Final Transcript

STATE OF NORTH CAROLINA: BHIDD Consumer Call COVID-19 Update

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SPEAKERS

Kody Kinsley
Suzanne
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Dr. Carrie Brown
Michiele Elliott
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PRESENTATION

Moderator

Ladies and gentlemen, thank you for standing by. Welcome to the BHIDD Consumer Call COVID-19 Update. During the conference call, phone lines will be in a listen-only mode. [Operator instructions]. As a reminder, today's conference call is being recorded.

At this time, I'd like to turn the conference over to our host, Deputy Secretary Kody Kinsley. Please go ahead.

Kody

Thank you so much, and thanks to everyone who has called in to take some time to touch base with us. We really value these opportunities to have two-way conversation about what's going on and what you're experiencing in the midst of everything that's happening right now. We're really happy to take the time to be with you.

We have a great group of folk that are on. In addition to all of you, we have some folks from the department and I'll let them be introduced in a little bit after I make some initial, introductory remarks.

I actually want to start by acknowledging that a friend and wonderful member of our community and family member experienced a loss recently, and I know that they're probably not the only person that has been touched by the moment that we're in. I don't want to give out any more details, but I just want to share that my heart's heavy at the moment as we are in the midst of this, and that life continues to move forward in a lot of different ways.

For some folks, that's a sun setting that can be really hard to experience in the midst of all of the broader stress and uncertainty that's happening with COVID-19 right now. I just want to send out my love to that person and let everyone know that I think that our team here at the department is incredibly focused on the real-life, real person-to-person impact that our work has.

I say our in the broadest sense. I consider all of us on this call, all of our consumers and family members and everybody we partner with we have—you take time out of your days, weeks, months, years to live this work, to be an advocate, to speak out on behalf of people in North Carolina that have behavioral health needs or have different abilities that are in needs of fair, just, and equitable supports.

I'm just really, really grateful for your work and for being the voice of what is right, and for allowing the department to hold your trust as we work to create systems that are truly fair and equitable and rise to the bar that they should rise to in providing the services and supports that we need to provide to every North Carolinian and to see a day where the state truly embraces the health and wellness of all people. So, thank you for allowing us to share in that responsibility and for holding us to it.

As I said, these are really important times and our choices matter. I know that over the past several weeks, we've been rolling out a large number of policy changes and I am sure that each of you, in addition to providers and other groups of folks, have been working hard to stay on top of that. I know I've been trying to stay on top of it. It feels like there isn't a day that goes by where we don't have an announcement about a telehealth change. I'm sure that to a degree that it's gotten quite confusing.

We're working to make sure that all those pieces continue to fit together and that folks can understand the broader context of how the details fit into the bigger picture and all the little dots of paint make the image that we're trying to make in the policy changes that we're making to support folks in COVID-19.

I'm really grateful to my team that's been working around the clock, including a lot of the leaders that are on this call that can speak to the details, who worked to make sure that these policies really have positive impact on people's lives now and for a longer period of time.

Additionally, we've also worked on the funding piece. As you know, that was one of the first things we did, is try to create some flexibility in funding that helps sustain services and make them available in other places. Many of you will know that we received a recent grant from SAMHSA for an additional $2 million. Relative to the amount of money that we have to spend to support folks, especially with regard to the number of people that are uninsured in North Carolina, $2 million is a bit of a drop in the bucket, but at this time, I'll take every drop I can get and we'll work to put it to our most critical use.

With a million people without insurance in North Carolina, I think all of you know that some of our greatest needs are really around the folks that are uninsured and underinsured and continuing to expand some access to them is critical for us right now.

I appreciate that all this context you all have—as we come into this week, the legislature will be returning, and what we have discussed at the broadest sense is that the behavioral health system and the IDD support system already had a lot of gaps coming into COVID-19. We know we had 12,000 people on the waiting list in the registry of unmet need. We know that we have 1 million people without insurance. We know that the single stream funding from its heyday seven years ago, at a peak of $312 million, had been greatly reduced for years and LME/MCOs had been using their savings to attempt to fill that hole, but that well has run dry.

