is that the functional assessment provides us a good understanding of what activities of daily living or instrumental activities of daily living, somebody may need assistance with. But we've also found that there are some focused assessments that have really helped us hone our interventions and guide our participants to, as Rachel referred to, healthier lifestyles. So, we look at focused risk assessments around pressure sore development, respiratory distress, and urinary tract infections.

And I don't think it would surprise anybody that these are areas that if we manage early we can avoid hospitalization which is why we really are looking at where are the risks and how can we intervene before we have a real problem. Next slide.

From the comprehensive assessments, the individualized care plan is developed. And the care plan really is initially the creation of a problem list that's generated from the assessment visit. It's both problems identified in the functional assessment as well as our focused assessments. And ultimately we look to say for this particular participant what are our concerns around health, mobility and function, and what's the ultimate impact on that person's community participation?

It's really important to understand that the problem list is generated but the care plan is really a result of collaboration with the nurse, social worker, and our interdisciplinary team members who work with the participant to establish a prioritization of problems. What we've understood is we're working with people and a ten problem list is overwhelming for anybody. So, what's the priority of the participant, how can we provide some education, some insight as to what their risk factors are, and really have a discussion about what we found in the assessment and what is the person interested in addressing.

It's really important after the education of the risk factors to really have a healthy respect for the dignity of risk that's exercised by the participant. Someone who has lived with their disability for 20, 25 years is very articulate about that which they want to address and that which they're just comfortable living with.

We look to really focus on identifying the interventions that the participants want to engage with that we can focus on in a six month interval. And this six month interval is chosen for both the reason that we have to reevaluate every six months, but it's also long enough to see a change but not so long that it feels so overwhelming to the person that they can't engage in interventions that can make a tangible difference in a relatively short period of time.

Next slide. So, this is Rachel back again. And I just want to pause again to reiterate what Jean said which is we are here to support the participants in their goals and priorities. And sometimes I think as healthcare professionals this can be a little challenging for us because we know, or sometimes we think we know what is best. And to Jean's point, having that discussion and allowing people to say this is important to me should be the priority. That should be number one.

And where we can step in as part of their interdisciplinary team is to say, "Well, this could be important to and I want you to understand why."

And to Jean's point of the dignity of risk, it should be that people are making informed decisions and sometimes given our population, especially here at ICS where the literacy level can be very low, you want to make sure that people really understand why it's important to us. And once they do, if they choose not to do something, then we have to allow them to do that. And I'm going to talk a little bit more about some alternatives we can step in and do in the circumstances.

But at ICS, the number one pursuit, as I said, really identifying and prioritizing is the participant, and their family and friends. And if we all think about it, that's who we go to if we need to make a decision and then we go to the experts that we know and it's the same here at ICS. I'm a nurse practitioner. I will tell you that I get daily phone calls from family friends asking me for my expert opinion, so that's what we do. Sometimes I don't feel like an expert in certain areas, but that our members should have access to people who know healthcare and should discuss it with us when we need to and that we should share our information with the.

So, the IDT at ICS is comprised of nurses, and social workers, and care management coordinators who really make sure that the services that are initiated by the member or the care manager actually go into effect and are delivered and are delivered to the member's satisfaction.

Paraprofessional coordinators, we have that separate from care management coordinators because as I said before, it is the biggest service that we provide. And it is – I want to say – I'm hesitant to say, but it is one of the most important services we provide. So, having a dedicated person on each team that makes sure that all of the participants on that team receive coordinated home care is very important.

And lastly we have a role called the senior aide which is a new development here at ICS but that is someone who is a specialist in home care and has been a home care aide for at least five years and has shown leadership skills and that they have come over to ICS to really help our members who are having challenges in care delivery, whether it's because they cannot stabilize their home care, or because they're having some challenging situations, whether it's medically or due to behavioral health issues where care cannot be delivered consistently.

