



NCAPPS Webinar Transcript: “Person Centered Healthcare Delivery Centering Patient Experience in Accessing Care”

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SPEAKERS

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Alixé Bonardi 00:00

Well, hello and welcome. We are starting to see people come into this webinar space and I'm seeing people have begun to say hello in chat. So, welcome everyone. Today's webinar we will be moving through today but just want to welcome everyone to this "Person Centered Healthcare Delivery Centering Patient Experience in Accessing Care from the National Center on Advancing Person-Centered Practices and Systems. Next slide please.

Alixé Bonardi 00:37

Welcome my name is Alex Bonardi. I would like to do a visual description of myself I'm joining you today I'm a white woman, middle age with shoulder length dark hair with gray streaks. I'm wearing glasses with dark frames today, which helps I hope conveys that I consider myself serious, but I also care about style. My black My background is blurred right now. If it were not what would be visual is a map on the wall behind me and an aerial photograph of where I am right now. Thank you for joining us today to learn about how telehealth and house call visits are two approaches that have helped people with disabilities access health care while avoiding the challenges of leaving their home for health care. My co-director of the National Center on Advancing Person-Centered Practices and Systems Bevin Croft and I would like to welcome you to this webinar. This webinar series is sponsored by our NCAPPS Center, the National Center on Advancing Person-Centered Practices and Systems, which is funded by the Administration for Community Living and Centers for Medicare and Medicaid Services. These webinars are all free and open to the public. Next slide please.

Alixé Bonardi 02:05

The goal of NCAPPS is to promote systems change that makes person centered principles not just an aspiration, but a reality in the lives of people across the lifespan. What I'm excited about today is this conversation that we'll be moving into, which is a deeper discussion around Person Centered practices and how this relates to people's experience of health care. Next slide please.



Alixé Bonardi 02:37

A few logistics before we get started, participants are all muted during this webinar, as we see we've got a number of people still coming in, over 200 people at this point. And you can use the chat feature in zoom to post questions and communicate with the hosts. I would like to say just a reminder, when you use the chat feature, make sure that you right above where you would enter in chat that you choose everyone if you would like the messages to go to everyone who's participating in this webinar. Towards the end of the webinar, our speakers will have an opportunity to respond to questions time allowing that have been entered into chat, so please don't hesitate to engage in chat, early and often. The webinar is captioned in English and Spanish and to access the Spanish captions, there's a link that will be the disrupt into chat that you can use to access the Spanish captions. We also have included the slides available link that's available to the slides. This live webinar includes polls and evaluation questions, so please be prepared to interact during those polling times. Next slide please.

Alixé Bonardi 04:07

The feedback and follow up you should know about after the webinar, you can send any follow up questions and feedback to our website, our web address, and ncapps@hsri.org That's NCAPPS@hsri.org. Please note that during this webinar, this email addresses not monitored. The recorded webinar, along with the PDF version of the slides and a plain language summary will be available within two weeks at our website, ncapps.acl.gov. We will also include questions and responses in the materials that are posted following the webinar. So next slide.

Alixé Bonardi 04:53

Next slide, please. So, let's get started with a poll. Who's here? There's a poll that should be coming up on your screen. And we ask you to identify to answer this question. How do you identify? There's this one question, but there are a number of options. So, you can scroll down to choose options, you can choose more than one. And we use this, this polling question to understand who's here with us, and give our panelists a little bit of a sense of who's participating. We have a number of people participating. So, I will keep the poll open a little bit longer as people are reading through the options, including options including person with a disability or who's, who uses long term supports, family member, self-advocate, peer specialist or peer mentor, social worker, or counselor, care manager, researcher, community or faith-based provider organizations, government employees, hospital, affiliated clinic employees or health maintenance organization members. The pace of response is still quite high as people are responding. So, I want to make sure people who are choosing to respond, have a minute to do that. So, we'll give about five more seconds before we close the poll. Okay, let's end the poll. And I think everyone should be able to see, we are joined here today by we have some people with disabilities who are people who use long term supports, welcome and include and also family members of people who use long term supports self-advocates, people can choose one or more than one options, so we might have some overlap there and peer specialists as well. We've got a larger portion of people, the preponderance of people are social workers or care managers, and government employees. Researchers are joining us as well, as well as people representing community or faith-based provider organizations and hospital employees and folks from Health Maintenance



Organizations. Thank you everyone for joining us. Okay, at this point, I would like to, to briefly introduce our panelists who are with us today. We have two co-facilitators; Nicola LeBlanc will be setting up the conversation with a summary of the issues and Sarah Blahovic will speak from personal experience about health access needs and her perspective on what can make health service delivery person centered. Sarah will also help facilitate the conversation. We have four panelists joining us here today as well. Dr. Clarissa Kripke is a clinical professor of Family and Community Medicine at the University of California San Francisco. She directs the Office of Developmental primary care whose mission it is to build the capacity of the health care system to serve transition age, youth, and adults with developmental disabilities through clinical service, advocacy, Research and Training. Dr. Vincent CSL CO is a family physician, and an assistant professor in the Department of Family Medicine and Pediatrics at the Albert Einstein College of Medicine, and a director of primary care at the Rose F Kennedy children's evaluation and Rehabilitation Center at Montefiore Medical Center. He's the medical director at adapt community network as well formerly known as United Cerebral Palsy of New York.

Alix Bonardi 09:23

Dr. Bob Baldor is a professor and the Founding Chair of the UMass Chan Medical School, a State Department of Family Medicine. Dr. Baldor has served in a number of leadership roles, including as the medical director for the Center for Developmental Disabilities Evaluation and Research at the UMass. Eunice Kennedy Shriver Center. And Tawara Goode is our final panelist here, and Associate Professor and Director of the Georgetown University National Center for Cultural Competence and the Georgetown University Center for Excellence in Developmental Disabilities. Her research writing and expertise help us bring better understand the importance of and the writing and expertise, I'm sorry, and the influence and implications of culture on the subject of Person-Centered health care access for people with disabilities. We so appreciate having each of you here and in this at this time I'd like to turn it over to Nicole and Sarah.

Nicole LeBlanc 10:31

Hello everyone, welcome.

Nicole LeBlanc 10:45

We're so glad you guys be here for today's conversation on house calls and person-centered practices.

Nicole LeBlanc 10:58

I live in Silver Spring, Maryland.

Nicole LeBlanc 11:05

I'm a policy wonk.



Nicole LeBlanc 11:24

Next, I would like to have Sarah and the other panelists introduce themselves share their background.

Sarah Blahovec 11:40

This is Sarah Blahovec, I am a white woman with wearing glasses with brown hair. pulled back in a ponytail. I'm wearing a blue shirt and I have a virtual background of bookcases, white bookcases behind me. And so yeah, I am. I'm here in my personal capacity, but I am the civic engagement and voting director at the National Council on Independent Living and as someone who's a person with a disability have benefited from telehealth myself. So, I'm very excited about this conversation. And Nicole I believe we are supposed to go on to our slides next before we introduce everyone else, correct?

