Introduction

Purpose

The Disability-Competent Care Self-paced Training Assessment Review Tool (DCC-START) is for health plans, health systems, and health care provider organizations to assess their disability-competent care (DCC) training and identify opportunities to augment their training to support DCC. The DCC-START consists of a series of questions across the major pillars of DCC. After answering these questions, you will be directed to resources tailored to your responses that can enhance the effectiveness and completeness of your DCC training materials.

For more focused results, respond to all questions as accurately as possible. It may also be helpful to have training materials readily available while completing the tool. For more information on how to use and complete the DCC-START please refer to the User Guide.

Organization of the Tool

Demographics: This section covers six key questions on characteristics about the participant population. Staff completing the self-paced assessment should understand the population being served by the organization and their overall needs.

Preliminary Assessment: This portion of the assessment asks ten questions to identify which section(s) of the subsequent DCC Self-Paced Assessment are most relevant.

DCC Self-Paced Assessment: The self-paced assessment includes a list of eight to 35 questions based on responses in the Preliminary Assessment section. Answers to these questions will determine opportunity areas in the Summary section.

Summary: This section includes opportunity areas for training staff on DCC. There are two parts to the summary: (1) a recap of participant population characteristics and (2) opportunity areas based on responses to the Preliminary Assessment and DCC Self-Paced Assessment.

Navigating this Tool

Complete each section in the order that the tabs appear on the bottom of the workbook, from left to right.

Demographics Tab (not linked to any logic or coding)

Which of the following represents the largest percentage of your participant population?

1. Payer type
   - Medicare only
   - Medicaid only
   - Persons with both Medicare and Medicaid
   - Other/Unsure

2. Health status
   - Persons with 0-3 chronic conditions
   - Persons with 4-6 chronic conditions
   - Persons with 7+ chronic conditions
   - Unsure

3. Community of residence
   - Urban community
   - Suburban community
   - Rural community
   - Other/Unsure

4. Residential setting
   - Institutional
   - Shared or supported living
   - Alone (with or without long-term services and supports (LTSS))
   - With family
   - Other/Unsure

5. Age distribution
   - 0-18 years
   - 19-25 years
   - 26-44 years
   - 45-64 years
   - 65-84 years
   - 85+ years
   - Unsure

6. Identified health concerns
   - Physical disabilities
   - Intellectual disabilities
   - Sensory challenges (e.g., seeing, hearing)
   - Behavioral health issues (e.g., mental health, cognitive disabilities, substance abuse)
   - Other/Unsure

Preliminary Assessment

Are your staff trained in…

Q#	Question	Trigger Q#	Trigger Q
1	Providing accommodations to persons with a disability in health care settings and the significance of accessibility in communities? (1)	15	Are staff trained to address and accommodate physical and equipment access? (4.2)
1	Providing accommodations to persons with a disability in health care settings and the significance of accessibility in communities? (1)	29	Are staff trained to enhance the participant's functional capabilities through the use of equipment and environmental modifications? (6.3)
1	Providing accommodations to persons with a disability in health care settings and the significance of accessibility in communities? (1)	30	Are staff trained in accessing local community resources? (6.4)
2	Identifying and understanding the diverse experiences of persons with a disability? (2)	9	Are staff trained to understand how adjusting to a disability varies depending on the participant's experiences? (2.2)
2	Identifying and understanding the diverse experiences of persons with a disability? (2)	11	Are staff trained regarding the difference between aging with a disability and aging into being functionally disabled? (2.4)
3	Providing access to health care and the rights of individuals with disabilities? (3)	13	Are staff trained in how the Americans with Disabilities act (ADA) applies to the delivery of health care services? (3.1)
3	Providing access to health care and the rights of individuals with disabilities? (3)	14	Are staff trained regarding the basic principles of the Olmstead decision and how it applies to accessing long-term services and supports (LTSS)? (3.2)
3	Providing access to health care and the rights of individuals with disabilities? (3)	15	Are staff trained to address and accommodate physical and equipment access? (4.2)
3	Providing access to health care and the rights of individuals with disabilities? (3)	18	Are staff trained to identify and address procedural access issues, such as scheduling and appointment duration? (4.4)
3	Providing access to health care and the rights of individuals with disabilities? (3)	17	Are staff trained in documenting and making information regarding provider access available to both participants and care coordinators? (4.6)
4	Identifying, addressing, and removing barriers to health care for individuals with a disability? (4)	15	Are staff trained to address and accommodate physical and equipment access? (4.2)

