FUELING BUSINESS ACUMEN: How CILs are Securing Contracts with Health Plans and Payers

Presented by Bill Henning, Richard Petty, Audrey Schremmer, and Patricia Yeager

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>> TIM FUCHS: All right. Good afternoon, everybody. I'm Tim Fuchs with the National Council for Independent Living. Fueling Business Acumen: How CILs are Securing Contracts with Health Plan and Payers. So, we are recording today's webinar as always so you can access it on our ILRU website. And we are currently in presentation mode as we will be for most of the day. But we've saved plenty of time for questions and answers today. So let me just quickly talk about that and then I'll remind you all before we go to our Q&A break. So we've got two Q&A breaks today. One in the middle of the presentation on slide 11 and one at the end of our presentation before we break. And there's a few ways you can ask questions. So assuming you're on the zoom webinar as opposed to being only on the phone, you should see the Q&A tab at the bottom of your screen. If you don't see that, you can wave your cursor over the bottom. Sometime it will auto hide. And that's a great way to submit questions. They show up right away and we'll take them in the order they come in in the Q&A break. But if you can't access that Q&A for any reason then you have a number of other options. If you are using C.A.R.T. captioning today, you'll see that display right here in Zoom. But some of you use the full screen cart at StreamText.net. That was in the conversation email that was sent to you. It allows you to manipulate the font size, color and contrast, and some people prefer that. And that's got a chat feature.

And I'm logged in there. So you're welcome to submit your questions there. If you like, you can also email me. My email is really simple. It's just Tim at NCIL.org at NCIL and I've got my email open and I'm happy to voice your questions for you if they come in that way. And, finally, we've not used this in the past, but if you want to raise your hand in Zoom, I'll be happy to open up your line and that way, you'll be able to ask a question audibly if you have a microphone some of we're going to provide that just as a new option for folks. So whole but what of ways to ask questions. You can submit your written questions at any time during the call today. Don't like worry about that. You can use the Q&A tab, but we will wait until the Q&A break to address them. Finally, the chat feature that's available here, you're welcome to use that. We just ask that you use it more for comments or maybe to communicate with a friend you see on the participant list. We don't typically use that for questions, but if you do enter a question there, no problem. We'll find it. We'll see it and we'll be sure to voice it during the Q&A break.

So, I mentioned the captioning. If you don't have that on, you can click closed-captioning to pull up the subtitles here. And, again, you can make that box larger. But if it's not sufficient, you might consider that StreamText link that I mentioned. That URL is a little too long to readout but, again, we'll put that in the chat so you can see it. And that was in confirmation email so you should have it. And last thing I want to mention is we have a brief evaluation. So when the webinar is over, and in the webinar today, the evaluation will actually come up on your screen. It will take you to the evaluation. So if you would, please take a minute and save a minute after our webinar and tell us what you think. We really appreciate your feedback. We take it really seriously. And if you take a minute to share that with us, we would appreciate it.

All right, well, speaking of appreciation. I want to thank our presenters for being willing to do this with us. We've got a great group. Some of you may have realized when you saw the announcement that this is actually an encore of version of the workshop at the NCIL conference. So we're happy to push this out to a larger audience today and with us we have Bill Henning. Bill is the Director of Boston Center for Independent Living. And we've got Richard Petty and he's the co-director and will be moderating. Audrey Schremmer is the Director of Three river city in Kansas area. And Patricia Yeager is from Colorado Springs independent center. So thank you for being with us. Those are the housekeeping things I want to do run through. I'll be here just to help the webinar go smoothly, I hope. And I'm going to turn it over to slide 4. Richard is going to review the learning objectives with us. Richard.

>> RICHARD PETTY: Tim, thank you for leading this webinar today. And for considerably more work and organizing this team, and arranging the activities of this webinar. Thanks to you and to your colleague, Eleanor Canter, and other colleagues. I’d also like to acknowledge Brook Kernis. Carol Eubanks, Instructional Designer. Sharon Finney and Dionne Rauseo, and our colleague, Darrell Jones. Dr. Judith Halt and Marilyn Hammond. We're proud of this webinar and excited to present the webinar that was done at the last NCIL conference in July of 2019.

And this is, indeed, latest information, new information, and already excellent team. And you'll hear more from our presenters in just a moment. We have learning objectives for today. What we hope that you will learn today is how Centers for Independent Living will benefit from contracts with health plans and payers, and not only are we going to be discussing how the center itself, but also how can your constituents, the people with disabilities you work in the community and the benefits to them. And there are many when Centers take on this role.

And, we'll be addressing the connection to the core center for independent center living center and other services we typically offer to the services that health plans and payers offer and need to purchase. And we're going to talk about the specifics of getting contracts with health plans and payers. That's going to be a very important part of our webinar today.

And I am very pleased to introduce to you Bill Henning. Bill is the Director of one of the nation's premiere Centers for Independent Living, Boston Center for Independent Living. Bill is the Executive Director of Boston Center for Independent Living.

>> BILL HENNING: Thank you, Richard. I can talk about our center, BCIL. We have a staff of 45 people. Our budget is $4 million. We have 8 programs out along with the provision of core services, including Consumer-directed personal care attendant services. PCA. Community organizing as well. We now have three community organizers on staff. And we have two manage care initiatives. Well, it's actually one. Since the slide was prepared, we've reduced from two to one, and I think that's an important thing to note, because sometimes our ventures into this field or any field work, and one of the initiatives is highly successful and the other didn't work out. And we terminated it. And I think that's something really important to keep in mind. We're not cemented into these initiatives.

And what we do with the one that's successful is we provide coordination around LTSS, which is known as long-term services and supports and PCA services for non-profit insurance company covering duals. People age 18 to 64 in both Medicaid and Medicare and we have been doing an LTSS coordination as well through a formal consortium of disability service providers working directly with insurance companies providing managed care.

The initiative that's successful for the duals is likely to expand this year as the number of plans in Massachusetts has grown by 3 or 4. So it's a very positive element. Patricia.

>> PATRICIA YEAGER: Thanks, Bill. Let me see if I can change the slide here. Independent center we've been around for 30 to 32 years and we began in 1987 as an at home skilled Medicaid home health provider. The woman who started us was a person with quadriplegic and used the services herself and we came up in a very pure way. We came across CIL in 1994 serving 6 counties in the Pikes Peak area.

The skilled in-home care, skilled Medicare/Medicaid care was our core service and in 2003, we became the first agencies in Colorado to offer IHSS, non-skilled called it family and friends of family line of business. And we flipped from skilled to non-skilled in 2014.