This, unfortunately, has hit us at a time where there was already a lot of gaps and things were already very stretched and we were holding things together with paper clips and tape. Unfortunately, we come into this moment where there's even more stress put on the system and we all know that the impact of COVID-19 will not be in this moment, but will be for a very long time. The longer the thick of it lasts, the longer tail it will have.

So, the biggest, most vocal piece of what we are advocating for obviously is going to continue to be around broad-scale system change, expansion of access to insurance, and other things.

The bill that the legislature is considering right now is really a short-term bill and we really deeply appreciate their partnership and the work they're doing in addressing our most pressing needs, but all this needs to fit into the context of the broader reforms that we have to do to continue to support folks, get the investment in the right pockets, which is in the upfront prevention and health care for folks, to support them.

That is kind of big picture where we are. I want to give another quick update and then turn things over. As many of you know, last week Governor Cooper announced our strategy to stay ahead of the curve, and that that effort really connects to three big pieces. I want to give a little bit of context there.

When the COVID-19 pandemic started really moving and growing, our goal was to flatten the curve. Our goal was to minimize the number of people that each of us interact with to reduce the likelihood that the virus would spread, so reduce the growth rate of that. So, that was flattening the curve. We haven't put our curve into a downward trajectory yet. We have started the flattening. It's been a very low slope, which I think is a huge testament to the work that these strategies have done and frankly, to all of your partnership. We can tell people what to do, but they don't always have to do it and I appreciate you all spreading the word and having folks take this seriously to make some really hard choices. That flattening feels good.

Now, the governor, keeping our eyes on the future of where we need to be, has driven our focus with support of our DHHS team, obviously, and Secretary Cohen and myself and others have shaped out a strategy for staying ahead of the curve. How do we keep that flat? It really comes to three pieces, which you heard the governor speak about last week. That's testing, so how do we increase the number of tests that we're doing so we really understand the disease and where it is?

When we find a positive, how do we trace that? So, how do we know every person that that person has come in contact with to try to understand where that virus may have spread to and then potentially test them or refer them to do something different? And then, what are the trends, the various data points we need to monitor? Obviously, it'll be around positives; it will be around where the disease is moving throughout the state; it will be around various sources so that those data trends can re-inform our policy thinking so that we can shift things as needed.

With that information, we are positioned to, at the end of next week, start to move in towards a phase of very cautious, very smart reopening, and those are through three phases as well. You can find out more about those phases on our website and they look like first, for a few weeks, keeping the shelter-in-place in order, but opening up more businesses as deeming them essential and then a few weeks after that, it looks more like some restaurants and some other facilities that vary capacities and then, down the road, longer from now, more modified mass gatherings and things like that.

Long story short, this kind of gentle roll-out allows us to monitor the trends while we're doing the phased reopening, understand what works, understand what doesn't work, and then be sure to keep us all safe along the way and make adjustments as needed. I think you can see that this all leads to a modified operations for a longer term. I think we all are quickly adjusting to the reality that we're in a bit of a new normal for a while and I know that's hard.

That's the next policy arena that my team is looking towards, which is if our behavioral health system must survive in a new type of reality, what do we need to be doing different to support that? How do our systems work together? And how do we not only rise to the challenge that COVID-19 is impacting, the number of increase in domestic violence cases, the increases around potential crisis that impacts around other family issues? How do we address that? Then, how do we also sustain the supports in the system to address that for the longer term?

That's where my head is—constantly thinking ahead of the curve, trying to help us keep driving towards our broader goal of making North Carolina behavioral healthier and supportive more consistently and effectively of all individuals that need supports, creating a more equitable space for everyone. But to do that, I continue to need all your help and all your partnership and all your feedback. Thank you for standing with us and helping us do this work together.

Without further ado, I'm going to turn things over to Suzanne [ph], who I believe will tee us off for the rest of the call. Thank you all.