DCC-START – *Preliminary Assessment Tab Crosswalk*

Q#	Question	Trigger Q#	Trigger Q
4	Identifying, addressing, and removing barriers to health care for individuals with a disability? (4)	16	Are staff trained to identify and address communication barriers commonly experienced by individuals with disabilities? (4.3)
4	Identifying, addressing, and removing barriers to health care for individuals with a disability? (4)	18	Are staff trained to identify and address procedural access issues, such as scheduling and appointment duration? (4.4)
4	Identifying, addressing, and removing barriers to health care for individuals with a disability? (4)	19	Are staff trained in understanding how financial challenges may affect individuals with disabilities? (4.5)
4	Identifying, addressing, and removing barriers to health care for individuals with a disability? (4)	17	Are staff trained in documenting and making information regarding provider access available to both participants and care coordinators? (4.6)
5	Implementing the care coordination components and practices? (5)	20	Are staff trained about the importance of establishing a trusting relationship with the participant? (5.2)
5	Implementing the care coordination components and practices? (5)	24	Are staff trained about the role of the interdisciplinary team (IDT) and the importance of working as a team? (5.3)
5	Implementing the care coordination components and practices? (5)	22	Are staff trained about the difference between formal and informal supports and their value to the participant? (5.9; 6.2)
6	The concepts of providing person-centered care to individuals with a disability? (5)	25	Are staff trained about the components of a comprehensive participant assessment? (5.5)
6	The concepts of providing person-centered care to individuals with a disability? (5)	26	Are staff trained about the key components of an individualized plan of care (IPC)? (5.6)
6	The concepts of providing person-centered care to individuals with a disability? (5)	27	Are staff trained to assess and support the participant's ability to self-direct? (5.7)
7	Supporting the participant's choice in utilizing community-based services? (6)	28	Are staff trained to support the participant's choices related to independent living and long-term services and supports (LTSS)? (6.1)
7	Supporting the participant's choice in utilizing community-based services? (6)	29	Are staff trained to enhance the participant's functional capabilities through the use of equipment and environmental modifications? (6.3)
7	Supporting the participant's choice in utilizing community-based services? (6)	30	Are staff trained about accessing local community resources? (6.4)
8	Integrating behavioral health in primary care? (7)	31	Are staff trained about behavioral issues, mental illness, substance abuse, and chemical dependency? (7.3)

DCC-START – *Preliminary Assessment Tab Crosswalk*

Q#	Question	Trigger Q#	Trigger Q
9	Mental illness, substance abuse, and chemical dependency? (7)	32	Are staff trained to identify and address mental health issues? (7.1)
9	Mental illness, substance abuse, and chemical dependency? (7)	33	Are staff trained about the differences between chemical dependency and substance abuse? (7.2)
9	Mental illness, substance abuse, and chemical dependency? (7)	31	Are staff trained about behavioral issues, mental illness, substance abuse, and chemical dependency? (7.3)
9	Mental illness, substance abuse, and chemical dependency? (7)	34	Are staff trained about the recovery approach to mental health and cognitive disabilities? (7.4)
10	The various types of disability? (1)	10	Are staff trained about progressive disabilities and the impact they have on a person's ability to adjust to new and possibly continuing limitations? (2.3)
10	The various types of disability? (1)	12	Are staff trained about the differences between intellectual disabilities and cognitive disabilities? (2.6)
10	The various types of disability? (1)	35	Are staff trained about the common limitations demonstrated by individuals with intellectual disabilities? (2.5)

Self-Paced Assessment (Q1-8)