At the time we did this, we had 360 staff. We're down a bit. There's a lot of competition in our field. So we're down just a little bit to 320 staff. We have 250 roughly in the care providers in the field. And in 2018, we had annual revenues of about $12 million and our payroll was $10 million annually.

So, you know, in our city, we're a pretty big employer and a big advocate for the ADA. and all other sorts of inclusion of services that are provided and the Center provides. I know we'll talk more about other services. So Audrey, do you want to take it from here?

>> AUDREY SCHREMMER: Yep.

>> TIM FUCHS: This is Tim. Did you want to cover any of these others on slide 7?

>> PATRICIA YEAGER: We're trying to keep this abbreviated a bit. So 2018, we served 312 individuals in home health and 2762 people in independent living and those are our two big divisions. Hospital 2 home is a 12-month project, or pilot, that transitioned 24 people and saved the hospital roughly $500,000. And we now have a contract with them to continue the program. We also run a Veteran's Directed Care, we call it the VDC, Veteran in charge. We have about 115 enroll leisure. And we have housing vouchers and we run various fee-for-service for division of vocational rehabilitation and with the schools. So we have a pretty robust fee-for-service that uses our independent living skills and figures out who might pay for them. Not the Consumer, but someone else.

So now, Audrey.

>> AUDREY SCHREMMER: Okay. Thanks. So, through rivers, I like to say we're example of a small CIL that can do it. But we have actually going over the couple of years. But we provide the traditional services in Northeast Kansas and we've got a range from what we call frontier counties to big city for us. We went over 50,000. I know Bill and the others are going to laugh. But it's a lot for us and then we also have the front row Army installation in the area. And our service was began by individuals that were Veterans with disabilities that came back home and were unable to get housing and jobs, and became volunteered group and became a center in 1986. So now, at the time we did the slide, we had 17 full-time/part-time staff. We're at 19 now. We deal with contracts with managed care organizations, different health plans, Veterans administration and TRICARE which is brand new. And I have to thank Patricia as we worked through this process, she shared more information with us that helped us move forward on our Veteran contract.

We currently serve about 300 individuals through our in home fiscal management services. Independent living skills training, we have around 600 individuals there. The nursing home transition services, which is something CIL does, but under managed care, we were able to get contracts to help cover some of these things we used to have to scrounge up and get donations and do all kinds of other things to help. So we do that.

The home modification program is also supposed to be a part of the manage care, the different insurance companies like to brag, but they help do home modifications. That is struggling tremendously. So we're ever hopeful, but it's one of the simplest turned difficult services we try to work through with health payers. So, I think that was it from my slide. Right?

>> RICHARD PETTY: Audrey. Thank you very much. And Patricia, and Bill. And for those of you following on paper or if you're on the phone only and have a way of viewing the slides, we're now at slide 9. And the question is to our participants, to our presenters, and that question is: This is a big darn bill. This takes a lot of effort and work. All of you already know that. And it's different. Not many of us went to business school. Not many of us have had previous experience in developing contracts and negotiating contracts with large corporations. And, so, the question for all three of you:

Why should centers contract with health plan and payers? What's the benefit?

>> BILL HENNING: All right, I'll jump in.

>> AUDREY SCHREMMER: Okay.

>> BILL HENNING: This is Bill. I think it's a tremendous vehicle to provide services. Basically core IL services as it is to people who are enrolled in these health plans. If you look around the country, there's a tidal wave of managed care entities, health insurance plans. They're in the Medicaid market in all of our states. And Medicaid is such a ticket to independence, whether it's through personal assistance, purchase of durable medical equipment, we exist to steer people away from medical model of services, get in the game and help influence that rather than insurance plans that will, by default, medicalized services for consumers. I think it really fits in well. If you can negotiate a contract and be reasonably close to solvency, I think it's good for consumers. It's getting in on a game that's sweeping the country which is better or for worse.

>> PATRICIA YEAGER: I want to jump in. And this, to me, this is a stealth advocacy role to take on. We have seen over and over again, if we are not at the table with programs and services, they will not accommodate us and they don't serve us well. So I would argue that we need disability-friendly healthcare. And the healthcare, the managed care and hospitals do not understand what that is.

So we need to be in there helping them by providing services and developing relationships so they think to call us when they have a question about, how does that person get on the table? What am I doing wrong? And you know, nobody knows it better than we do. And I think the medical system knows, and we need them to connect with our friends and colleagues and consumers from dying frankly. So if we can share our knowledge, that's so much better.

>> AUDREY SCHREMMER: This is Audrey. I absolutely agree with Bill and Patricia that my very first thought is we do this because we want to help the people that we know are out there that need our help. And I have, I'm sure we can all think of so many examples. One of them that I share why we were passionate about getting in with our Veterans program, well, actually -- well, yes, Veterans, but current wounded soldier project that's at Fort Riley. And we were with the head injury program and everyone is separated by disability. If you have a head injury, you go here. And you're a wheelchair user, you go here. Everyone was divided. Jeez, people are people and why would you do that? And then they came up with the question, one of the problems with the traumatic brain injuries are the loss of smell. And they were concerned about how a person could live in their own apartment if they couldn't smell smoke if there was a fire what would they do? I was waiting for the punch line to this and the issue was serious. Well, you have smoke alarms. That's how most of us find out there's a fire. It's from a smoke alarm.

So sometimes the other part with the medical model, just looks at all the "Can't" and in the IL world, we just look at "Can." And also the money, honestly, if we can get paid for what we're doing, then we can use the grant dollars to cover more people in our Service Area. And I saw in the chat somebody posted a question and I forgot to bring up the budget. I've been at 3 Rivers longer than I thought I was going to be, 22 years this year. When I started, we were at 300,000 for budget. We're now at $1.3 million. And that does not include the wages for the Internet healthcare workers because we run a self-direct model where the consumers are the employers. So we have grown dramatically through this whole process. So there's benefits to both sides.

>> RICHARD PETTY: Thank you, all. And we're going to move to slide 10. And this is a great question. So what steps did you take to get contracts? This is what is a mystery for many people. So let's unpack this.

>> AUDREY SCHREMMER: Bill, you wanted to go next?

>> BILL HENNING: Being critically engaged in the advocacy in trying to shape how it operated, and we did some things we're very proud of working with straight allies to get our Consumer based implementation counsel, to get establishment of an ombudsman program and get an establishment of, really, this long-term services and support coordinator for consumers.