Suzanne Thank you, Deputy Secretary Kinsley. Since we don't have Deputy Secretary Richard from Medicaid, I am going to ask Deb Goda to give us a Medicaid update before Nick takes us into a question and answer part.

Deb Thank you so much. Hi, guys. I wanted to give you an update on the bulletins that have come out recently that are applicable to behavioral health. Bulletin number 55 is just a note that we did receive the approval for the expanded flexibilities in home- and community-based services through our Appendix K, that has to do with the telephonic contact with beneficiaries, simplifying person-centered planning process, deferrals of the [indiscernible] during this time, and service changes around relatives as provider and additional services.

We also have bulletin number 60, which—I have just lost access to my screen, so that's always fun. Can you do 55 while I get my screen back?

Suzanne Yes; 55 was the home- and community-based services. Number 60 is the fidelity reviews for supported employment and the [indiscernible] for the surrogate [ph] community treatment teams, that those fidelity reviews have been suspended during COVID.

I can keep going if you'd like. We've also published number 63, which is the North Carolina Innovations and TBI Waiver Community-Based Services flexibilities, about the retainer payment.

Deb Number 59 is our Telehealth Clinical Policy Modifications for Outpatient Behavioral Health Services. It clarifies the codes that can be provided telephonically when two-way audiovisual options are not accessible to the beneficiary. We have received a lot of questions about that, so there is now the ability to provide those services that are listed, as well as two research-based interventions for the treatment of autism spectrum disorder, and that would be the family adaptive behavioral treatment guidance and multiple family group adaptive behavioral treatment guidance. Both of those will also be able to be done telephonically, if the individual cannot use two-way real-time audiovisual.

We also have issued guidance on retainer payments for NC Innovations and TBI waivers. I'm having a good time with my computer today. I don't know why. There's also additional guidance there about outpatient respiratory therapy for folks who do need to have respiratory therapy and are unable to have someone come into their home. If you have the opportunity, that is special bulletin 67. I would ask that you take a look at that as well.

Suzanne Thank you, Deb. Nick, I think we're ready for you to give the callers instructions on how they can ask questions.

Moderator Thank you. [Operator instructions]. We do have several questions in queue. It'll be just a moment, please.

Thank you. Our first question today comes from line 227. Please go ahead.

Robin Yes, hi. My name is Robin Sipe [ph]. I heard them mention lowering some of the—I don't know if you say restrictions—on having family members as providers in the house. I know the hurdle for us has been that my son is not 18. I was wondering if there's been any more talk or chatter about lowering the age, because I have a daughter who's home from college and she is 18 and she could help provide services to him.

Deb That is something that we [indiscernible] we have drafted a second Appendix K to CMS to ask if minor children can have their services provided by relatives who live in the home.

Robin I was just going to say, are you optimistic that that might happen?

Deb I am optimistic that that might happen.

Robin Okay, because I actually was just talking with someone in the—for our family, it would help us, like three- or four-fold because my son would get more service than he's able to get right now. I'm trying to work full-time, but I can't. I have to help him do his stuff.

Then, my daughter can't work because the place where she was working is only hiring people who have to pay their rent and that sort of thing. So, she's living at home, so she's not desolate in terms of not making money, but certainly would like to make the money. And she's an education major, so that would help her too.

Deb I understand completely and yes, we're putting that one forth to CMS. We had already submitted, by the time that came up as a discussion, we had already submitted our K and we did not want to risk delaying all of the other flexibilities by adding in additional things. CMS was in process.

But yes, we are putting that forth. We do understand that that need is there.

Robin

Great, great. Thank you. I just thought I would bring it up as a parent, because I know I've brought it up to our care coordinator. Thank you.

Deb

Thank you.

Moderator

Next we have a question from line 199. Please go ahead.

Joanna

Hi. Can you hear me?

W

Yes.

Joanna

My name's Joanna Pinchek [ph] and I have a question about family crisis planning. The scenario is, I have a daughter, 29, she's on the waiver. She lives at home. My husband and I are both in our 60s. He works at Costco. He's currently taking time off because he was concerned about working and then coming home to us and causing exposure.