Q#	Question	Trigger Q#	Trigger Q
1	Are staff trained regarding the need to focus on functional limitations as compared to medical diagnoses? (1.1, 5.4)	11	Are staff trained regarding the difference between aging with a disability and aging into being functionally disabled? (2.4)
1	Are staff trained regarding the need to focus on functional limitations as compared to medical diagnoses? (1.1, 5.4)	29	Are staff trained to enhance the participant's functional capabilities through the use of equipment and environmental modifications? (6.3)
1	Are staff trained regarding the need to focus on functional limitations as compared to medical diagnoses? (1.1, 5.4)	32	Are staff trained to identify and address mental health issues? (7.1)
2	Are staff trained regarding the key categories and types of disabilities? (1.2)	10	Are staff trained regarding progressive disabilities and the impact they have on a person's ability to adjust to new and possibly continuing limitations? (2.3)
2	Are staff trained regarding the key categories and types of disabilities? (1.2)	12	Are staff trained regarding the differences between intellectual disabilities and cognitive disabilities? (2.6)
3	Do staff know participant demographics? (1.3)	9	Are staff trained to understand how adjusting to a disability varies depending on the participant's experiences? (2.2)
3	Do staff know participant demographics? (1.3)	11	Are staff trained regarding the difference between aging with a disability and aging into being functionally disabled? (2.4)
4	Are staff trained regarding possible health care disparities for individuals with a disability? (1.4)	9	Are staff trained to understand how adjusting to a disability varies depending on the participant's experiences? (2.2)
4	Are staff trained regarding possible health care disparities for individuals with a disability? (1.4)	12	Are staff trained regarding the differences between intellectual disabilities and cognitive disabilities? (2.6)
4	Are staff trained regarding possible health care disparities for individuals with a disability? (1.4)	15	Are staff trained to address and accommodate physical and equipment access? (4.2)
4	Are staff trained regarding possible health care disparities for individuals with a disability? (1.4)	16	Are staff trained to identify and address communication barriers commonly experienced by individuals with disabilities? (4.3)
4	Are staff trained regarding possible health care disparities for individuals with a disability? (1.4)	18	Are staff trained to identify and address procedural access issues, such as scheduling and appointment duration? (4.4)
4	Are staff trained regarding possible health care disparities for individuals with a disability? (1.4)	19	Are staff trained in understanding how financial challenges may affect individuals with disabilities? (4.5)

DCC-START – *Self-Paced Assessment Tab (Q1-8) Crosswalk*

Q#	Question	Trigger Q#	Trigger Q
4	Are staff trained regarding possible health care disparities for individuals with a disability? (1.4)	30	Are staff trained in accessing local community resources? (6.4)
5	Are staff trained in identifying and understanding participant needs and concerns? (1.5)	17	Are staff trained in documenting and making information regarding provider access available to both participants and care coordinators? (4.6)
5	Are staff trained in identifying and understanding participant needs and concerns? (1.5)	25	Are staff trained regarding the components of a comprehensive participant assessment? (5.5)
5	Are staff trained in identifying and understanding participant needs and concerns? (1.5)	26	Are staff trained regarding the key components of an individualized plan of care (IPC)? (5.6)
5	Are staff trained in identifying and understanding participant needs and concerns? (1.5)	27	Are staff trained to assess and support the participant's ability to self-direct? (5.7)
6	Are staff trained regarding the differences between the traditional medical model and the person-centered care model? (2.1)	27	Are staff trained to assess and support the participant's ability to self-direct? (5.7)
6	Are staff trained regarding the differences between the traditional medical model and the person-centered care model? (2.1)	21	Are staff trained regarding transition plans and the unique needs they may serve for individuals with disabilities? (5.8)
6	Are staff trained regarding the differences between the traditional medical model and the person-centered care model? (2.1)	22	Are staff trained regarding the differences between formal and informal supports and their value to the participant? (5.9; 6.2)
6	Are staff trained regarding the differences between the traditional medical model and the person-centered care model? (2.1)	28	Are staff trained to support the participant's choices related to independent living and long-term services and supports (LTSS)? (6.1)
7	Are staff trained to consider how biases and experiences may influence attitudes regarding persons with disabilities? (4.1)	20	Are staff trained regarding the importance of establishing a trusting relationship with the participant? (5.2)
7	Are staff trained to consider how biases and experiences may influence attitudes regarding persons with disabilities? (4.1)	23	Are staff trained to identify and address potential signs of abuse for individuals with a disability? (5.10)
8	Are staff trained regarding the concepts of dignity of risk and self-determination? (5.1)	21	Are staff trained regarding transition plans and the unique needs they may serve for individuals with disabilities? (5.8)
8	Are staff trained regarding the concepts of dignity of risk and self-determination? (5.1)	28	Are staff trained to support the participant's choices related to independent living and long-term services and supports (LTSS)? (6.1)