So, the senior aide is really going in there with their specialized eyes and saying, okay, this is what I'm assessing. And they're really in service of both the member and the home care aide. And to mediate what's going on in the home.

Next slide.

So, in addition to the IDT, the team at ICS, we have resource supports. And these resources are here because as Jean said before our members have certain secondary conditions that they're at risk for and we believe also that they need the specialized care in order to achieve their goals. So, wound care – we have a group of wound care nurses. We have three wound care nurses that will go out and do visits and follow people who are either at high risk to develop wounds or have an active wound.

We have rehab services which Jean will talk about. And we also have a group of social workers and nurses that are helping people who are currently in transitions. These people – transitions we're defining as they're moving from a facility, whether it's a hospital or a nursing home back into their home. Sometimes they can also be going from a hospital to a nursing home, that there are specialists that are there to help the member with a transition and also to make sure that they are aware of what they need to do to maximize their health.

One of the other things that we do, we have here a resource for consumer-directed care. And that our members, the participants know that they have an option for consumer-directed personal assistance where they have the opportunity to hire and fire and train their own aides. That is something that we use often here at ICS for members who would like to direct their own care and they don't want to work with a licensed agency.

It also is a great choice for members who require skilled services that is out of the scope of practice for aide. And really we all have a shared goal at ICS. And this is a really important bullet to me because we're all working together to keep the member at home and healthy. So, going back to health mobility and community. That is always our three goals that we're focusing on here at ICS. And although sometimes we might want the member to change some behaviors, sometimes that's a pretty hefty thing to do. So, if we have a member who comes in who has been a smoker for 20 years, our ability to get them to stop that behavior is extremely limited in the

short term. And what we use here is the risk reduction strategy where we work with the member to say, okay, so we acknowledge that you smoke. We also acknowledge that you need a home care worker and how can we adjust that behavior so that either the home care worker isn't exposed to that, so can you smoke outside of your home care hours, or can we change the environment like you go outside to do that so the home care worker isn't involved, isn't exposed to that.

So, risk reduction is something that we use often here and I think it's in the short term steps for long term goals. Sometimes you'll get people there, but it's an intermediate step.

I think that Jean talked about the dignity of risk and we have to respect that people can make informed decisions that we don't think is right for them. I always say to my staff, if someone followed me around 24 hours I'm sure I would be called non-compliant. We make bad choices sometimes. We have the cheesecake after the steak. You know, I think you have to allow that, our members or the participants to do the same.

As we move onto to talking about some of these specialized services a little bit more, again, I'm going to talk about the aide because it is essential. This is really the service that we can offer to our participants to help them stay at home. Without it, they wouldn't be able to. And there is actually a study that's done by a gentleman named Robert Buchanan looking at people who had to go into the nursing home who had had multiple sclerosis. And they tend to go in at an earlier age and they key indicators for that are becoming incontinent. Back w

When you look at the needs of our membership and the role that the aide can play, those are subtle but big changes in going from relying on family support to needing a paraprofessional in your home.

These people are also, for us as healthcare providers, and in long term support they have the most contact with the member. Even if we contact the member every two weeks, it is still not the same as going in there every day, or three times a week, or two times a week to see what's going on.

I think we have not done a good job so far in maximizing this role. If we can give the PCA some education and train them and allow them to go, they can be the first to really connect back with us. And I will tell you from personal experience we worked with one of our preferred home care providers to do some training on multiple sclerosis and what can occur do to the disease process. I will tell you that the home attendants were hungry for knowledge. And I got the most interesting messages/voicemails after the training saying, "I just want you to know, I'm giving you an update and Miss So-and-So, she's walking a little weird. Okay, bye."

So, they're able to apply this and I think we need to set up systems where we can continuously get their feedback on what's going on in the home.

As I said in the last bullet is really talking to the ability for us to work with this consumer-directed program and allowing the member to have control. And in some of our members who are, you know, many of our members who are very dependent on care, they live in a world that is beyond their control. So, when you can give control back to them, it can make a huge difference.