If my husband and I were to get sick, what happens to our daughter? We're trying to figure out how we can—would she go to a residential setting? Would staff come in? I don't know if staff would come into a house that has the virus? Is there a respite care somewhere?

For her, it feels like that mental health issues for our kids would probably be worse than the virus. Anybody have any ideas?

Deb

Is your daughter on the waiver?

Joanna

Yes.

Deb

Okay. I would say that it is probably a good time to talk to your care coordinator and start creating a plan for what would happen in that situation. There are respite placements. There's out-of-home respite. There's institutional respite. The potential of maybe a short-term alternative family living placement or group home placement. But I think you want to explore those ideas now, so you're not trying to do it in the middle of a crisis.

Joanna

Alright. I just spoke with my care coordinator, because I asked her who would step in. Would Alliance step in? She said, no, they do the

	paperwork. It would be our provider that would provide those kind of services and not Alliance. I called her provider, and unfortunately they have no residential settings under their umbrella. She did look into some respite and she got a place in Wake County, which is pretty far away, a respite care community. That’s pretty much it. [Indiscernible].
Deb	It may be a conversation with your care coordinator and your provider together to talk about any options, maybe looking at another provider agency that could provide residential services so that you can get introduced to them beforehand and just talk about—because Alliance will do the service requests, but the care coordinator can help you navigate what options might be available.
Joanna	Okay.
Deb	Alright.
Joanna	Thank you so much. Goodbye.
Deb	I didn’t mean to cut you off. Oh, I miss in-person meetings, guys.
Moderator	Sorry about that. We’ll move on to line 95. Your line is open.
Ron	Oh, I think it was my number. This is Ron Lowe [ph]. The other day, I was involved in an LME board meeting, and those of you that know Tom Savage, brought up the following issue. A local business in his area was offering steep discounts to healthcare providers. So some folks working in our industry show up to take advantage of the discounts, and they were told they were not considered healthcare providers. I was hoping that maybe somebody could take a look at that, and maybe in the governor’s daily report, if he or maybe Cohen or someone could address that and let the businesses know that those mental health workers are healthcare providers because they go into the homes and you know the whole drill. That’s my concern, if something could be done about that. Thank you.
Deb	Thank you so much for bringing that up. We will put that forward.
Ron	Thank you.

Dr. Brown	Hi, sir, yes, this is Dr. Brown. I did want to say that I 100% agree with you that mental health workers are healthcare providers, and what we've tried to do on our website is to try to clarify that. So I know on the Department website, you might notice that when there's guidance for healthcare workers, we've actually put behavioral health. We've called out behavioral health as a healthcare worker in that same set of guidance's. But I agree we could do more to sort of reinforce that concept, and I appreciate you bringing it up.
Ron	Thank you. Gas station owners not going to be reading that website. I doubt it. Very little. That's why if something can be done via the press, via news, I think it would be greatly appreciated.
Dr. Brown	Yes. Thanks for the comments.
Moderator	Next, we'll to the line of 124. Please go ahead.
Laurie	Hi, my name's Laurie Ledbetter [ph]. My husband Jim and I are here on behalf of our daughter Rachel who in an ICF group home. She is autistic and non-verbal and has significant behaviors. And for the most part, they're well-managed, but she is going on her sixth week of being shut in at her group home. It's in Durham, and they can't leave. And they have a day program offsite that is about ten minutes away that they shut down. When they closed the doors, it was March 18 when we were told we couldn't come see her, which I understand.
	But they have been shut in, and this is the sixth week. I'm trying to see if the day program can't be opened back up for them at least to get out. It's a Monday through Friday day program and for them to at least be able to get out of the house, even if it's one day a week, because I know—this is a women's group home. I know the men's group home goes also, and then a third group home, I believe it's in Sanford, comes and uses that facility.
	So I understand they all can't be there at the same time, but it would be everybody in the group home with Rachel who would be going. I'm just looking for it one day a week. But I'm very concerned. Her behaviors have escalated, and I'm just concerned about her mental health with not being able to get out.
	I've made several phone calls trying to see if we can't get creative in trying to do something, haven't really made much headway at all. So I

was just seeing if you all could guide us or give us somewhere else that we might be able to call or maybe give us an answer. I don't know.