DCC-START – *Self-Paced Assessment Tab (Q1-8) Crosswalk*

Q#	Question	Trigger Q#	Trigger Q
8	Are staff trained regarding the concepts of dignity of risk and self-determination? (5.1)	23	Are staff trained to identify and address potential signs of abuse for individuals with a disability? (5.10)
8	Are staff trained regarding the concepts of dignity of risk and self-determination? (5.1)	22	Are staff trained regarding the differences between formal and informal supports and their value to the participant? (5.9; 6.2)

Self-Paced Assessment (Q9-35)

Q#	Question	Tool section
9	Are staff trained to understand how adjusting to a disability varies depending on the participant's experiences? *(2.2)*	2.2
10	Are staff trained regarding progressive disabilities and the impact they have on a person's ability to adjust to new and possibly continuing limitations? *(2.3)*	2.3
11	Are staff trained regarding the differences between aging with a disability and aging into being functionally disabled? (*2.4)*	2.4
12	Are staff trained regarding the differences between intellectual disabilities and cognitive disabilities? *(2.6)*	2.6
13	Are staff trained in how the Americans with Disabilities Act (ADA) applies to the delivery of health care services? *(3.1)*	3.1
14	Are staff trained regarding the basic principles of the Olmstead decision and how it applies to accessing long-term services and supports (LTSS)? *(3.2)*	3.2
15	Are staff trained to address and accommodate physical and equipment access? *(4.2)*	4.2
16	Are staff trained to identify and address communication barriers commonly experienced by individuals with disabilities? *(4.3)*	4.3
17	Are staff trained in documenting and making information regarding provider access available to both participants and care coordinators? *(4.6)*	4.6
18	Are staff trained to identify and address procedural access issues, such as scheduling and appointment duration? *(4.4)*	4.4
19	Are staff trained in understanding how financial challenges may affect individuals with disabilities? *(4.5)*	4.5
20	Are staff trained regarding the importance of establishing a trusting relationship with the participant? *(5.2)*	5.2
21	Are staff trained regarding transition plans and the unique needs they may serve for individuals with disabilities? *(5.8)*	5.8
22	Are staff trained regarding the differences between formal and informal supports and their value to the participant? *(5.9; 6.2)*	5.9; 6.2
23	Are staff trained to identify and address potential signs of abuse for individuals with a disability? *(5.10)*	5.10
24	Are staff trained regarding the role of the interdisciplinary team (IDT) and the importance of working as a team? *(5.3)*	5.3
25	Are staff trained regarding the components of a comprehensive participant assessment? *(5.5)*	5.5
26	Are staff trained regarding the key components of an individualized plan of care (IPC)? *(5.6)*	5.6
27	Are staff trained to assess and support the participant's ability to self-direct? *(5.7)*	5.7
28	Are staff trained to support the participant's choices related to independent living and long-term services and supports (LTSS)? *(6.1)*	6.1
29	Are staff trained to enhance the participant's functional capabilities through the use of equipment and environmental modifications? *(6.3)*	6.3
30	Are staff trained in accessing local community resources? *(6.4)*	6.4