And, basically, having put our name out there, the plans came to us. We ended up only contracting with one of them, but why did we only contract with one? Because we thought only one gave a deal that was amendable to our consumers into the organization. That it had a chance at some solvency. We make a little bit of money out of it as it is. You can end up with another arrangement and not make any money like the arrangement we're in drop deck actually. But actually, it was going to allow this plan the latitude to go where the consumers want to go. Strictly speaking, we're to help them access LTSS, long-term services and supports. But by mutual understanding, we work on other issues, peer mentoring, we're work on social determine meant of health, assisting people to get into the housing system and employment system. Because it's all inter-related in the well-being and integration, and independence of consumers. And enrollees and health plan, and the medical plan would help them which is our constant theme as Audrey and Patricia said. Some of them do, but it's a dice role and our staff is especially geared for this.

>> PATRICIA YEAGER: So, how we started in this is that our Money Follows the Person transition staff were telling me about all the consumers they were working with. And nursing homes wanting to get out of nursing homes. But we're put thereafter an acute episode of visit to the hospital that really didn't need to be there. And I started thinking about, well, what can we do, really? My goal is to do away with Money Follows the Person, because we don't have people in nursing homes. Because we don't have hospitals putting people in nursing homes. But that's probably not my lifetime. But we decided to look at the hospital, go after the partnership with two hospitals in town. One was amendable, and one was sort of not. So the one that was amendable, we asked our community partners and our Board members if they knew anyone from that hospital who would be on our Board, our Board of directors.

And we found the Director of inpatient rehabilitation center decided to come on to our Board and be our knight in shining armor, our champion, if you will. So he put this whole project together. It takes a lot of planning.

We did meet with the case management staff at the hospital. And asked them questions: What are your pain points? What is your pain point that causes you? What do you need when you think about people with disabilities in the hospital? And that's part of their complex cases. I know you're going to hate this terminology. But that's their terminology. Complex case that we can't get out of the hospital for variety of reasons.

And, so, we build a program around that. Assessments, there's a whole plan. And I have a webpage to share with you that shows you everything we did, all of our documents. It will set you up if you want to follow it or tweak it to your side. But we put together marketing PowerPoint that we didn't take the PowerPoint in PowerPoint, we took it on paper and sat down face-to-face with the Director of Case management. Our friend, the Director of Rehabilitation in the hospital, and several other people and said, what do you think? Here's what we can do. Give us feedback. And they loved it, but we had to find funding for it as a pilot so, we went to several healthcare foundations who loved this idea. And want to see partnerships between hospitals and non-profits.

So we got funding from several grant sources in the hospital, but in 15,000, and we can find a pilot to run. We didn't know if this was going to work and they became partners in this. And we ran it for 12 months. And they told us that for every week that we kept someone out of the hospital, it saved them $20,000. And that usually, the person did not come back. So there's no hit on re-admission. Because when hospitals have re-admission, they usually don't get paid for that. They should have fixed it the first time. So we were able to keep people from coming back from our community-based team from other non-profit that could provide certain services.

So we reduced -- we demonstrated and reduced re-admission. Better outcome and financial savings. It's a trifecta. Everybody benefited. We took the hand of a Board member, our Board member from the hospital who helped us walk through this, vetted on our materials, and all that kind of thing and that's how we got started.

>> RICHARD PETTY: And Patricia, let me just break that down. So, you identified a need and I pain points for potential payer. You found a friend in the value of the beast. I'm sorry, I shouldn't say that about the health plan and certainly about hospitals. And then, you made the case. Here's how we can help you, not only the people that you serve, but also the work that we do will make them better, and better able to deliver for the community. But we will also save you money. And then you negotiated the contract with them and demonstrated success over a period of time.

>> PATRICIA YEAGER: Right.

>> RICHARD PETTY: I'm sorry, go ahead.

>> PATRICIA YEAGER: That's good.

>> RICHARD PETTY: I apologize.

>> AUDREY SCHREMMER: That's okay. So, we took different tactics, depending upon which organizations we were trained to work with. And before managed care came to Kansas, we had pursued working with private insurance companies to cover in-home services. We attended a presentation by our state insurance companies saying that it was mandated in Kansas and anyone with a long-term care consider also had the in-home care option. And that invigorated us. And, so, we tried to reach out to all the insurance salespeople who sold long-term care policies in Kansas. And we reached out to them personally. We marketed to all of them and got nowhere. But we got a Board member who developed a really fast-moving, well, injury that just incapacitated him very quickly. And through his membership on the board, he's gone, hey, wait, I have long-term care and he had to press really hard with the insurance company. And, finally, they said, oh, yeah, you're right. So we contracted with them. And they were like, whoa! This is saving us money. So we've got a few more off of that. It's not easy. And I encourage anybody that's going to try to do it, you've got to make sure you have a robust finance department to figure out how to build and how to track all of this. But we jumped in first and figured it all out afterwards.

And then we got some phone calls from people through Workers' Comp injuries. You know, someone that needed transportation to and from ongoing doctor's appointments. And that was a very simple one. And, so, we kind of had baby steps and then when something works out well, you find more people calling you. And that's happened now and it's expanded. In our managed care contract, which are significantly larger, they were mandated when they came into Kansas and they had to reach out to all the providers. And we had wonderful meetings, but that didn't mean they were willing to move forward on it and we were incredibly persistent. Like what Patricia said, we put together groups and PowerPoint and here is how we're going to save you money. We met with all of the individuals. It kind of went nowhere but we kept at it and kept although it. And then we got referrals and they fell by the wayside. And, so, it occurred to us even the major companies in the world constantly advertise, constantly market.

So we ask ourselves, why do we think they're just going to go oh, you CILs, you're so wonderful. We're never going to forget you. No, in the scheme of things, we're tiny in their world. So we decided we'll do whatever it takes to stay in front of them on a regular basis if they have provider groups or what's the word? Advisory boards. We make sure someone in our CIL from Kansas is there for each managed care group and do what we can to stay integrated, and keep reminding them that we're the most cost-effective game in town and we'll keep people in their homes and healthy for the long run. So. We're good?

>> RICHARD PETTY: Excellent, thank you very much. There's an important theme here. And that is it would be very easy to think these folks were fortunate, they were lucky. But the thread here is there's a lot of preparation that had already taken place by the time those pivotal events occurred. There were people on their boards. There were people in the community they were connected to. There were people who knew the work they were doing. They were prepared. They looked for the things that those organizations would need. And as Audrey said so well as she was wrapping up is they did everything they could to be in front of those organizations. So much to be -- much to be considered there about preparation.

And, Tim, I believe you're going to be fairly happy with us. We're a moment early. Let's move on to questions from our participants please.