Michiele — This is Michiele with DHSR.

Laurie — Hi, Michiele.

Michiele — I totally understand what you're saying, and so many of our facilities are grappling with that. With the ICF facilities, they also fall under CMS certification, so they're trying to adhere very closely to the CMS guidelines about visitation and going offsite. And that may be where a lot of the hesitation is coming from.

Laurie — Well, I'm just [voices overlapping]. I'm sorry.

Michiele — No. I was going to say that for us, these settings, a lot of them have extremely fragile folks medically, and so they're extremely cautious about having the clients leave the site or having someone come onsite.

Laurie — Right, which I understand, but like I said, everybody in the group home, it's six women and at least two caregivers per shift. They would be just traveling with them. It's about seven to ten, I don't even think it's ten minutes away, to the facility. No one else would come in. I mean, I'm trying to think, is there not some creative way that they could at least get out the house and with the same group of people that they're in the house with now, not have anybody else come in?

They have three shifts that currently come in. I'm sure their temperature's taken and all that with each shift change, so I know all the precautions are taken and it would just be the same people, just a change of scenery. I understand everything. Nobody else can come in. And I understand why we can't see her. It's been six weeks now, and it's just of great concern to us about her mental health. I don't know about anyone else, but I know she's had some hard times.

Michiele — What I'd like you to do, if you're willing, is to email me so that I can, myself or one of our staff, can give you a call, talk about this individual situation. Perhaps reach out to the facility and find out what measures they're putting in place for people for their clients to have activities during the day and if there is any work around for this. My email is michiele.elliott@dhhs.nc.gov.

	And I work with a gentleman, Steve, who has a lot of expertise with the ICF facilities and knows a lot of them from having visited and would love to have him be able to talk to you and get a better understanding, and then we can reach out to the facility.
Laurie	Okay. And let me make sure, Michiele, I got your spelling right. michiele.elliott@dhhs.nc.gov?
Michiele	That's correct. Right.
Laurie	Okay. Yes, I certainly will, and I thank you for that.
Michiele	No problem.
Laurie	Okay. Thanks so much. I'll be in touch probably this afternoon.
Moderator	Thank you, and as a reminder, since you have provided your line number, you are not required to announce your name.
	We'll move on to line 175. Please go ahead.
W	Hi. I have an Innovations waiver question for my daughter who's 17. It's regarding teletherapy sessions when a provider is present. So staff is in the home during my daughter's physical therapy session, which is a teletherapy session, and that requires hands-on assistance. Can the staff provide and be paid for that hands-on assistance? Because I don't want to get into a double billing situation, but that would be very helpful if the staff could do that.
Deb	That is a very good question, and typically you cannot, but I will happily take that question back because we're in strange times. So I can, if you want to send me an email, I will follow up on your question.
W	Okay. Is this Michiele Elliot, or is this somebody else?
Deb	This is Deb Goda, so it's deborah.goda@dhhs.nc.gov.
W	Okay. Great. Thank you.
Deb	Thank you.
Moderator	Our next question will come from line 62. Please go ahead.