We need to really make sure that they know that that's an option for them should they choose to elect it, because there are some, you know, there are other things that they have to identify the people, and hire them, and train them, but that it is a great service for people who want to maintain some control over their day-to-day life.

Now we're going to move to talking about the risks and how we try to address these risks in people who are physically disabled. I will tell you that I recently was writing an article for looking at collecting morbidity and mortality statistics on people with multiple sclerosis and the three reasons that people died who had MS were due to wounds, pneumonia, or urosepsis. So, why that's very disturbing because it is preventable. It's also very hopeful because there are interventions that we can do to prevent them from occurring. So, when we look at pressure, what we do at ICS is kind of two-fold. One is can we identify those at risk and prevent it from occurring. So, to do that we – on all of our members we perform a Braden nursing assessment. And the Braden looks at six risk sectors, one being sensory, can they feel their skin. Two, moisture, are they wet because that actually makes for an environment for the skin to be impaired. Are they active? Are they moving around? Are they able to change positions? Once they're either laying down or sitting up, are they eating well? And how did they transfer? Is there friction or shear, so is their skin kind of being pulled when they're going to move to transfer?

So, we perform that on all of our members at every nursing assessment, so that's being done at least every 180 days. It will also be performed if the participant is having a changing condition. The thing that always gets me with the Braden score is that we have to remember the lower the score, the higher the risk. It's kind of opposite to our nature, but the lower the score, we really want to make sure that we're putting in interventions to reduce the risk.

So, what does that mean? How do we reduce the risk? So, here on the next slide we talk about some interventions that we train our staff in doing. And I just want to pause for a minute to say that the nurse identifies, performs the assessment, and says if someone is at risk or not. But the interventions are all coordinated by a social worker. And I think that's really important because it goes to show, and our numbers in our reduction in the ability to prevent wounds are below the national average. To show that people do not have to have a medical degree to be able to really improve health outcomes.

So, here are some things that we do at ICS. We offer everyone an inspection mirror. So, it is a mirror that is kind of on a hook that can allow someone who doesn't have the ability to look, you know, kind of turn their body around, to give them a view of the area. It's commonly their backside that their looking at to see is there any redness there. We also offer our members a moisture barrier lotion to put on. This is really important for our members who are incontinent.

Jean will talk about this a little bit but that we do some pressure mapping which is a – it always remind me of topography, but it is a device that our members can sit on and it will show some areas that have high pressure to them. And then we try to get them a support service, a seating cushion, whether it's a ROHO or some type of gel or air device to reduce that pressure, and either their cushion on their chair or on their bed, to reduce that from occurring.

And, finally, one of the biggest things I think that we do here is really education. And that is stressing the importance of member's repositioning themselves, whether it's while they're in their bed to turn and position, or it's to shift their position while they're in the wheelchair. And this can be as simple as for members that are paraplegic and have the ability to do it themselves, leaning forward sitting in their wheelchair. And sometimes if they don't you will see wheelchairs that have the ability to tilt for them, so to recline back and kind of lift their legs up so that they are adjusting the pressure off of the areas that can cause breakdown.

And next we're going to talk about respiratory impairment. Again, I will say that this is a very devastating area should one of our members who is functionally impaired to the level of being quadriplegic, this is something we worry about greatly. Pneumonia, once they get it, can be very hard to recover from. So, again, we look at who is at risk. We very much focus on our quadriplegics in this area. We want to make sure that they understand seating and positioning again. You should be, if you're eating, your head should be up and elevated at 90 degrees. We want to make sure that they get their flu shots. And for those, especially the quadriplegics, that they're getting – that they've had their pneumonia vaccine.

We ask are you having difficulty swallowing. And if they are, or if we notice them, and if we ask them to take a sip of water, if they say that's something that they do on a regular basis, we want to make sure that they are doing that correctly. And sometimes we'll get a swallowing evaluation for that.