Sarah Blahovec 12:33

Can we go to the next slide?

Nicole LeBlanc 12:44

I'm reading this one Sarah. Correct?

Nicole LeBlanc 12:46

Yes.

Nicole LeBlanc 12:47

Telehealth is becoming more accepted. Prior to COVID-19 pandemic there was resistance on telehealth and if quality of care could be upheld in a virtual way. Independent doctors have gone bankrupt during this pandemic and are moving to large scope practices. The error of the sole practitioner is over if you read the headlines for the beginning of 2020. major declines in preventative health care visits for chronic health issues due to fear of COVID. There's been declined in immunizations during this pandemic, especially with kids. And this is one solution we see as a way to address things like that doctor nurse shows up at your house gives you your shot. Next slide.

Nicole LeBlanc 13:51

The healthcare challenges. People with developmental disabilities in the families face on a regular basis are enormous and need to be highlighted. The time is now for us to build a society and health care system that plans for disability and is accommodating to our unique needs. If we all live long enough, we will all join the disability club for the time is now for us to build healthcare system that plans for living with disabilities in the 21st century, especially when we look at the long-term impact of lung COVID.



Sarah Blahovec 14:31

Go to the next slide. Great, this is Sarah speaking. And just to continue framing this conversation before we bring up the other panelists. We wanted to just take a few slides to talk about both the benefits of house calls and telehealth services and also some of the challenges that we are seeing. So, in terms of benefits, house calls in hell to health, they remove transit barriers for people with disabilities and other vulnerable populations who don't drive. So, you know, it can be really challenging, particularly whenever it comes to public transportation right now, especially for people who are immune compromised, and the transit mask mandates have ended, it can be very challenging to safely get to the doctor's right now. And so, telehealth and house calls are able to assist with that, in some ways, as well as remove some of the transit access barriers or just the burden of trying to get transit to go to the doctor's office. The second benefit that we have listed here is that it's less stressful and it causes less anxiety whenever we're seeking medical care, especially during a major pandemic as a high-risk population. So, both in terms of that transit and also being in the doctor's office, if you're able to have a house call or a telehealth visit, it is possibly a little bit safer because you're not being exposed to so many people. It also saves time and money for families and people with disabilities, especially juggling the stress of caretaking working and household management during this era of uncertainty. So, you know, it takes time and an energy to be able to go to the doctor's office, it can mean taking time off work or having a family member or caretaker take time off work to transport someone to the doctors. And that includes not just the time of the actual visit, but also the time getting to and from the doctor's office. It can be a stressful environment, medical setting, in a doctor's office can be a very stressful environment. So being able to have the option to get medical care in your own home can help to reduce that stress and also reduce some of the time burden and the amount of energy and activity that you need to expend on going to the doctor's and of course, as I've mentioned, less time wasted in waiting in traffic or on public transit, you don't have that commute to the doctor's office, I live in a metropolitan area. So sometimes getting to the doctor can take an hour or longer just one way. So, it can be certainly a really big burden, especially for some very short visits such as refilling a controlled medication, it could you know you have a five-minute appointment to refill the medication and have you spent two hours getting to and from the doctor's office. Next slide please.

Sarah Blahovec 17:51

Continuing on the benefits of house calls, it allows doctors and nurses to use a social determinants of health mindset, you know, to help meet people where they're at in terms of the medical disparities that they are experiencing and address those needs and may help doctors be more aware of what that person's situation is like, particularly their socio-economic situation. It reduces rates of readmission to hospitals, it exposes challenges or issues that may not be brought up whenever patients are in a doctor's office, because they might be in a lower stress environment and be able to share you know more information and doctors may be able to observe more information about their patients. It reduces exposure to viruses for the disability community and high-risk populations I've mentioned before. And also, for people who are dealing with chronic pain and very uncomfortable or challenging to manage symptoms when it can take a lot of energy and it can be very difficult to be able to kind of muster through the pain or the symptoms to get to the doctor's office. And so, if you're able to have that visit,



meet you where you're at it can reduce exacerbation of those symptoms and make it just easier for you to actually get to the appointment. Next slide please.

Sarah Blahovec 19:19

And then I wanted to just cover a few of the challenges around house calls and telehealth. First, patients who live with others may not have privacy for their important appointments. You know, whenever you're in a doctor's office, you're able to be in that room with that door closed. Whereas if you're in a house maybe with roommates or you know you're living with other people you may not have the complete privacy that you should have whenever you are in a medical setting. And this can also be you know; I've seen concern about people who are in abusive situations and what does this mean for them? Well, someone in that they're living with have more access to information or more control over their health decisions. So that is something that is a concern and an area that needs to be discussed. Telehealth technologies may not be fully accessible. So, for people who, you know are blind or low vision or need to be able to use their own assistive technology, the platform that the doctor's office is using to facilitate those health house calls, or the telehealth appointments may not be fully accessible, and that can cause access barriers. Doctors can't do a physical exam during telehealth and may miss essential signs and symptoms. This would not be so much the case obviously in a house call visit because they are physically present. But if you don't have a doctor who's physically present, it can limit their ability to treat certain conditions to be able to do a physical exam of someone's body and the symptoms they're exhibiting. And then, of course, for some patients, particularly low-income patients, and patients in rural areas, they may not have access to reliable internet service. And so that can be a challenge in terms of being able to access telehealth they may not actually be able to do it, because they may not have the internet service or the technology even to do it if they don't have, you know, access to a computer or a smartphone. So, with that, I'm going to hand it back over to Nicole who is going to invite the other panelists up to introduce themselves.

Nicole LeBlanc 21:44

Now we will turn it over to Vincent, Tawara, Bob, and Clarissa. Let's talk about the nuts and bolts, what are the benefits of doctors doing house calls, or people with disabilities and other vulnerable populations?

Clarissa Kripke 22:03

So, I'm Clarissa Kripke. I am a family physician who provides care in people's homes, to people with complex developmental disabilities, people who are dependent on technology who have skilled nursing needs, who many of whom need 24-hour skilled, skilled nursing care. I don't know if we are supposed to each introduce ourselves and then answer your question or go into our questions.



Sarah Blahovec 22:34

Yeah. Yeah, I think if you could each introduce themselves. And actually, I think we had a question before that, Nicole on. What's what is your role and area of expertise related to supporting Person Centered health care for people with disabilities? So, to kind of frame your introduction.

Clarissa Kripke 22:55

Great. And I'm a middle-aged white woman with the logo of my program in the background, and I put that in the chat.

Sarah Blahovec 23:07

Great and Bob, do you want to go next?