W	Hi. My question's also along the lines of physical therapy. So, is there any flexibility in the assisted technology equipment and a limitation on the budget for that? Because physical therapy—our son uses a lot of equipment, and this is equipment that he can also use at home safely. It's just that he doesn't have access to it right now. So in the long term, it might be better for him to have it anyway so that he can use it more effectively and efficiently. So considering now that he can't go to physical therapy safely, is there any consideration that he can get this at home so that he doesn't lose ground and he can then continue using it long term, thereby reducing [indiscernible] physical therapy services needed?
Deb	I understand, and that would be durable medical equipment. If you would like to send me an email, I will happily pass that on to our durable medical equipment folks. It's a little bit outside of what I do day-to-day, so I don't know the answer to that. But I'll happily get you to the right folks.
W	Okay. So I was told that there's also the assisted tech service in the Cardinal Innovations waiver. I'm sorry. I'm not very—
Deb	Oh, no, no. You're right. We do have an assisted technology category, but that is for only for things that cannot be covered under durable medical equipment because we're not allowed to pay for under the waiver what can be paid for through regular Medicaid. So if he's doing physical therapy exercises with something that's coverable under durable medical equipment, we can't pay for it through the waiver.
W	Okay. And who should I send the email to? I'm sorry.
Deb	My name's Deb Goda, and my email [overlapping voices]. You got it?
W	I got it. Yes. Thank you.
Deb	Okay.
W	Thank you.
Deb	You're welcome.
Moderator	Thank you. Next we'll go to line 188. Please go ahead.

W

Yes, hi. This goes back to a question they asked earlier. I have an adult son who needs assistance and parents that are close to 70. And so I wanted to know if he's on the registry of needs, what would we do? We don't have a care manager. He is on CAP/DA [ph], but I don't know what we would do if we were to become sick.

Deb

And with CAP/DA, if I'm not mistaken, you do have a case manager. CAP/DA also has respite programs that are available, and they do have a lot of the same Appendix K waivers that we have. So I would say reach out to your case manager, and let them know that these are your concerns. And ask them to help you with some contingency plans.

W

Okay. Thank you.

Deb

You're welcome.

Moderator

Next we have a question from line 89. Your line is open.

Amy

Hi there. This is Amy Brindle [ph]. I just wanted to first off take a second to thank everyone that does these calls. I know we all, especially the parents and caregivers feel so isolated right now. And this has been like a lifeline that we can actually have someone to talk to, and you all have been so forthcoming with your answers. And if you don't know, with your emails.

But this is something that was touched on last week, and I think Kody answered it. If someone is hospitalized, and I appreciate and respect all the protocols of the hospital, but we know a special needs child or adult is going to be in a completely different situation than if it's one of us. They may not even understand what's going on.

And I know that you said you're working with the hospitals and that maybe it was through ADA that they have the right to have their caregiver present, but I know that my son, who is on a ventilator at night already, would be scared. I don't know if he would give up. And a lot of others just simply wouldn't understand. And it's just a terrifying thought that we would be separated in a situation like that.

Can you go back over what we might need to say if that were to happen so that we were allowed access into the hospital with our loved one?

Victor I don’t know if Deputy Secretary Kinsley is still on the line or not. This is Victor. What I will say is a couple of things. One is, and I know it has seemingly taken us forever to get this guidance out, but we do have some guidance that we are hopefully going to get published this week. And it does speak to what the Office of Civil Rights says about the ability to accompany someone with developmental disabilities in a hospital setting as well as ADA guidelines.

What I would say is that you can actually refer them to the ruling which we will have posted on our website. We do recognize that hospitals are doing all they can to try to keep all the patients safe and all the visitors safe. So there will probably be hospital settings where they will be hesitant to want to allow someone in to accompany a loved one, and that’s going to be important to be able to speak to those guidelines.

But I think probably your best bet will be to refer them to what the ruling says, and the ruling does say very clearly that for persons in a hospital setting, that they may require additional supports, including someone to be with them when they are in a hospital setting.

Amy Okay. And if they just said no, then we can refer them back to your website?

Victor You can refer them to the website. The website is going to refer them to what the ruling says. So actually you are referring them back to the Office of Civil Rights or to the ADA guideline.

Amy Okay.

Victor Yes, you can just refer to them to the guidelines from the Office of Civil Rights or to the Medical Disabilities Act.

Amy Okay. I appreciate that so much because I know so many parents are really worried about that. Even if it’s not COVID, they’re still not allowing visitors. So if they were to be hospitalized for another reason, it would still be under those same protocols.