And if needed there is a device called a Cough-Assist where they can – it helps them, for those with an ineffective cough to expel air by projecting a [blast] of air in there.

And, finally, talking about urinary tract infections, we are looking at people who, as I said before when we were talking about Peter, have neurogenic bladder, that require catheterization. Are they doing that correctly? Are they doing it often? And we want to observe their technique to see if they are using clean technique and not introducing bacteria, unwanted bacteria, or it can be prevented. And then there's also a device called an introducer catheter, a tip catheter, where it avoids the dirtiest part of the urethra which is the lowest like half an inch to an inch. And it threads the catheter up to avoid that area.

So, those are some things that we're doing here to address those three areas. And I'll turn to Jean.

Jean Minkel: So, looking at the next slide, in addition to the risk factors that we've talked about in terms of pressure management, urinary tract infections, and respiratory, the folks that we originally worked with with physical disabilities it was quickly identified that having them be able to access the appropriate wheeled mobility device was one of the most important things on their problem list. And the management at ICS reached out to a group of therapists who had had an experience in recommending individualized equipment. It's now referred to as complex rehab devices.

And I think one thing that's really important is the experts really needed to embrace a partnership with our participants in the process of recommending equipment. That if someone has lived with

a disability, has an experience level, we needed to capture that information in individual interviews. The intake process of what works with your current device was as important as identifying where you're having problems with your current device.

Home visits have added a huge dimension on what's the environment of use, both inside the home as well as the surrounding neighborhood. Is it a hilly environment? Are the curb cuts not so consistent with code? What are the challenges that the wheelchair rider is facing on a daily basis?

We recognize the therapist had a set of tools, whether it's literally a set of tools, or a knowledge base regarding the equipment that could meet somebody's needs, but equally important the participant has knowledge of their past experience and their desired outcomes.

And it's only in a recognition of partnership of the therapist having the ability to offer particular pieces of equipment as part of the solution in combination with really respecting the participant's knowledge and their desired outcomes.

We have a favorite saying that with joint participation in the process becomes joint responsibility in the outcome. So, it's not the expert therapist telling somebody what they should use. It's really a collaboration of what is likely to serve the purpose in the environment the person wants to use it in. Move to the next slide please. Next slide.

So, the picture at the bottom of your slide there, oh, go back one for me. Here we go. Thanks. If you look at the picture at the bottom of the slide, you'll see a display area that was purposely built to be exactly that. We wanted our participants to know that this was a consumer purchasing experience, that there are a large number of models of products, devices. And when people come "rolling in," they get a chance to see what could be. It's not just what they've been told is available. It's what do they think could match their needs.

We work with rehab technologies suppliers and we really look to match the individual product recommendation to the functional need that the member brings to us. Early on in my work here at ICS I was asked to see a woman with cerebral palsy who was propelling a manual chair quite effectively, however she was four months pregnant and brought to the care team concern that once the baby was born, how does one push a wheelchair and manage holding and/or managing her child.

And we very quickly came to the conclusion that a powered wheelchair enabled her then to become an effective parent as well as to be able to mobilize in both her home and community environment.

Next slide, please. As much fun as it is to be a part of the recommendation of new equipment, to our members and participants the most important thing is keeping what they have in terms of mobility devices and assistive technology in their home working was really an overriding need. So, we've created several mechanisms for maintenance and repair. And it's particularly critical if the equipment someone is using was individually configured for them, we need to know that it's going to be operating on a daily basis as consistently as your automobile is.

So, we have an on-the-road repair program where technicians with the vans go to people's homes and we like to address the problems that can be addressed in the homes, fix the problem replace the seatbelt, fix the foot pedal, keep the caster from falling off, and keep people moving. It's incredibly efficient. People really appreciate it. And needless to say, if your chair doesn't work, trying to get it someplace isn't really the most effective response.