Sarah Blahovec 23:19

You're mute muted.

Bob Baldor 23:24

Okay, you can now hear me. Hi, I'm Dr. Bob Baldor. I'm an older white male. My preferred pronouns are he and him. Have a graying beard and I'm wearing glasses and zooming from my office in Springfield, Massachusetts at UMass Medical School. And the bookshelf behind me has a few mementos from my worldly adventures and I have a Norman Rockwell picture on the wall of a child getting a shot and questioning the doctor's credentials. This is always something I think it's important to do is to question the expertise that you're that you're getting. I stated earlier, I'm a professor of family medicine. And over the years I've been involved in caring for folks with developmental and intellectual disabilities. I've served as a role with the Center for Developmental Disability Evaluation Research at the UMass Kennedy. Eunice Kennedy Shriver Center. My primary medical practice, though, has really as a primary care physician has evolved to taking care of those who have intellectual and developmental disabilities. But I'm a professor so that means I've done a lot of publication as well. And national speaking, I authored a chapter in something called up to date which a lot of physicians and other providers around the country use on care of the adult with intellectual and developmental disabilities and have spoken nationally about these things as well. I look forward to participating more in the in the panel as we go along. And why don't I kick this over to Vincent your turn.

Vincent Siasoco 25:03

Hi, good afternoon. My name is Dr. Vincent Siasoco, I am a middle-aged Asian men, short black hair, with clear glasses, wearing a white shirt and a red tie. My background is blurred, covering up a messy room. So, I'm a family physician based here in New York City, Long Island area. So, I've been working with this population. Since I finished my residency, I, in my career, I've overseen outpatient clinics, multi-specialty clinics that serve this population, I'm overseeing group homes, day programs throughout New York City. I'm also involved with different national organizations state organization. I'm a board



member of the American Academy of developmental medicine and dentistry, clinical director for Special Olympics, and I'm happy to be here, I'm looking forward to the conversation.

Sarah Blahovec 25:54

And then Tawara? Introduce yourself?

Tawara Goode 25:54

Good afternoon, everyone. I'm Tawara Goode, I self-identify as an African American female, what's rich brown skin, my hair is styled in natural twist. I'm wearing a maroon top, turquoise necklace and earrings, and a column for scarf and glasses. I'm coming to you via zoom from my home basement office since March 2020. In Washington, DC. In terms of my experience in this space, my body of work has really focused on Person Centered health care, really ensuring that healthcare providers, personnel and organizations make the integral link between person centered care in the cultural beliefs and practices and languages of persons with the lived experience of disability and or mental health needs.

Tawara Goode 26:03

Great. Okay. And then I think the first question we wanted to get into is, what does Person Centered healthcare mean to you, and we'll start with Clarissa.

Clarissa Kripke 27:18

Person Centered healthcare to me means that the goals of care are set by the person and by their supporters, not by the physician or the healthcare system, or by default, it also means that the goal of healthcare is to maximize people's potential and to enable full participation, not necessarily to achieve independence, to normalize or even to care people, which is an odd thing for a doctor to say. But we can provide medical care within the disability understandings of the social model of disability and neurodiversity models of disability. And finally, person centered care is about care that's accessible. And when we talk about accessibility, a lot of people think about reasonable accommodations, but my patients often need care that is not accommodated in a clinic setting. And we have to develop special health care delivery systems that work for people who have a much more intensive need for care who need quicker response times and who need help with accessing care. So accessible, accessible care, not just accommodations, if people can't be reasonably accommodated in a clinic setting.

Sarah Blahovec 28:55

Vincent? Do you want to go next?

Vincent Siasoco 28:57

Yeah, you know, so when I think of picking her to healthcare, I think of the provision of health care that's continuous, comprehensive, well-coordinated by a team of different disciplines. But the



importance of that team is that it is really led by the individual based on what their wants and needs are. I think, as Chris was saying, you know, it needs to be accessible, it needs to be available and at the comfort level of the individual, and understanding of what those services are, and making sure that the individual is aware of what the services are being provided for what the reasons are and making sure that they're okay with what's happening around them. And that the team is listening to them to the individual and making sure that everything is coordinated. I think that's really key. It's one thing to say, well, I'll refer you here, I'll refer you there. We'll schedule this appointment, but I think it's very important to make sure that the team is working on behalf of the individual and making sure all their needs are met.

Sarah Blahovec 30:01

Thank you. Tawara?

Tawara Goode 30:09

Thank you, Sarah. So, as I was thinking about what this person said a cure mean to me, I really looked at that, and within the context of healthcare that is responsive to the interests and the needs of the person, their family, and the communities in which they live. And doing so with the understanding that care cannot be person centered, if it does not address culture, the multiple cultural identities of which disability is only one and the language of the person. In other words, person centered care must also be culturally and linguistically competent. So an initial read of the word, person centered health care, may give the impression, to some that the focus is only on the person with the disability, I think it is really essential to note that among many cultural groups, the person is always viewed within the context of their family, whether that's biological, or birth family, as well as their chosen family, they are not an island, they may need practice, they may indeed practice interdependence, rather than independence. So, we have to take all of these cultural factors into consideration. I also think that this has a just an array of implications for healthcare providers that may involve decision making, and decision making and issues around care and treatment that extends to the family rather than solely the person. Because that's what the person would prefer in terms of decision making. So, confidentiality and other health care policies immediately come to mind. But again, it's looking at the person within the context of their own multiple cultural identities of which disability is one, their families and the communities in which they live.

Sarah Blahovec 32:11

Thank you for that, and Bob?

Bob Baldor 32:15

I actually want to, I think, all the things have been centered, just really so right on important I want to pick up a little bit on this concept of the shared decision making that we just mentioned. And I think that's a key a key piece of Person-Centered Care and North Have you shared decision making when we're talking more and more about this in medicine, right is you have to have a proper understanding of



the person's needs, their desires, and they have to have a really good understanding of the choices that are available for them. And so, you know, oftentimes there's, there's limited understanding, or it's we'll take the time to really help to, to bring those things forward. So, people really can appreciate it. Sometimes it's doing all bunch things, sometimes it's doing nothing, you know, and being respectful of those choices. And I think that what we've just heard is that oftentimes, when there is limited understanding, it's really important to appreciate the perspectives of those who are closest to the to the person. And so, it's really respecting autonomy. And I always keep in the back of my mind, the words like a first do no harm as part of this. And I go back to what it was a guy, Dr. Francis Peabody, he said it back best in in 1907. He said, The Secret and caring for the patient isn't caring for the patient. And in many ways, I think that sums up what patient centered care is all about.

Sarah Blahovec 33:43

Thank you. Nicole, do you want to take the next question?

Nicole LeBlanc 33:49

Next question. Let's talk about the nuts and bolts. What are the benefits of doctors, doctors, nurses doing house calls for people with disabilities and other vulnerable populations? Post order, Vincent, Tawara, Bob, Clarissa.