>> TIM FUCHS: Yes, we're couple of minutes ahead of schedule so we have plenty of time for Q&A. I saw couple come in through the chat. I'm going start with those now. Just to remind you all, you can submit the question using the Q&A tab. If you're using the full-screen C.A.R.T. captioning, you're also welcome to use the chat box there. I'm logged in. And if none of those options work for you, you can email me at tim@ilru.org. Or you can raise your hand. And I will unmute your microphone. So, let's start with these question that is I saw come in from Alexa during the last section. So the first one, Alexa says when you say you coordinate vouchers, do you mean you're the referral agency or something else? Was that you Patricia? First one?

>> PATRICIA YEAGER: Yeah, just briefly, we get the vouchers or the consumers bring vouchers in, and we help them look for housing. We do all the paperwork. We do the checking the housing unit to make sure it meets standards. And then every year, we have to do a recertification if the person is still needing the voucher and that sort of thing.

>> TIM FUCHS: Great.

>> PATRICIA YEAGER: Which by the way, a lot of people have come in who did not know we existed and didn't know the services they could find here. And it's been very helpful with our other programs.

>> TIM FUCHS: That's great. All right. And then Alexa has a second question. She said Bill subscribed this process when the health plan came to him. If only. She says, what if they ignore you? What would help get them at the table? And I know Audrey and Patricia, you all shared some stories around Board members building connections for you all. But I know you've got some other experience. So what tips do you all have for getting to the table and for building these relationships if you feel like they don't even know who you are? Anybody have any experience wither that? Anybody done it the hard way?

>> BILL HENNING: Well, one of the things I will say we've done with the network of centers in Massachusetts, when the duals program came was about to go live a year before it was live, we got together and hosted the perspective plans and did a basic IL-101 to them and offered our services up that way. And we are planning to do that again sometime this year as they bring on three now plans. So there was this element of working collaboratively. This is a statewide initiative by the state's Medicaid programming conjunction with the private health insurance plan. So that's one way to do it. Think beyond yourself. It may not be what your network does, but that's one way to put your name and brand out there.

>> PATRICIA YEAGER: I'm going to jump in here. We don't have managed care in Colorado. So I'm involved with the hospital. But my advice is if you're starting out, start with one. Just do one. One that you already have a relationship with. Somebody that you can get in relationship with fairly easily. Don't try to conquer the whole state all at once. We haven't done this before, so we were happy just to get to know one hospital and work with them. So just try one.

>> BILL HENNING: Yeah, and you'll know, BCIL is with just one plan. Same here.

>> TIM FUCHS: Great.

>> AUDREY SCHREMMER: And from the, just to give it a different twist with the Veterans care after visiting with Patricia last summer at NCIL, we had two, actually the current soldiers, I guess, that needed some assistance. And Patricia was sharing with me how the individuals themselves kept calling their insurance provider the V.A. saying we need it. We need it. We need it. Until they finally made it happened. So we shared that and these individuals cut contacting the insurance carrier and said I need this now and lo and behold, we have a referral to help the individuals, two of them with the traumatic brain injury and we're doing the basic IL skills with them, helping them learn to do things normal in life and when that happened, I don't think if Patricia had not shared with me to pressure that way and I can tell you on the Workers' Comp side, one of the Centers for Independent Living set up a booth for a conference and we didn't know that existed. And insurance providers also have a conference and we set up a booth and educated all of them. So in some ways, just do an outreach like we always do, but maybe to a different population. Same story.

>> TIM FUCHS: Great. Good tips. Good segue, because the next question we have is both about Veteran services. Anna says, can you share your experiences with getting contracts for Veteran services? Audrey, you want to start off? Then I'm going to go to Patricia for sure because she's had success with that.

>> AUDREY SCHREMMER: Yeah, so, we had Veterans services many, many years ago, 15 years ago, Veterans are able to self-direct their care and it was contracted through each VA hospital and we have 3 in our area. And I don't even remember that long ago how we made it happen. I really think it was that individuals knew it was an option, and that's what they chose. Then at some point, the VA said you have to go with home health and we're not a home health, so they stopped all of that. Ever since then, we have been fighting to get that returned to our Veterans as well as they've been advocating for it as well.

And, so, we have just kept pushing, and we actually called and talked with the social workers at the VA just kept saying this is their right. These individuals fought in the war for us and now you're telling us they can't self-direct? That's not respectful. It was a powerful statement and we work with legislatures. And it's been a long time swinging back around. But we learned through the process, each VA is self-standing and there's no one higher power that tell them you do this and you do this. So we worked with each one. We get a direct contract with them. They each actually have a bill in invoice that's slightly different and it was again, the individuals themselves wanting to push this through saying I want this.

So it's been a bit of a process. And the active soldiers, mostly because of our proximity, and we have two staff that were in the armor and now work from these, so they have that connection to do the wounded soldier project.

>> TIM FUCHS: Great. What about your path, Patricia?

>> PATRICIA YEAGER: Well, there is a program at the VA, Veterans administration at the federal level that we really want to push. Called VD-HCBS at the time. Veteran-Directed Home & Community Based Service. And they said you ought to be doing this. And, so, it usually runs through the AAA. Our AAA [Away from mic] I see him shaking his head. So, --

>> RICHARD PETTY: Patricia, we were losing your audio.

>> PATRICIA YEAGER: Can you hear me now? So, there's a whole process you go through to become accepted as a Veteran directed -- let's see, Veteran directed care provider. And we have a webpage that shows you how we did it. Richard has it. I'm sure he will be posting it. But we went through it. Our home health staff went through it and when they get the manual together, they said, hey, this isn't us. This is more IL. And oddly enough, three years later, its back under home health because of the case management service coordination part of it.

But we set up and went through all the hoops of getting certified and all of that. And then as Audrey said, we had one person who kept calling every month, the VA person saying my father needs this, I need this. And they gave us a contract and the door opened up for them to contract with us. And thus, make that referral. It is at the hands of each VA. And the big boys at the top are really pushing this. They want to see this happen. And, so, talk to your VA and get your advocates on it. They had a lot of fun. We had couple of other Veterans join in the chorus about we need this and it was gratifying because their pushing made it happen. It isn't us, but we look self-serving when we're pushing too hard. But when the people who need it advocate for it, it's a win-win situation.

>> TIM FUCHS: Great. So what about direct care? Is that something that either of you are familiar with? We've got a question from anonymous. But it said can you give me on how to get into your local direct care and I know this exists and other VA hospitals in my state. Audrey, do you know anything about direct care?

>> AUDREY SCHREMMER: I'm trying to remember, because it's all called different things. And that's exactly right. Not every VA has rolled it out yet. And, so, if you're not finding it at your local, maybe simply it's not been rolled out yet. Don't give up. That's a big thing. We've literally been at this for 11 years to get back to the Veteran's Directed Care. So this is not a simple thing.