DCC-START – *Self-Paced Assessment Tab (Q9-35) Crosswalk*

Q#	Question	Tool section
31	Are staff trained regarding behavioral issues, mental illness, substance abuse, and chemical dependency? *(7.3)*	7.3
32	Are staff trained to identify and address mental health issues? *(7.1)*	7.1
33	Are staff trained regarding the differences between chemical dependency and substance abuse? *(7.2)*	7.2
34	Are staff trained regarding the recovery approach to mental health and cognitive disabilities? *(7.4)*	7.4
35	Are staff trained regarding the common limitations demonstrated by individuals with intellectual disabilities? *(2.5)*	2.5

Summary

The intent of the Disability-Competent Care Self-paced Training Assessment Review Tool (DCC-START) is to assist the organization's leadership and staff to strengthen efforts to promote disability-competent care (DCC). The DCC-START delineates the organization's current DCC training practices and identifies a core set of training components. The opportunity areas are based on the responses to each section of the tool. These opportunities are recommended to enhance disability competence training, implementation, and adherence.

The companion list of resources in the User Guide will assist in addressing the opportunities identified below. This list is not comprehensive, but can be considered as a starting point. Additional resources are available at the Resources for Integrated Care website (https://www.resourcesforintegratedcare.com).

Health plan/Org: Date completed:

Demographics Information

[bullets based on responses]

Opportunity Areas

The following is a list of opportunity areas recommended to strengthen your DCC training materials. These opportunities are listed by training component and are based on responses in the Preliminary Assessment and DCC Staff Training Assessment sections. There are a variety of methods through which training can be delivered, received, and conducted. The use of different training mediums may be beneficial and could include videos, first-person stories, role playing, dialogue, problem-solving discussions, and presentations. As an added practice, instituting comprehension reviews can test the disability readiness and aptitude of staff and having training materials readily available may assist in supporting the implementation and/or refinement of DCC practices.

1. Understanding the population being served

Most people will experience some disability, temporary or permanent, over the course of their lifetime. Disability does not define individuals, their health, their talents, or their abilities. Disability is the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, developmental, or some combination of these. Disability may refer to, for example, difficulty walking, balancing, climbing, seeing, hearing, reading, understanding, or remembering.

The impact of disability varies across individuals and may reflect the interaction between the person and his or her environment. For example, a person who uses a wheelchair and lives in a community with accessible transportation, pathways, parking, and buildings and whose workplace, school, and health care providers offer accommodations, experiences disability differently than a person whose environment is not accessible and where accommodations are not provided. It is important to note that not everyone identifies as having a disability, even though they may have a physical or mental impairment that could benefit from accessibility or accommodations in health care settings.

1.1. Are staff trained regarding the need to focus on functional limitations as compared to medical diagnoses?

A diagnosis identifies the source of an individual's disability while functional status identifies the impact of the disability. Someone with a disability-related diagnosis may or may not have diagnosis-related functional limitations. For example, a person diagnosed with arthritis - who has inflammation in connective tissue, may not have limitations performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs) yet it is still considered a disability. There are three key elements for staff to understanding functional limitations:

1. ***Define functional limitations.*** Functional limitations impact a person's ability to perform ADLs or IADLs.
2. ***Identify ADLs and IADLs.*** ADLs are self-care tasks such as feeding, bathing, and dressing. IADLs are tasks that enable an individual to live independently in a community, such as using a telephone or communication device, conducting housework and basic home maintenance, shopping, and managing finances.
3. ***Understand why it is important to focus on functional limitations.*** Identifying limitations is the starting point for implementing accommodations and providing needed long-term services and supports (LTSS).

1.2. Are staff trained regarding the key categories and types of disabilities?

1. ***Identify the four major categories of disability.*** 1) Physical, e.g., spinal cord injury, multiple sclerosis; 2) intellectual or developmental (ID), e.g., cerebral palsy, autism; 3) sensory, e.g., vision, hearing; and 4) behavioral, e.g., schizophrenia, major depression, alcoholism.
2. ***Identify the differences between visible/invisible and permanent/temporary disabilities.*** Visible disabilities are those that are readily evident to an observer (e.g., the need to use a wheelchair). Invisible or hidden disabilities may not be as easy to identify such as: hearing or vision loss; diabetes, arthritis, or mental illness; difficulty remembering, learning, or understanding; and endurance limitations. Visible and invisible disabilities can be either permanent or temporary. Permanent disabilities are limitations that will remain with individuals for the rest of their lives (e.g., cerebral palsy, multiple sclerosis). Temporary disabilities are only with individuals for a limited duration, such as broken bones or impairments following surgery or cancer treatments.
3. ***Understand why it is important to know if a participant has a disability.*** If the participant has a disability, either visible/invisible or permanent/temporary, he or she may have functional issues that need to be addressed.