Nicole LeBlanc 34:06

Thank you, Nicole. Well, I think Sarah did a really great job talking about the benefits of house calls, you know, to reiterate, you know, I think it's the benefit one, obviously, is the comfort level that the individual has with somebody going into their home, they are being seen in their own environment. It's comfortable, it's convenient, if decreasing stress, you know, they are surrounded by loved ones. So, you may have one physician going there, but because of their environment, definitely decrease in distress and also agitation and behaviors yet that may arise. Obviously, as was discussed, you know, it avoids transportation issues waiting it now a busy waiting room or addressing or being concerned about some of the issues that you would see if you had to go on site to a doctor's office. And I see, I think a benefits I'm thinking of it not only contractors but also as a physician, you know, the benefit of me going into somebody's house, talking about the social doesn't just help, you know, I can see the home environment I can, I can address some of the flaws with food security, get a better idea with the family dynamics of what's happening. You know, it's different when an individual comes with a family members and appointments for 15-20 minutes or to see the environment at home can really make a difference. And also, I think one of the points also was, was increasing your admission, I think, you know, when someone's working, hospitalized, you have the discharge, next hospital setting, that's talking about what's going to be done at the home setting. But you don't really know until the person gets home during a house called post discharge and seeing what's going on, were they able to get their medications, was everything at the discharge planning meeting, implemented at home, I think that would be key, and also avoid admissions read.



Tawara Goode 35:58

Next, thank you, Dr. Cisco. I think that as we look at home visits or house calls, that persons with disabilities can receive the care that they need in the comfort of their home, with family or with friends, or whoever that they choose. I think that Sara did a great job talking about transportation, etc. What I will say that is that it may again, bring back a common practice earlier in our, in our society, in which many doctor visits for at home. And so that I think, by this becoming a practice, and that we're able to look at the efficacy of the practice, the cost efficiency of the practice, that it may indeed, set, set the stage for us receiving care and settings other than hospitals and offices.

Bob Baldor 37:06

I think I'm up next on the list. This is Bob again, actually, you know, I think what's really neat about house calls, is that home visits, you can actually provide a variety of services. It's an acute problem that can help take care of and keep somebody out of the emergency room. It's a wellness visit or preventive visit. But I actually want to tell a story of Brian. And this is actually how I got into house calls. And so, despite 30 years ago, now, I'm in my office, seeing patients and I can hear loud commotion out in the waiting room. And the nurses come in and you got a problem out in the waiting room. So, I've got a problem out in the waiting room. And so, I go out. And there's Brian. Brian is holding and yelling. And he's got he's a big guy. And he's bouncing around. He's got two people kind of pulling him through the waiting room. And so, I go up to him and people are afraid of him that they're backing up against the walls of the waiting room. And they got to see him, and I look at him and I can see his fear. I'm like, this guy is totally afraid. And I said the folks, the caregivers always how did he get them here? So, we had a van. So as well spring back out of the van and went out in the van and I sat in the van with him, and he calmed down. I said, well, maybe I could do a house call. And that's how it started for me. And of course, he was he was living in a group home. And when I went to the group home to see him a totally different persons, right. It's an environment totally relaxed, I could actually do an exam, everything that was to be really comfortable to be able to provide services. And of course, while I was there, he lived with three other people in the group home folks that take could you see him and her and him. And so that's how I started doing cost. But I think it's really that coat that comfort level. And the other part of it, of course was I actually saw a totally different person in the home, versus what I had seen when they were outside of their environment, huge amount of anxiety, huge amount of fear, and realizing this was a different person that I'm seeing in the home. And it's a different vision of who this person really was, seeing them more as a person as opposed to an out-of-control patient. So those are the things that I always resonated with me when I think about the importance of house calls and home visits.

Nicole LeBlanc 39:30

Well said.

Clarissa Kripke 39:31

I loved your story, Bob and that is also how I got into doing home care is that people with complex disabilities were showing up in the clinic and they arrived with a driver who couldn't give a history the



patients couldn't give a history. The nurse was back at the home and couldn't leave to come and I said Well this makes no sense. It's a lot easier to move me than it is to move you why don't I come to you I can round with your nurse. I can meet more of the whole team that involves multiple service agencies when I go to the homes, it's not a tiny exam room that we're trying to accommodate with large wheelchair. It's a home where people, other professionals like their caseworkers the dieticians, the physical therapist, other people often round at the same time, so that we can interact directly in ways that we couldn't in the office, and the nurse that provides their care could also be there at the same time. So. So it really respects the role of the entire team, I think, to why we're saying that, that this is interdisciplinary team-based care with patients and caregivers at the center of the team. And for people who have complex teams with multiple service agencies, many direct care supporters, direct care workers, shifts of people, and other clinicians involved in the care, it can be much better coordinated when you're in in the home. And those people who are involved in the care are much less disrupted than when they have to leave the home and accompany people to a doctor's office for an appointment that isn't all that useful. Also, like other people have mentioned, the environment impacts health and function. And if you don't know what's going on in someone's environment, their social environment, and their physical environment. So, you know, are there barriers in their home is the home setup well, for their needs, are? How are the attitudes, the people that are caring for them? Who else is involved in their life, which makes a big difference in people's health, and then the things that we recommend if our goal is to maximize pretend potential and to help people participate, and its pragmatic, it's more flexible? Doing care in the home has low infrastructure costs, when people say, you know, I want to come to your clinic, I don't I don't have a clinic, I didn't have to build a bricks and mortar, place and pay all the money associated with keeping up, you know, a physical clinic and all the things that you need to do with the clinic, I describe my practice as me my computer and my cell phone. And it's a little more than that, but not much more than that. And all you need to do to set up a homecare service is to have a salary. And there's not that that huge overhead that you also have to, to fund in a clinic-based setting to make that work. You can do homecare in rural areas. It's simple, it's direct, it's flexible, and it offers a higher continuity of care at a reasonable price. I see some people in the chat we're talking about, is this cost effective? And I think we can talk about that. More as we as we get to the next questions.

Sarah Blahovec 43:11

Yeah. So, and this ties into that, but what can we do to advocate for the creation of house call programs done by doctors and nurses? And how can we deal with some of those barriers, like cost effectiveness? So, starting with Bob?