>> PATRICIA YEAGER: This is home healthcare, right?

>> AUDREY SCHREMMER: I'm not sure if it's home healthcare.

>> TIM FUCHS: I don't know. I'm just going from the question. But if you want to offer us more information, we'll see if we can find anything about it. And if we do know, we'll address it in the next Q&A break. Okay.

>> RICHARD PETTY: Tim, quickly, there is a new home Veterans home-based program that was piloted on the East Coast and West Coast. And is barely making its way into the other parts of the country. And maybe they're certain different patterns in different states, if it is this program.

>> AUDREY SCHREMMER: It pays to get a friend.

>> PATRICIA YEAGER: It pays to get a friend inside your local VA. Take them to lunch or whatever. But it pays to have somebody that you can find out what's going on.

>> AUDREY SCHREMMER: Yeah, if they're referring to the full title being the Veteran's Directed Care program, that is the HCBS which is going through the transition. And I think it's going to roll out in our area in April.

>> TIM FUCHS: Okay. Let me see if I can sneak this in before the next slide. John is asking, you know, so, they have an issue in their area, because the hospital seems to provide their own home healthcare and home care. So they haven't had much luck there. Patricia, did you run into anything like that? Was UC attempting to do any of these on their own when you contacted them? How did you make the case with them to let them take this over?

>> PATRICIA YEAGER: Well, UC didn't really have its own healthcare. Other hospitals do. But the case we make is that we go in and assess and talk to the patients. I'm going to go back and forth here on terminology. We talk to the patients. We talk to the family. We do an assessment of both. We go after the home and look at the home and see is it set up for this particular person to come home? We have paraplegic, people are hemiplegic come to a tri-level House. So we go out and we look at it and we make recommendations. We have contracts in the community with Medicare providers. We're not a Medicare provider. We do Medicaid.

So we have couple of contracts with Medicare home health. We have a DME contract. We have prescription delivered. We have food and transportation provided on contract. So we have a little network that the hospitals really can't duplicate. But we go after the home, and we can say to the hospital there's some problems here. Hospital did not have a discharge plan for one man who had holes in his floor. And no home health company would go there. The floor is fixed. And all of a sudden, we had a discharge plan. He could go home. He and his mother could both get home health services. I mean, hospitals can't do all that. And this is pure IL. And either we pay for it or we found someone to pay for it. And now, the hospital pays for it because they know that this is the way that the person has a safe way for home.

>> TIM FUCHS: That's a great way.

>> PATRICIA YEAGER: Our staff, the staff, they can't bring that network with them. So that's the piece that makes us different. And when we don't do just on that, we do a lot of other things.

>> TIM FUCHS: That's a great way to frame it. All right. I know Richard is chomping at the bit to get to the next question. I'm going to turn it over to slide 12.

>> RICHARD PETTY: Thank you, Tim, Patricia, Audrey, and all of you. Patricia is something is happening. We're losing your audio. So it's not losing it, but it's getting very muffled at some point. So if you can help us, that's great. I'm not sure what it is. And those who answered, thank you. So let's move on to an important question. How do you find the people that work in the health plans, the leaders, the decision-makers, the people who will make the decision about whether those health plans will contract with you? Those people who with whom you make the first contact, how are you going to reach out to them? How do you find them? How do you know how to connect with them? So there we are. How do we do it?

>> BILL HENNING: Well, I can go first. So I'll continue. I did say plans come to us, but it may be that the marketing people that come to you first for instance. I think it's a series of discussions, at least that's been our experience talking with a number of plans. And I think it's like an interview. You know, I think many of us hire people. We interview them. We have questions. So you're testing them on a series of things that are importance to you. So you would ask about finances, of course. I keep saying you want to be solvent. We never enter this to make money. And we'll lose money on programs that's a good program, the one we dropped was when we're losing way too much and it was a red, Inc. But do they understand independent living or open to understanding it? I don't want attention in a fight.

We want an open mind. They're not going to understand IL or recovery the way we do. But can they learn? Will this be a good relationship? How you see the bureaucracy? Can you get to the finance department to process bills? Are there too many forms to fill out in order to submit an assessment that a Consumer of LTSS needs? Can you reach a care-manager? It's a flowing discussion where you may be as director or Program Manager makes this assessment. Usually, with trusted staff. We talked to many plans over the years, you know, the other centers have too. And I think of it as job description and just sort of getting to the person who has the power I think that's asking questions. So maybe Patricia has something to add?

>> PATRICIA YEAGER: Tim, can you give me a thumbs up or thumbs down when you can't hear me? Because I'm not sure what's going on.

>> TIM FUCHS: It sounds good now. But I wouldn't worry about it.

>> PATRICIA YEAGER: I moved some thing around by my computer, so that might help. So how can you identify? We only have two hospitals in town. We call them both up and talk to their case manager directors and kind of pitch the plan to them. One was interested, one was not. And, so, that was how we figured out who to work with. Now, we have a pilot. We have hilt. And still, the other hospital hasn't figured out how valuable we can be. So we're, you know, you identify them. If you can get a pilot just to work through it together and show what the outcome is, then you have something to share with others.

>> AUDREY SCHREMMER: We also do constant outreach. And you're right, it is hard to know who the right person, and you're going to find by trial and error. Whatever their title is for the director or managed care came in, and that clearly is not the right level. They just nod their head and go yeah, yeah, yeah, you're great and so are we. And you have to look at the structure and see who is at what level. So most of them have a long-term supports and services director executive. That's probably the level you want to get to, to get the decisions. But sometimes the best way through them is the care managers. So we also work at that angle as well. Develop any relationships we can with the care managers. And in our case, a lot of the care managers used to be our staff, because we had the coordinator contract for the state and then they just gave it to managed care when they rolled in.

We also make a point of getting materials to all of our doctor's offices in the area as often as we can. We give brochures and we drop-off packets with their nurse staff to remind them of the services that we do as CILs. And through the recent accessibility contracts that we did through United Health and NCIL that was also a great method to get in to the medical places and remind them that this is one of the other services that we do, because they often forget.

So, anything you can do to stay in front of the whole span is going to be helpful. And also it helps to reach individuals who might get missed otherwise that are in need of care. So, I say typically, start with somebody who actually does hands-on service. And ask them, who is the person they talk to? Who is their boss that makes the decision? And then you work at getting in front of them. Patricia may have used couple of other words that's going to stick with my team talking about pain point. We typically go in and say we are so great. We can help you and we're cost-effective. But we ought to ask that question what is your pain point? We think we can fill in some gaps. But let's talk about what you think your gaps are and see if it's a fit. And then definitely, go back to Bill's experience too. If it's too hard to do category, walk away. Sometimes we push through things, and you're just like, oh, my God, this is so painful. We could do it cheaper if you were paying us. So we're losing money trying to get paid. So there's a lot of angles on that too to pay attention.