Victor Yes. And the hospital visitation policies are likely to vary a little bit from one hospital system to the next, so being able to refer them to what the official rulings and official guidelines say would be your safest recourse.

Amy Okay. Thank you so very much.

Victor You're welcome.

Dr. Brown This is Dr. Brown. I think the other thing that you can do is to try to the extent that you can talk to, or request to talk, it's always hard, I know, but a request to talk to the attending physician for your loved one. The original CMS guidance did permit visitors in a situation of end of life and also for critical, emotional wellbeing situations.

So it may be that you, working with the loved one's treatment team, can advocate on a case-by-case basis for certain times of the day, be creative about how it gets figured out. But that may be another avenue just to try pursuing.

Moderator Thank you. [Operator instructions]. We do have another question. Give me just a moment please. Our next question is from line of 288, please go ahead.

W Yes, in regards to the earlier question about crisis and what to do with our children in crisis or if we were taken ill. And the suggestions—well, it's ironic. I just dropped my daughter off at NC START which has two respite beds in the triangle area, crisis respite beds. I've been trying to get her in since December, and so while all your suggestions are well and good, frankly most of them are not operational.

Obviously now she's not in for the crisis she was in in December. I had to take her to the emergency room after we looked for two days for respite. But in terms of temporary AFLs or any of that, we couldn't find anything. And I just think those are not rounded in reality recommendations, with all due respect. There's just nothing out there for us.

And I have a great care coordinator, and it's just not there. When two of us spend two full days trying to find something and can't find anything, there's something wrong. And there's more people in crisis now than ever, I'm sure.

Deb I understand, and I'm sorry that was your experience. And I'm sorry if it seems like a trite answer. It's the starting place. It's just start having those conversations with others and with the family. And yes, it's hard to get somebody when you're having a mental health crisis in addition to your developmental disability.

W I don't want to call it trite. I respect your response, but I'm not always sure that the responses are grounded in what's out there. I think there just isn't anything. And earlier, I heard you say, or someone, I don't know who it was, say, well, if you're on the registry for unmet needs, you have a whatever they're called now, care manager, care whatever.

I have had to inform person after person of that reality, and they say, oh no, we're not entitled. And I said, yes, you are. You call your MCO, and you say I need someone to help me. And then they get one. But people aren't even being told that by the MCO/LMEs. There's such a gap in information; it's appalling to me.

Deb And I think that that is, we need to continue. I know we're trying to give out as much information as we can now, and I think we need to continue that after the crisis has passed as well.

W And encourage the MCOs that when they send the letter of being on the waitlist, that they say, you may have a care manager or here is the person that you call if you have problems or need assistance. I think it's incumbent upon the MCOs, but they're not doing them.

So that's all. I have a bunch of comments. I'm really frustrated, but I'm glad my daughter's in respite for a month.

Deb Thank you so much.

Moderator Thank you. And we have time for one last question that will come from line 64. Please go ahead.

W I have two tools that I would like to email that you could get to some of these people in reference to what happens to me when I get sick, what happens to my individual. And one is a COVID-19 disability form, and it's very pertinent to what they just spoke of if what if the individual goes and is non-verbal, perhaps doesn't even know how to wash their hands sort of situation.

So it's a good tool. I don't know how it was developed or who developed it, but I think it would be a good place to start have dialogue. And also there's a webinar. I believe it's maybe tomorrow or maybe Wednesday that is talking to the very topic as well. And I'd like to get that event addressed to you so you can spread it. Should I send it to Suzanne?

Suzanne Yes, please.

W Got it. Okay. It will come your way. Thanks.

Suzanne And on that note, I want to thank everybody for their wonderful questions, your continued participation in these calls. You can continue to ask your questions through the web form on the CMH website or through the bhidd.covidquestions email. So feel free to continue to ask your questions.

For the near future, we will continue to have these calls, and we will continue to send out the reminders at the end of the week for the following week. And thank you again for your time. That will conclude today's call.

Moderator Thank you. With that, that does conclude our conference for today. We thank you for your participation and for using AT&T teleconference. You may now disconnect.