Bob Baldor 43:33

Yeah, thanks. This is Bob again, and I think that, you know, your advocacy is absolutely essential. And there just a whole variety of barriers, and really different ways of approaching and addressing these barriers. And, but whether it's trying to think of how to schedule these things travel that's involved, being able to really provide the right care at the right time, and you have the right tools that are available, you know, this is an acute issue, or is it a chronic problem, you may need some different supplies, and then their concerns for safety, as you're going is the appropriate supplies, cleaning equipment, and, and so



on. I think the key issue here, though, is obviously related to reimbursement. And, you know, for the most part, we mainly have what's called a fee for service world, where fee is paid for different things that are done in the fees that are paid for cognitive work. And that's what we're talking about here house calls, it's like primary care house calls, it really pales in regard to the fees that are paid for when somebody's actually cared for in the emergency room. It's like well, why aren't they paying that for us to go to the home you know, and having to help offset those, those costs? So clearly advocacy for payment reform is a is a big piece of this and a lot of this I think about it's, you know, we should pay as much to keep people healthy as we do to treat them when they're ill. You know, I often think about if this you know, somebody's got a heart attack, and they end up in a hospital, and they have all these things going on \$30,000 Bill, no problem, we pay for that. But we pay for somebody to spend time with a nutritionist. And we pay with somebody to spend time with, you know, with a behavioral counselor to help them stop smoking or to be exercising and so on. You no see, that's that we don't pay for those things. It's always amazing. I think it flows into this concept as well as we, as we go along with it. I do want to talk about telehealth, though, which is really important advocacy right now, payment reform is a huge issue and many of us in primary care. And that's the audience you have here been banging their heads against this for years, saying how can we value primary care services so that we can do these things that we would prefer to do and to keep people healthy, but telehealth advocacy is needed. Right now, telehealth has been here because of the pandemic, I think it's a huge benefit for a number of people. And they will say actually, they spend some time in a rural area. And because we don't often have the broadband, half the time a tele video visit gets converted into a telephone call, you know, to help care for people, but I still think just huge numbers there, obviously, positives and negatives, everything. But this has been a huge benefit for many people. I can't cross state lines, I'm not allowed to bill to see somebody now I live in a small state, I have patients that I see from New Hampshire, New York, and Connecticut, but I live in Massachusetts, and I can't take care of those people unless they come into my office. I can't you know, strange rules that are out there that the pandemic they went away and all of a sudden, this week, they're back in the we can't do those things. As part of it. The other advocacy, I think is how do we pay for in home medical devices, whether it's scales, or blood pressure cuffs, or pulse ox is or portable EKG machines, and so on. So, a lot of this advocacy is really, I think, important to make all this happen. And I'll let other folks chime in as well. And the other perspectives.

Sarah Blahovec 47:04

Yeah. Clarissa

Clarissa Kripke 47:07

I think that when we're talking about people who have very complex needs, it's an for a primary care doctor, it's an order of magnitude more work, it's not 10% More work, it's not 20% more work. It's an order of magnitude. I've done some time motion studies on myself where I wrote down everything I did for my patients. And that's, that's what it comes into. And you really can't take good care of people with that level of need when you have a panel size of 2000 patients. And so that's what most primary care doctors have. So, I have a panel of 100 patients who have very complex needs, and that's a full-time



job. So, I think we need to think in terms of special practices for special populations that have special funding, in terms of where that funding might come from, it might come from medical or Medicare, or private health insurance directly. But some of the funding some of the funding is contracts with health plans that see the value. But it might come from the long term care side, where if you have people who have a lot of long term care needs for their long term that the costs of their long term care are a lot greater than the cost of their medical care, you are actually saving a great deal of money I was I was surprised when I got into doing the home care visits, how much money I was saving, that it might be expensive to put me in a car and pay for me to transport myself across town to go to someone's home. But when you can compare that to having two staff members in a special wheelchair van and portable oxygen and they may have a seizure on the way and you may end up in an ambulance on the way to the to a doctor's office, then it starts just to be a lot more cost effective for an able bodied person like myself to get into a car and go to somebody than to try to get somebody who's needs very complex assistance. Who it's going to take a whole half day of two staff people's time and special transportation to get there? It starts to look quite cost effective and to have direct access to my cell phone as opposed to have to go have having to go through layers of other staff and people if you cut out all that bureaucracy you actually save a fair amount of money and you make it doable by having a small patient panel. We do homecare with dental care which is in enormously helpful. We have advanced practice dental hygienists who go into the homes and do cleanings and they can take very high-resolution pictures and decide who needs hospital dentistry, we have people who respond to psychiatric and behavioral emergencies in the home. And who can do that without calling 911 without taking the risk of transporting someone in the middle of a crisis. We have phlebotomy and X-ray if we need it, that can go out to the homes. So, we can create wraparound services. And a lot of I actually don't go to the home. For emergencies, very often, the homes have nursing and I do a lot of telephone medicine and telemedicine with a nurse on site, so it's not working directly with the patient or non-medically trained caregiver, but working with another trained medical professional, whoever, who I have a lot of trust and relationship with who has their eyes on the patient who spent a lot of time with them, and whose judgment is frankly better than mine, because they spent so much time with the person. So, when you're talking about people have these kinds of complex needs, then you really have to add up the total costs and then look at the cost effectiveness of it. And I think that the model of care is actually quite cost effective. Because you use save all the clinic bureaucracy, you save all the long-term care costs, and it's effective, whereas coming to the office frequently isn't. Pinson?

Nicole LeBlanc 51:50

Hi, it's Vincent. So just want to make sure everyone can hear me, okay. So, I, you know, I agree with what Bob and Clarissa was saying, you know, in regard to payment reform, and how can we pay for this, and I think that's really important, reimbursement is very key. I have different hats here in New York City. And I oversee a few multi-specialty clinics. And, you know, unfortunately, but if I wanted to our doctors couldn't go out there because there's no reimbursement for that. However, there's other aspects, where I work in group home settings where they can get paid from a different avenue. So, I think payment reform is really key to this. And as Bob was saying, you know, we are in a fee for service world, but as Chris was saying, the amount of money that can be saved with the value of home care visits, if we ever get to a value based system, I think that's where it's going to really shine and, you



know, really show its worth, but unfortunately, we're not anywhere near there yet. So, I think, you know, we have to look at the payment reform, we have to somehow to get to value based care, whatever road that's gonna lead us to, I think that's going to really highlight the work and the value of home visits. I think one of the issues also is, is recruitment. As you know, it's hard to find a nurse, it's hard to find doctor, it's hard to find health providers that will take care of this patient population. And having one that's willing to travel could also be a challenge. Not everyone can have a bob or Clarissa going home. So, I think recruitment, you know, is a challenge. So how do you recruit that? How do you recruit those types of individuals? So, do we offer loan forgiveness? What are the perks? Can we get doctors and nurses to get involved with the homecare type of system that will want them to get involved? I think that's an issue that needs to be addressed. And also, I think, you know, when I think of home care visits, I think it's great, but I think one of the panels was saying, you know, when you go on site, it's all good. But there's just too many times you can go on site during the course of say one week. So, what is the backup and I think, looking at different models of care? Um, I think that's key on my end, for example, with our ICs, with our group homes, for the most medically fragile, we'll have our PCPs (Primary Care Physicians) going at least once a week. But we do have those nurses that are always in constant communication with we have a telehealth program where we're connected with, with outside doctors as a backup. So, if our PCP is not on site, they're not available. We have eyes and ears, looking at the individual. But unfortunately, that's not available for everyone that may live in a community in a housing project or in an urban setting or a rural area. So, I think we have to look at all the other avenues in which to provide support to that whole visit for that primary care provider. Thank you.