We have found that if we do provide people an environment for maintenance, they'll take advantage of it. So, we have what we call our maintenance workshop. We like to think of it as Jiffy Lube for wheelchair riders. And it's the classic if you address the squeaky wheel before the wheel breaks you can stay functional.

So, once a week, once in our Brooklyn office and once in our Bronx office we have a technician available and our participants can either make an appointment to have a small problem addressed, or the "be roll-ins" and get the technician to identify worn tires or a frayed chord and get the parts ordered before they have a fundamental breakdown.

Chris Duff: Jean, I'm afraid due to time I need to break in here. We are having lots of people come in with questions. And I think the content you are providing is excellent and I think we'll probably need to follow up some more in a different webinar. But I'd like to at this point open it up to questions and so if the operator could give brief instructions for that and then we'll proceed.

In the absence of the operator giving instructions for the calling in—

Operator: Sorry hello.

Chris Duff: Can you give the directions for calling in, please?

Operator: Directions for Q&A questions-and-answers? Okay, I'm sorry. Thank you. Ladies and gentleman, if you wish to ask a question, please press star then zero. You will hear an acknowledgement tone. If you're using a speakerphone, please pick up the handset before pressing the numbers. Once again, if you have a question, star-zero at this time.

Chris Duff: Great. Thank you. While we're waiting for the questions to come in, let me raise a few questions that came in writing during the presentation. There's a question from Heather Nugent at Prime West and I think she identified an issue that is something that we struggle in this field for over a decade. She indicated there was no reference to mental health or chemical dependency in this presentation. And I will add, many of our previous presentations.

She says, "It's interesting this population has the highest percentage of mental health and chemical health issues. I know that's something we struggled when I had a program in Minnesota." Rachel and Jean, can you just talk a bit about how do you work on addressing the behavioral health and chemical dependency issues that your participants are dealing with.

Rachel Stacom: Sure. So, we have – we talked about care managers and we talked about care managers as social workers. So, we have within our teams we stratify both the members and the staff. So, members who have behavioral health needs are managed by a behavioral health social worker. And they are specialists in their area and they will link them to the community resources since we don't provide the ongoing therapeutic support, but it is important to us that we have someone who understands this person's disease and condition.

And I didn't get a chance to speak to it today, but similar to that we have specialists in multiple sclerosis, in spinal cord injury, and as I said behavioral health to address our members needs.

The second point that I'll make is I talked about harm reduction. And I used smoking as an example, but very often we have members who are using chemical substances – are using substances, whether it is marijuana or alcohol, and we do something similar with them. We try to get them into treatment. We do some crisis intervention and try to link them with services.

But if all else fails we do use harm reduction, so we can still provide them with care.

Chris Duff: Thank you very much.

Operator: We do have a question now from the line of Sheryl Paris. Your line is open.

Sheryl Paris: Yes, hi. My question is about the senior aides. I would like to know exactly how does that mesh with, I know, having different providers and different aides in there, is that aide actually an employee of the company who goes out and assesses the work or the relationship between the other aides that are being placed in there by the (inaudible)?

Rachel Stacom: Yes. They are an ICS employee. And you're right, because otherwise it would be very complicated to say they're from this agency and talking to another agency. So, that they are there as peer support for the aides and also for the members, but they are an ICS staff. So, it's the same as the social worker going in or nurse going in from ICS.

Sheryl Paris: Oh wow. Thank you.

Chris Duff: Yes. That is something that ICS is unique with nationally. They've been doing this for a couple years on a pilot basis. I think that deserves some further attention in a future webinar. They've been able to capture the knowledge and competency of people who are in the home with their members every day. And in a very successful way.

We have another question here from Valerie Pearson at PMG Health. Again, I think this is for you, Jean. Is the Braden information sent electronically or hard copy? And does your team have access available, have access to this information on a shared technology platform?