>> BILL HENNING: That was our experience. Keeping it up and being paid to do it. Losing more money to do it. On one of the plans, but the other is all thumbs up.

>> RICHARD PETTY: Did any of you have a try, and have any positive experience in trying, especially; in that phase where you're trying to find out whom in the organization is going to be the decision-maker? Did you have any positive experience in going to where they hang out? Going to the same places, meaning, going to conferences and meetings, and places where you might begin to make those connections? Any successes there?

>> AUDREY SCHREMMER: Yeah, and let me jump in and say that was my best success was actually in two-fold. The BCIL conference and couple of self-direct conference where you have time get to know the people. But I also sat on a work group that the state had requested that some people from the managed care companies be on this work group as well to reshape the head injury program. My goodness, we learned so much. We had so many misconception about things. It really gave you time to focus on the contract and focusing again on what are the pain points? And that was probably one of the best, best efforts that we've done in working out thing to help serve consumers.

>> RICHARD PETTY: Thank you. And let's move on. Go ahead.

>> BILL HENNING: I just want to add quickly, Richard. What we did with one of our advocacy partners, we go to small foundation grant, as it was a health insurance plan foundation, and promoted the role of independent living in managed care, invited the state Medicaid directors to come and speak. And that created engineer from the majority of the MCO to come out in the duals plan or accountable care organization to show up. And that facilitated the kind of dialogues you were talking about. So you can initiate it. I think going to conferences is great. You can hold that event yourself.

>> AUDREY SCHREMMER: True.

>> BILL HENNING: We have marketable product.

>> RICHARD PETTY: Thank you, Bill.

>> BILL HENNING: Independent and very marketable. Because it saves them money.

>> RICHARD PETTY: Yeah. And, this is important for a lot of folks. And it should be. It should be very important. Has working with health plans and payers caused you to compromise your mission or compromise your adherence to independent living practice? Consumer direction is vitally important to who we are, as what we are as Centers for Independent Living, and in the ways that we are highly responsive to our constituents, and in how there is control in all levels of our organizations, among other important things.

Has doing this caused you to compromise in any way?

>> BILL HENNING: No.

>> PATRICIA YEAGER: No.

>> AUDREY SCHREMMER: Yeah.

>> BILL HENNING: I mean, you know, even as a further benefit, Richard, you start to work with a plan and maybe get in their head, or you get privy to information. If they're not doing something right, to a certain degree, they're laying out an advocacy agenda. You might go through channels more to raise an issue than, say, hit it head on. But you're becoming privy to things you otherwise wouldn't be. You're advancing the mission on the individual, but also a systemic way. I don't want to dress it up too much. But if you do a good job, you can have some influence. You're kind of an outlier into this world and people can take notice if you do it well. Again, I don't want to overstate it. I wish it was as true as I could paint it. But I do think we have a bigger influence. And I do think other plans take notice of the work that she the centers do when they do it well. Patricia or Audrey?

>> PATRICIA YEAGER: No, I mean, it does not compromise our mission or the way we do things. I think the next slide speaks more to case management and we'll talk about that. But we are really able to show the case managers in the hospital what is Consumer-directed services? How do you give people information and allow them to make the decisions? We've done a lot of, you know, preaching the independent living BBQ sauces I call it for those folks.

>> AUDREY SCHREMMER: Yeah, and from my perspective, I would say technology has caused me to compromise more than the managed care process. I have an angst some of the system, like the authentic care -- not it. EVV. Electronic Visit Verification. And I can continue to argue against them, but we're force to do use them. So there's that portion that's very frustrating. But I also can't imagine what these individual's lives would be like if we were not there advocating, because there's no way we can reach all these people who are getting the in-home services for managed care if we weren't partnering. And, so, sometimes you just see how the rights are just stomped on. And who else would be there for them? We wouldn't have that contact to help them. I feel like one individual where the care-manager decided they can get around on their farm without wheelchair and they didn't need any assistance in their home. And I was like what...? Who thinks of these things? And, so, of course, we had to step in and make the case and argue. I had another time where a care-manager made the assessment that the person answered the door so quickly, she couldn't possibly be disabled. I'm like what? So, right? Yeah. Yeah. She didn't need our help. So sometimes your mind gets blown by some of these individuals. And we're there to advocate where I don't know that we would have contact with all those people to help them if we weren't contracting with the health plan.

>> RICHARD PETTY: Yes.

>> BILL HENNING: That's our experience, totally.

>> RICHARD PETTY: And, so, we have talked about consumer direction, and that has continued with technology perhaps being a detriment to Consumer direction. We have talked about individual advocacy, which is something that pretty much known else offers. And we've talked about systems advocacy. That's us. That's who we are. So, all of those have continued within your centers. And that's exciting. Let's move to slide 14. And her concerns in several presentations that we've been part of in which there were those who were in the audience, who were concerned that Center for Independent Living should not provide case management. How do we address that?

>> BILL HENNING: I would defer to Patricia to lead off on this one.

>> PATRICIA YEAGER: [Laughter] This question. You know, there's case management and then there's IL influenced case management. Service coordination. The way we look at this is that we were showcasing it for others. But from the hospital to home, people come out of the hospital and they're kind of in a crisis situation. If you've ever come out of the hospital or had a family member come out, and this is a new event for them, everybody is sort of, their hair is on fire. And they can't think about, well, what do I need to do or this that or the other? This is a temporary situation. So, usually, our program is 30 to 60, to 90 days. And we have a service coordinator who works with them intensely during that period of time.

And a lot of hand-holding. Have you thought about a lot of things that you know, we do in IL, but we don't wait for people to ask us questions when they come out of the hospital. We kind of a little bit more aggressive about saying have you thought about this? What do you need here? That kind of thing. But we do it with the IL philosophy. And we work to get them out of a patient mentality to a Consumer mentality. And one of the way we do that as part of our Consumer division. And independent living division staff, we spend a lot of time saying you can't work harder than the Consumer. Consumer has to take the lead. You come out of the hospital, that's a little different story.

So Mandy, our service coordinator works with IL staff to work with that bridge. Administrative comes from the IL staff. Peer support comes from the IL staff. But service coordination, person that holds it together and holds the Consumer, the patient together is 30, 60, to 90-day deal to help them move on, heal, get through the healing process and move over to the Independent Living Center. And we find that works very well. We don't use our independent living staff to do all of that assessment and intensive care management to get them home. But, really, it's not that much different than what your Money Follows the Person case management does. And, so, I'm a big proponent of this. It's not lifelong. It's a short period of time to get them over to the independent living model.