Sarah Blahovec 54:44

And Tawara.

Tawara Goode 54:46

Yes, thank you. I just want to think the comments have been said before, especially looking at it from a clinical perspective, as well as the cost on which always seems to drive things within healthcare. I also want to revisit the question because the question does speak to house call programs for doctors and nurses. And on doesn't, we didn't really, I think, cover very much about the role of telehealth, although I did hear some of that. So, my comments will speak to both of those. So, one thing I wanted to say is that, um, house calls and house call programs already exist. And I think we need to be able to acknowledge which of those programs already exist, say, for instance, the Visiting Nurse Association, where they perform both virtual and in person home visits, how do we ensure that I'm going to call them generic healthcare providers have more skill and knowledge in terms of supporting people with disabilities, including those who have mental health needs and advanced age, because I think that really is key and critical, it speaks to some of the issues within our workforce. There are other programs such as Headstart programs, Headstart programs have to enroll a certain percentage of children with disabilities, they do home visiting, how do we link into existing programs to be able to expand capacity, I think we also need to be very clear on what we the proverbial we are advocating for and advocating with and advocating on behalf of. And so, some of the issues that we're seeing, relate to workforce, and



that and the inability or the incapacity within the workforce in the generic healthcare system to support people with intellectual developmental and other disabilities. What is it that we do about that, and training in policy, and obviously, in resource allocation? So, I think that that's also very important. The other thing is that it's sometimes I think, it's hard to advocate for things without an evidence base, without some data that tells us the efficacy of what we're doing, that it actually works. And from my lens, it needs to be able to work for all people with disabilities, across the age span, across race, ethnicity, language spoken, and other cultural identities, I think that that is really key, and critical. And then as we think about advocacy, and thinking that persons with lived experience of disability, development on other disabilities, as well as their parents, and, and, and others who are supporters need to be able to lead the way in, in this advocacy to do policy change. A it impacts their lives in particular, there can be some policymakers that are immune are reticent to really listen to health care providers but hearing the voices of people that live with in there, their, their regions, their settings, their districts, is going to be really key and critical. So this advocacy has to be clear about what we're advocating for, with and for whom on and take full advantage of existing programs that home visiting and telehealth can be a component of the last thing I'll say, as it relates to telehealth is that we don't have a lot of data on how telehealth works for people with the full range of disabilities, including those who are in crisis. So, as I look at the researchers that are on the call, and other advocacy organizations, we need to go about building that research. Getting that data so that we can use that to affect policy change.

Sarah Blahovec 58:52

Yeah, and one thing I did want to mention really quickly because I think it is relevant to this and we're talking about things like telehealth and you know, cultural competence. Writer and advocate by Alyssa Thompson did a piece I believe it was last week on the on telehealth and interviewing black disabled women about their experiences and their perspectives on telehealth. And I'll put that in the comments because I think it's a really important thing to read and to make sure that there's you know, diverse perspectives and different people from different backgrounds talking about this and so that just kind of popped back in my mind as I was listening to you speak to Ara, it's a good piece on that and then hand it over to leeks.

Alix Bonardi 59:47

Wow. To all our panelists, I want to thank you all for your comments and for your reflections on these few questions that Nicole and Sarah really put to you, you've been busily taking notes, and we have had quite an active discussion in chat. So, I'm going to bring forward some of the main questions to you. And I think we'll leave it up to each of you to respond. As you see fit. I'll start in with something that, that Tamara, you, you reference, and it's come up a few times through this discussion and also in chat. And that relates to education, to where you mentioned a couple things, there are definitely opportunities, and we have to figure out a better way to make sure that home visiting is home health, visitors have the skills and knowledge that they need to support people with, with disabilities living at home. That's one piece of it. And the other piece of education related to education I wanted to put to you is to each of you, both Bob and Clarissa mentioned that they came to the idea of home visits, you



know, really understanding the value of home visits as, as individual clinicians, right, in practice, right. So, my question to you all is, can you suggest ways or ways to advocate for clinicians coming into the field? To understand the value of home visits already. What are what are the levers? What are the key points that, that that new clinicians and I'm gonna say, new clinicians and also, this is also long term supports, people in long term supports need to see the path for home visits as well, providing long term supports, but what are the what may be the ways that we could try to advance this so that it's not left to individual clinicians trying to figure out how to provide care to one person maybe when it's not going right? But have this be more of a sort of a model of service and considered part of the way we do work? This is I'm asking specifically about home visiting, we can get to the telehealth question in a minute, too, because there's a number of questions about that as well.

Bob Baldor 1:02:32

I was just gonna jump in here. This is Bob, again, I think the this is not a usual mode of care, you know, is part of the part of the issue. And that's kind of the kind of people kind of come into it. And again, because of the barriers that are involved in doing it. So actually, so you know, what has happened in a lot of medical schools, though, has been more of an emphasis on this, where students required to do home visits as part of their clinical rotations. And although it's often not necessarily driven by disabilities, per se, but the idea of really trying to understand people and who they are. And so at least in medicine in this lesson discipline, there's an emphasis on thinking about the whole person care. And so, for a lot of medical students, the curriculum in play medicine, which is a very brief period of time, by the way, maybe only five weeks out of there, their four years of medical school, but during that five weeks a requirement to go and do a home visit on somebody you've seen in the opposite, you can really appreciate and understand that that person. So that's part of this is to get that exposure and have that as part of the medical school curriculum. And we do see that and a number of places around the country. There's also a more of an emphasis also, I think, on disability. And certainly, some of that's been brought in probably because of the aging society, that we're seeing, really thinking more about how to care for folks, as they're as they're getting older. So, it is there. But you know, it's a small part of, of the educational process.