Jean Minkel: The Braden is available in hard copy. We have it embedded within our electronic care management system. So, the information is available to all members of the care planning team. And is used accordingly so that the intervention can be targeted to the exact risk factor that was identified during the assessment.

Chris Duff: Thank you. Another question that we've received is from Jennifer Barron at CMS and she's asked how do you measure success and how do you know that you're achieving that success? And I think what's being referenced is the success, the goals that you've identified and the member have identified through the assessment process.

Jean Minkel: So, one advantage of the 180 day reassessment is it's a built-in opportunity to look back on the previous six months, identify what was on the original problem list, what was the agreed to interventions, what's the progress been to implementing those interventions, and ultimately what was the level of satisfaction for the participant themselves.

I'll speak specifically in the rehab world. When we do our initial assessment, whether it be interview, come in, see the person in the environment, we'll ask the question directly: what is it that you want to do that you can do now? It may be, "I've been spending too much time in bed and I want to be able to be sitting in the chair for several hours at a time."

After delivery we can do an inquiry back and say, "How long are you able to sit up in your chair now that you have an appropriately configured device?" So, each care team targets the intervention that was highlighted by the member. And that's part of the 180 day reassessment.

Rachel Stacom: The only thing that I'll add is that we also look at hospitalizations that are prior, so what's happening to people outside of long term care services. And as we were talking about, bridging the gap – how are they using the healthcare delivery system outside and can we reduce that? So, that's also an outcome we measure.

Chris Duff: I think that's common in a lot of programs across the country. They identify the handful of preventable in-patient episodes, potentially preventable in-patient episodes. So, that's what the talk about here, the pneumonias, the skin breakdown. And they track that in the plain data. And every time one occurs they go back to the team and step back and say, "Could we have prevented this? And how can we prevent this from happening in the future?"

So, there's a variety of approaches. We only have another minute or two left, and so I wanted to call everyone's attention to the survey link that's on the slide here in front of you. It's very important to us that we hear from you, what works, what you're still wondering about or needing to know. If you could just take a minute or two, we'd appreciate it. And also feel free to email any of us. We're listed with our email addresses at the end of the presentation here.

Is there one last question on the phone?

Operator: Ladies and gentlemen, if you have a question press star-zero.

Chris Duff: Okay. So, in the absence of that, let me ask one last question that has really kind of come up throughout many presentations. And that is the person says, "I really appreciate the concrete risk assessment approach that you have described. It seems, though, the success is based primarily on the participant letting you know at first symptom, earlier than in the past when they had needed to wait until progression before they are able to get the needed help.

“How do you get this early response from the participants?”

Rachel Stacom: That’s a great question. I will tell you in all honesty sometimes we’re successful and sometimes we’re not. But we really try to invest up front, to develop a relationship with people to engage in dialogue that says what’s important to you, how can we help you, how can we be in service to you. And ideally we have that conversation before crisis. And to say this is how we can help, and call us when this happens, that said, it is an ongoing challenge. Some people are easily engaged and some people are more difficult to do so.

Once we can show our benefit, we tend to be more successful. They’ll come back.

Jean Minkel: Right. Relationship, relationship, relationship.

Chris Duff: And that’s a theme we’ve been using through all webinars. Thank you very much on that.

I do need to wrap it up at this point. Many questions have come in. I just want to assure everyone that we will be taking these questions and responding to them directly or forwarding them onto our speakers. I think what we’ve learned out of today’s lessons, especially since we were not able to get to the latter slide, that there’s a lot of questions that people have about how do we actually in practice support people living their lives in the community. And so I would hope that we would be able to have an opportunity in the early part of next year to provide some more of this information.

So, thank you all for participating. A link to this presentation, as well as all the other presentations, are on the website. And as I said we’ll be responding to the questions.

We have a break for a couple weeks here due to Thanksgiving and then we’ll be having two more presentations on Tuesdays in December, the 3rd and the 10th. So, please look for the email telling you about these presentations and I hope you can join us in the future. Thank you very much.