>> RICHARD PETTY: Thank you.

>> BILL HENNING: I don't dispute any of that is why we do care coordination because consumers are in systems that are daunting that are overwhelming. We may not call a case management. And the reality is, everyone has a different level of control and independence. It's not one-size-fits-all. There's some very adept, we might just say, here's one other option you might look at. Or we say, you don't need us. There may be people who are varied. They may have cognitive disability and have some difficulty negotiating, reading materials, learning disability, English as a Second Language. So you take the Consumer where they are and ride with the, with the ultimate goal as Patricia says, independent living. That's what we do with all of our consumers, right? At some level. They come into get housing. They're not coming in to get some esoteric thing. I want to get out of the hospital and live at home. That involves a lot of real specifics. And you support those mechanisms to IL.

>> AUDREY SCHREMMER: Yep.

>> RICHARD PETTY: Yeah.

>> AUDREY SCHREMMER: And I would agree. I don't come from a background that sees case management or care coordination as negative. I guess, I never had that experience. So I look at it, again, everything is done with the IL flavor, IL philosophy. And you just, you look at the normal things we go through. We all have someone who helps us do thing for the most part. Systems are incredibly complicated. And whether you've got family or friends, and not everyone around has that. And one example that one of our, in our association meeting yesterday, the gal made the comment about somebody had been trying to get a birth certificate for 6 months. And they were able to do it in two days because they know the system. And, so, if you've got means to help individuals navigate systems more efficiently, more healthily, absolutely. That's the way to go. And somebody is going to be doing it, then it should be with that independent living philosophy background.

>> BILL HENNING: If I could tell a quick story. We give in our core independent living trainings, which we do for health providers through some of these relationships we have. And I talk about laundry. My nurse went into the consumer's home, saw laundry all over the place, and ordered up a laundry service. And he goes, I got some push back from people and I don't understand it. So the issue is you can imagine the training of bunch of nurses or whatever in there. And I go, start us. All right, who came to work today with dirty laundry on the floor, right? And half the audience raised their hand and half didn't. And I leave my bedroom with the laundry on the floor. Just think it through. Why was the laundry on the floor?

A, maybe the Consumer doesn't care. B, maybe they need a personal care attendant. Or C, maybe they need to get transportation, travel training to go to the Laundromat? Or another reason might be the washing machines in the basement of the apartment building aren't accessible and you could ask for a front loader instead of a top loader. And heck, if it was to get to the Laundromat by public transportation, now they find out they don't need in home meals. They can go buy their own groceries. This opens the world. This is the perspective we have when we do care coordination, not just look at the problem and have someone from a medical model solve it by their value system.

>> RICHARD PETTY: Some would argue that case management is easily a combination of core services. Individual advocacy. Independent living skills training. Peer support. And, of course, information and referral. And I'm sure Patricia alluded to this. Many would maintain the case management offered from within a Consumer-directed organization is better can case management delivered under any other circumstances. So let's move to slide 15.

So, when it comes time to be paid, how are the payment arrangements made? How does that work with the payers with whom you work?

>> BILL HENNING: For us, for BCIL doing coordination for long-term services and supports, we get paid by staff person on staff. So that's really great if the staff member has 80 Consumer cases or 20. We're getting the same rate. And it allows for a lot of flexibility and we make a little net gain on that. With the initiative where we were providing the same care coordination that we dropped, it was based on billable services, which I -- it was tremendous amount of bureaucracy, and the mantra kept being, oh, you're not doing billable services, billable services. And our staff was saying, I need to provide them this service, and that may not be billable. And it was just a misfit for us.

So, being paid per staff person, doing the service was a great way to negotiate it. And we're hoping to continue that. The billable service for each little component was a nightmare for us.

>> RICHARD PETTY: So would you have a contract with the payer, and then you would negotiate a contract with the payer, and you would negotiate a rate with the payer?

>> BILL HENNING: Right. So we have -- Jose runs the program and Jose, that's his name. Jose Torres. And he gets a presumed case with 55 consumers. Jose is really good, so he might have 65 to 75. Newer staff might be up to 45 or 55 and it averages out under the MCL understand that situation for us.

>> RICHARD PETTY: So this is different than them paying, you, as in fee-for-service unit by unit. How does that work?

>> BILL HENNING: Maybe Audrey or Patricia wants to say something?

>> AUDREY SCHREMMER: We have several contracts that are for unit. You have to figure out what is your cost and that is something that not-for-profit have not been good at traditionally and will give a plug for the business acumen. Centers are several trainings or webinars, and they're able to help you analyze this. And we found it extremely helpful to share that also with our staff. I make sure our staff are educated on what their actual cost per hour is. That includes overhead. That includes office supplies. You know, all of the things that they don't think about. And it increases their self-value as well. They go, wow. Okay. It's important to them suddenly to make sure that they give what they need to for that unit of service.

And then negotiate. I think for a lot of us, we don't do a very good job of negotiating. Again, not-for-profit, we tend to low ball things. And you have to understand, if you want to grow, if you want to expand, you have to make sure that you've got your overhead covered. And we also have to set down and analyze this on you are a regular basis, because your costs do go up. And that's difficult to go back to them and say, well, now we need to change our agreement. Expenses have gone up. We can demonstrate it. And you also have to have a very robust finance department. So I encourage everybody to get your base settled so that you can do it. And maybe start out small. And one of the other thing, which I didn't mention earlier, we used a unique model early on here. I don't have anybody that's 100% covered by a grant for the most part. I started with everybody at 70% covered by a grant. And then made sure we found contracts to cover that other 30%. So that freed me up from the get-go to pursue contracts. And that's very important to be able to do that.

>> RICHARD PETTY: Are of any you operating on a per member per month basis?

>> AUDREY SCHREMMER: We have one contract that's that way, yes.

>> BILL HENNING: We have had arrangement with our PCA management and do assessment under the Consumer-directed model. And you know, some consumers may get a whole a lot of unit skills training and some may not. And you get an average amount. That's changing a little bit because of state Medicaid. And we'll see how that goes. But that's how we run for the last 20 so years on that.

>> RICHARD PETTY: Okay. We're just coming close on time here. But that typically works this way. And let me ask you all. So, with that, I'm expect what that would mean is you get a rate that is an overall race for a number of people that you'll serve during a particular period, as an example, a month. And how well and how efficiently you're able to do that will make a difference in whether it's the payment that you get that covers your cost? And you do want to do that in way that doesn't shortchange any Consumer. But you do want to make sure that you're, that you are, indeed, covering your cost. Is that correct?