Clarissa Kripke 1:04:23

It doesn't surprise me that the people doing this work on this call are family physicians. I think family medicine was developed as a tool for social justice. And we are in our, in our training and in our DNA is to make a commitment to a community and then instead of hanging our shingle and saying, we have these services come to us to say we're committed to the health of this commit community and we'll make ourselves into who our community needs to be and if there's a lack of a certain type of service in our community. We'll, we'll roll up our sleeves, we'll learn what we need to learn, and we'll get it done. And so, we're, we don't recognize silos, we're not afraid of complexity. And, and that's, that's part of what we what we do. And I love the fact that our community came to us with an unmet need. And then we rose to, to meet that. And I'm in that vein. Everywhere I've reached out to a number of communities, I had a mobile clinic where we went to different rural communities that didn't have a resource to do consults. And every community I've been in, has a physician who's doing home care, and it probably



amounts to medical or Medicare fraud, they're coming in signing paperwork, and not really providing care. There in the home, there's, there's not a lot of oversight. And so we need to be cautious if we, if simply throwing money out there and saying you can hang a shingle is probably going to lead to a lot of fraud, you need the community to be to choose who does this work, and not just offer it to anybody who wants to take it or you're gonna get a number of people who can't be employed and other departments taking on this, this work. And you want to make sure that the community is selecting people that share their values. So, I take students with me, where when I go out to the homes, so medical students do have an opportunity to see what we're doing. But we need to be careful about, about how we roll this out. And it's not just about paying more.

Alixé Bonardi 1:06:55

You raise a really important point to Clarissa. I mean, the design of this, we've in both in chat, and each of you have alluded to some pockets where there have been some good examples. But there is not yet a great design that we can describe. And that's also to your point to where there's a there's a need for the research and the evidence base that will help identify what were the best things to keep? And what are the things to really guard against fraud being one and bad outcomes generally being the other for sure. Any other comments that, that you all would like to share in the context of education, both for care providers, and potentially also for people who are providing support in the long term supports and services area,

Tawara Goode 1:07:56

I would just only like to encourage that whatever professional development on that may happen, whether it's preservice on or ongoing continuing education, CMEs, etc. Is that part of that training will include the voices and the participation of the people with disabilities? I think that that's missing. And so, I think in an absence of that we don't have the lived experience perspectives that will be really necessary to inform individuals who are an part practicing medicine or nurse practitioners or pas, or physician assistants.

Alixé Bonardi 1:08:49

Thank you, Tawara. And I know that some training efforts have included, for example, standardized patient training exercises that include people with disabilities to try to help people better understand but yeah, the training component and including people with lived experience is a core element. I'd like to pick up on another comment that was made in chat. We've talked about a couple of different modes of care delivery in this conversation. We've talked about home visits as a priority, the value, and the need to advocate for that as becoming a way of providing care, but I think you said this is this isn't how care is typically delivered, right? Well, so can we flip it? How can that be changed? Right? So that's one area we've talked about? A follow up? question though. We've also talked about telehealth, and there are as Sara and others and chat have pointed out, there are some, some access issues that were improved with the rapid expansion of telehealth and certainly some things that were not ideal and particularly for people with disabilities. One of the questions that came through is, is there training on



how to do telehealth? How can people be supported to do telehealth, right? And how can as telehealth seems to be a thing that's staying, how do we keep the good, the good aspects and address some of the aspects that are not working for people with disabilities?

Bob Baldor 1:10:56

I just want to comment on I think things are slowly changing in somebody that Chad had mentioned dispatch health. And that's sort of a home-based program that's out there that I'm aware of. And in, you know, what's happening, I think is and again, this doesn't get to that whole payment reform thing coming back to that. But the idea that being paid to keep people healthy, but suddenly change your mindset to how to keep people healthy, suddenly you think, oh, maybe we should be doing care in the home. And rather than dragging them in, right. As part of that. So, we are seeing these little snippets is changing. And it I think we'll continue to see that the telehealth trend piece, I can't speak to that myself because it's doing telehealth because of the pandemic and just kind of thrown into it. And so, trying to figure this stuff out, and the so it's been an interesting, we do have medical students with us, and we've figured out a way to link a medical student into the visit so they can hear what we're doing. But that's a whole new world I think, you know, as well, maybe the focus and speak more to that.

Nicole LeBlanc 1:12:05

Now, the digital world definitely needs to be made more accessible, plain language ADA compliant.

Vincent Siasoco 1:12:13

This is Vincent, I think the telehealth education piece is something that really needs to be revved up for medical students and residents. I think it is a challenge, you know, especially depending upon whether the individual lives so if they live in a group home setting, for example, the provider may be dealing not only with the individual, but maybe DSPs or their group home staff. So how do they get the information? Who do they who do they go to? So, I think there are some challenges and I think that really needs to be addressed in regard to how are the medical schools and dental schools also going to be educating their soon to be graduating healthcare providers on the proper, I guess, protocols and, you know, techniques and providing quality telehealth. I think that's remains to be seen. It's not just medical, dental, but nursing, and also other disciplines that provide telehealth services. It's on almost on a case-by-case basis. And I'll hear different things from my medical students based on their different experiences. Such as students, I think its established attendees established physicians that had been in the field for 20 or 30 years and now all of a sudden, now they got to go to telehealth. So how are they able to communicate and what video it was screen? So, I think education is going to be key in the long run, whether you're a student or in an established position.

Nicole LeBlanc 1:13:34

Using telehealth things like you know, blood test results, you know, or things, you know, ideal. You know, okay, this is so and so's vitamin D lab.



Vincent Siasoco 1:13:47

I think that there's got to be a good compromise between telehealth and a physical exam. Oh, it's, we don't want telehealth to take the place of a physical exam or a certain assumption that someone has a cough and a cold or a UTI. These are different infections. When you know a physical exam may give more information, you want to avoid what's called diagnostic overshadowing, especially with our patient population. So sometimes a video monitor can contribute to that. So.

Tawara Goode 1:14:18

Alixé, I'd like to share that. I'm currently collaborating with the University of New Hampshire center for start services. And that's what the University Center for Excellence in Developmental Disabilities in that state. Also, colleagues at John Hopkins University, specifically the Kennedy Krieger center, and a colleague at University of Florida. And so, Georgetown, and what, what we're doing is we have a five-year funded pakora grant. So that's Patient Centered Outcomes Research Institute. is long but I'm gonna say for Corey. And it's really looking at. They're comparing the services provided by start, which are specifically focused on individuals with intellectual developmental disabilities who also have mental health needs. And I do want to emphasize that population that's often very much underserved and inappropriately served. And it's being able to examine over a five-year period of time, the differences between telehealth services for this population and in person services for this population. And I think that we need more studies on more ways in which we are, are actually having data gathered before making decisions, especially at a state level to invest in telehealth systems that may or may not work for the population.