>> AUDREY SCHREMMER: Yes. Yeah. And I would say, again, I laid out. We started a new program with our vocational rehabilitation. But we contract with youth services. And, of course, it was a reimbursement rate that we were like, there's no way we can work with it. So we need to do it in a group setting. So we laid it all out in a little chart. Do these classes. You need X number in the class. You can only have this many hours and we laid it out in a great pattern, so they can see if you spend more than X number of hours, you have gone over the amount we're going to reimbursed. But this also lets the supervisor knows we need to tweak things. And it reminds the staff, once you've gone over, then we analyze is there another funding source that can help cover that?

>> RICHARD PETTY: That's great. And thank you. Tim, I think we're where we need to be for Consumer questions. Not Consumer questions, but participant questions.

>> TIM FUCHS: Before we do that I want to look here quickly the slide 16, how to guide for marketing CIL services. So we've got link there. And that's too long to read. But you all have that in the PowerPoint, both on the screen in front of you, and also in the attachment and the confirmation email if you need that in a different format. If you have questions about the how to guide, you can contact ILRU at ilru@ilru.org. And I'm going to slide 17. I saw a question come in from Tim. Not me, a different Tim. And then we'll see if any other questions come through. Before I read the question from Tim, let me remind you all, you can pop your questions into the Q&A tab. But you're also welcome to use the chat on the full-screen CART captioning. I haven't seen much activity there, but I'll keep watching that. And you're also welcome to email me at tim@ncil.org. Or raise your hand. I think that covers our bases. Tim says can speakers share the marketing materials to hospitals and decision-makers? Speakers, Patricia, I know you have been exemplary and I've been impressed how your center has a lot of success with this and logged every step along the way. I know you have some stuff on your website. I was trying to find it before the Q&A break, and I couldn't. But is that something we can share with folks?

>> PATRICIA YEAGER: Certainly. It has the document that we market to the case managers at the hospital to send us people. It has the brochure that we give to the patient, our Consumer and their families. And PowerPoint, we use that and also just has a lot of materials in there that you can tweak, at least see what it looks like. So the webpage has all of everything, every step of the way. How we did it. Assessment. Funding and all of that. So if Tim will share that, it would be great.

>> RICHARD PETTY: Patricia, your preference, we can share the link or post it on the ILRU website at ilru.org, which we have been considering.

>> PATRICIA YEAGER: Well --

>> RICHARD PETTY: That's what we can do.

>> PATRICIA YEAGER: Yeah, I can't do this. Independent Living Center can't do advertise all over the country. So if I can scale this and get people to look at this process. So any way works fine.

>> TIM FUCHS: Maybe I can suggest rather than popping it into the chat and have it disappeared at the end of the webinar, Richard, will you post the archive of the webinar, if you can put the link there. It will be right there. And Tim and other attendees can access it that way.

>> RICHARD PETTY: Indeed, we will. And we'll be posting the Veterans Directed Services sheet link. Not sheet, page, excuse me.

>> PATRICIA YEAGER: And I sent you both the Hospital to Home and Veterans Directed Service. So that has all of our tools and all that kind of thing.

>> RICHARD PETTY: Great. That's excellent.

>> TIM FUCHS: All right. I don't see any other questions at this minute. I got an interesting note from Pat from North Carolina. Pat wanted to share about what they've done there. They said that they noticed they are starting to see consumers on MCL boards in the state and one way they've done that is through the CFAC, which is codified into law. And somebody help me with that acronym? CFAC? Anybody happen to know that on the panel?

>> RICHARD PETTY: I'll Google it as we speak.

>> TIM FUCHS: [Laughter] Thanks, Richard.

>> AUDREY SCHREMMER: Yeah, the MCOs do ask for customers and consumers to be on the Board and Advisory Committee. So definitely, pursue that.

>> TIM FUCHS: Yeah, that's codified into law there in North Carolina. And as a result, there are number of LMEs and MCOs. So managed care organizations and management entities? I don't know. I don't know that one either. But anyway, Pat says she's the one that serves on the Mental Health and IDD for 22 counties in part of the state. And says that that's the third year of a three year term. But anyway, just a success from North Carolina that I wanted to share from Pat. And something you all might consider, because as Audrey was saying, they're going to start looking for those folks. So if you can recommend consumers or board members to be that advocate, that's a great opportunity. Okay, we've got four minutes left. So, if you have other questions, please don't be shy. Bill, were you going to add something?

>> BILL HENNING: Yeah, I was just going to acknowledge what you just said and what Audrey said. I can't emphasize enough. I think we opened up with the idea of, you know, getting engaged in the game, because these are huge players in the lives of our consumers at very critical points in the healthcare system. And we emphasize providing services, but getting on governing bodies, just showing up at events where public hearings and raising our voice, holding them accountable, doing that systemic advocacy as well. It's complementary as we know. I can't emphasize it enough. That's been our model. We really built our individual service component with MCOs as an outgrowth of our advocacy. And maybe that's something we do really well. Some days, I like to think we do, but as this is happening in North Carolina, those kinds of stories are so encouraging.

>> RICHARD PETTY: Bill, I apologize for stepping on you there. CFAC is Consumer and Family Advisory Council. And I would hope that other states have something very similar or the same.

>> TIM FUCHS: You're right. Because Pat sent me the same. Thanks for both of you to spell out the acronym for folks. We've got another minute. I'm going to keep watching this, so if you have any questions, here's your chance. Let me say now that if you all think of questions later, please know that we remain available. So Bill, Audrey and Patricia has been generous to offer their time. Richard and I IL net project do technical systems all the time. These are the questions we get from CILs. So later today or whether it's in 6 months, you can always reach out to us for support. And if we don't know the answer, we'll point you in the direction of someone who does.

Well, no additional questions have come in and we're at 4:29 on the East Coast. I want to thank all of you. Richard, do you have any parting thoughts before we close?

>> RICHARD PETTY: Tim, I want to thank you, Bill, Patricia, and Audrey. It is a great pleasure and privilege to work with all of you. And everyone, thank you for being part of this webinar. And we're eager to answer other questions. And I hope you'll be able to participate in some of our other activities around working with managed care and health plans and health payers. Thank you, all. Thank you, Tim.

>> TIM FUCHS: Thanks so much for your time, everybody. Thanks for joining us. The archived version of this webinar will be up on the ILU website within 48 hours. Usually much sooner. And we'll add the resources that Patricia has put together on the Hospital to Home program to that link. So, have a wonderful afternoon, you all.