Clarissa Kripke 1:15:59

I have a number of thoughts one is that you can do combine telehealth like you can have nurses or these advanced practice dental hygienists in the home and somebody with perhaps more expertise or an MD, communicating with them on their equipment, and that that can get around some of the issues with physical exam and having a trained professional, actually lay eyes on the patient and see the environment and some of the access to technology and the ability to use it. So that's one thought I had another is that when working with people with complex disabilities, our adult healthcare system is set up to be very reactive, it'll you have to say I need help or I'm having a problem. And for people who have difficulty doing that, because of any number of reasons domestic violence, communication challenges, difficulty with understanding interpreting the sensations are having in their bodies, all sorts of reasons why people may have difficulty asking for help when they need it or recognizing that they need help when they need it. We need a proactive system. Most countries in the US have a regular health check system for people with developmental disabilities. And that's the best studied and most likely implemented intervention. And that can work with these other health delivery models to support primary care and to make sure that people that illnesses are getting recognized things that are undertreated or unrecognized, are getting brought to the attention of someone who can help. And my final comment is that I ran a consults or a multidisciplinary consults service. And we actually went out into places all over Northern California, including rural communities, and with people who were at risk of institutionalization, or were coming out of institutions and needed help setting up services in the



community. And many of the people that we served were people who had been assessed by a really expert multidisciplinary telehealth service and had and what we found when we visited the same people after they'd had these wonderful telehealth services, and then we went out into their homes and visited in person is that sometimes we didn't even have the chief complaint, the main issue correct. And you learn all sorts of things. When you're there in person, you see, there's no food in the cupboard. And that's why they're losing weight. You have a side conversation that isn't going to happen on telehealth with a caregiver who tells you what's really going on who's being mistreated, and how there, there was all sorts of stuff that we learned by being there in person that we were not able to determine through telehealth. So, we need to be careful about that. On the flip side, there are some people who really respond to the technology, even if you're in the same community. It helps. Sometimes it's less intimidating to meet with a team of people through the technology, and it's easier to focus on the patient. So, I don't think it's either or I think we're going to need both even for the same for the same patient.

Bob Baldor 1:19:39

We were talking originally about you know, so patient centered care and it's just interesting to me to realize that different people resonate in different ways of being treated and cared for and as we saw locally coming out of the pandemic. There are a number of people just can't wait to get into the office and around people saying well can't we continued to do telehealth, you know. So, I think this is a little bit trying to meet people where they're at. I don't think that any one of these is a panacea, by any means they all they all, they have, you know, pluses and minuses. And so, some of this is getting back to the original discussion around what's patient centered with what are the patient think is best for them as well. And that's important thing to be thrown into the into the mix as we think about how to move this thing forward and what's appropriate.

Tawara Goode 1:20:29

But I absolutely agree. And then if we think about state systems, especially in developmental disabilities, state agencies make a decision about how care is going to be delivered in and reimbursed. So that even there, though there's this mantra of Person Centered when you really look, it's cookie cutter, and it's not at all versus centered, it's just there for window dressing. And so, it concerns me that certain states may be looking at contracting with, with companies that have come out to be able to see that, again, without the evidence that really shows us that telehealth is going to be the way to go for specific population groups.

Alixé Bonardi 1:21:22

Thank you to each of you for your, for your thoughtful responses here. Now, I think we have another we have time for just one more question. I'm going to throw in something a little bit of a twist here. This is a question that just came into chat recently. Adriana was, was asking what panelists think about the personal health technology that's available, you know, people are taking charge of their health in certain ways with smartphones and smartwatches. And you know, how that plays into people's



experience of taking ownership and having more being more engaged to one degree or another with some of their health issues. So, I'd like to put that to you do each of you about your experience, or your thoughts on how that is fitting into people's person-centered care.

Bob Baldor 1:22:21

You know, my take on that these are great, I love these devices, gizmos and gadgets love them, and they're expensive. And, you know, and the people that can often afford them, the ones who don't need them. So, I'll just throw that out there. You know, we get to the point where they're actually much more accessible to people, because they're tremendous devices that are becoming available. You can even do like an echocardiogram in somebody's home with off your smartphone, and so on. So, they're there, but it's an accessibility issue.

Clarissa Kripke 1:23:04

often give a lot of information, but the quality and relevance of that information can actually get in the way of focusing on what's really important. I'm deeply skeptical that that's the answer, although I'm sure there are good uses for it. I much less enthusiastic about it, then. Then the people who are selling this stuff.

Nicole LeBlanc 1:23:32

For my end, you know, there's pluses and minuses, right? I think on the plus side, it makes people that have access to that type of equipment. You know, cognitive Metro Health they're, they are aware of it. And, you know, they will tell me X amount of steps were done this past weekend. So, I think that's a positive thing will accrue Of course, I will say, I'm also a bit skeptical too. And you know, concerned, you know, it not every smartwatch may be the same or every iPhone. So, you know, what is the quality? You know, how accurate is it? You know, how many false positives or false negatives, you know, so, just because it shows something that's going well, is that really accurate? You know, and again, it goes back to, you know, are they worried or properly is it is the battery working? So, there's a lot of questions behind this. Because, you know, I don't know what's happening in somebody's personal life when they're using these gadgets. So, it's something to consider. And I think until you could hook it up to our electronic medical records, you know, I think that's, you know, that's going to be it'll be a challenge.

Alixé Bonardi 1:24:41

Thank you, thank you to each of you. We are just about at time, and so I want to turn it back to you, Nicole, and Sarah if you have any final or closing remarks that you'd like to share from this conversation



Nicole LeBlanc 1:25:00

Well, this is one thing I think, you know, that we should, you know, explore as we look at the new normal, especially when we look at the impact of long COVID. And an aging population. And like, for instance, if one were to do the vaccine roll out, again, all over again, you know, giving the vaccine, having the doctors, nurses, and disability agencies to go to people's homes and get them their shots will be much easier than going on and inaccessible website where they say, "Okay, you got to drive X amount of miles for such and such Pfizer shot or whatever it may be."

Sarah Blahovec 1:25:39

I think it was really helpful. You know, as someone who is a patient and has family members who are in medical fields but doesn't have kind of the view of what it takes from the practice side of it, it's really helpful to understand some of the challenges and in delivering this kind of medical care. So, I think that was really informative for me. But I think, yeah, I think what really resonated with me was the research that needs to be done on these methods and on the barriers around them and the opportunities but on, you know, how delivering care can impact people with disabilities and other underserved populations in particular. So just really helpful information today. And thank you to all the panelists for sharing.

Alixé Bonardi 1:26:35

Let me echo that, Sarah, thank you to all of the panelists for your sharing today for the wisdom that you brought and for the work that each of you were doing. As you see, I think a poll should have just popped up on your screen. This is our final evaluation for the end and on behalf of the National Center for Advancing Person Centered Practices and Systems. A final word of thanks to our panelists who are facilitators today, and please make sure that you come and check out this webinar and others on the NCAPPS website. The post webinar evaluation is up, and I see people are filling out their responses, please know that there are actually a number of questions so you can scroll down to respond to all six questions if you'd like. And, and we would really, really appreciate hearing back from you. If you'd like to email us as well on additional ideas for webinars you're interested in participating in. We are always looking for how best to serve our community to build systems and practices that are more person centered and support people with disabilities, their families and their communities to experience supports in a more person-centered way. Thank you to everyone and wishing you all a good day. A good end of the week, and almost into may take care everyone