1.3. Do staff know participant demographics?

1. ***Identify the prevalence of disabilities in the participant population.*** Determine the disability prevalence in the service area by assessing the target participant population and the level and type of services being offered.
2. ***Identify the participant's disabilities.*** Identifying the prevalence of disabilities allows staff to determine, identify and be aware of the different types of disabilities within their target participant population.

1.4. Are staff trained regarding possible health care disparities for individuals with a disability?

1. ***Understand how age, race, and socioeconomic factors affect individuals with disabilities.*** Disability is present at higher rates among communities of color, persons with low socioeconomic status, and those living in rural areas. Individuals with disabilities are more likely than those without disabilities to have:
    a) Poorer overall health (e.g., complications from diabetes, stroke);
    b) Less access to adequate health care; and
    c) Increased presence of primary or secondary conditions (e.g., pain, fatigue, obesity, inactivity, smoking, depression).

1.5. Are staff trained in identifying and understanding participant needs and concerns?

1. ***Understand the benefits of including people with disabilities as advisors.*** Participant experiences can assist in identifying opportunities for improvement in the care of individuals with disabilities.
2. ***Identify methods or options for including people with disabilities as advisors.*** Including participants as advisors can help forge a better understanding of the population. Participants may become involved through participating on advisory committees, focus groups, and workgroups; responding to satisfaction surveys; and providing feedback online and via community forums.

2. Understanding the disability experience

The experience of having a disability varies from person to person. An individual's experience of his or her disability is dependent upon the type of disability (e.g., physical, cognitive), its manifestation, environment, age of onset, and status (i.e., stable or progressive). Further, the disability experience varies based on its impact on one's life, choices, and the availability of family, friends, and peer support.

2.1. Are staff trained regarding the differences between the traditional medical model and the person-centered care model?

1. ***Identify the differences between the traditional medical model and the person-centered care model.*** There are two common frameworks for understanding the way people experience disability. In the medical model, disabilities are viewed as impairments to be cured and fixed through clinical interventions. Under person-centered care, disability is experienced when interacting with the environment. Disability is seen as a construct of society, in which barriers reside in the environment and not in the individual. Thus, people with disabilities are not problems to be fixed; instead, removing barriers is the solution to providing care to individuals with disabilities.

2.2. Are staff trained to understand how adjusting to a disability varies depending on the participant's experiences?
1. ***Identify developmental periods when the onset of a disability can occur.*** a) At birth, commonly referred to as congenital (e.g., cerebral palsy, epilepsy, down syndrome); b) In early developmental years (e.g., intellectual or learning disabilities); c) Adolescence or young adulthood (e.g., spinal cord, brain injuries from an accident or schizophrenia); and d) Later in life (e.g., stroke or cardiac conditions that are commonly related to aging). 2. ***Understand the different dynamics and adjustment processes related to when a disability is acquired.*** For individuals born with or who acquire a disability early in life, the disability is innate to their self-image. Acquiring a disability later in life requires an adjustment to the disability and can affect a person's self-image and perception of the future.
2.3. Are staff trained regarding progressive disabilities and the impact they have on a person's ability to adjust to new and possibly continuing limitations?
1. ***Identify disabilities that are progressive (i.e., not static).*** Progressive disabilities include multiple sclerosis, muscular dystrophy, and amyotrophic lateral sclerosis (ALS). Some disabilities are not progressive (e.g., cerebral palsy); however, limitations may change as people age or acquire other health conditions or disabilities. 2. ***Understand how a progressive disability impacts an individual's functional limitations and requires an adjustment to the disability.*** Progressive disabilities involve the individual living with an uncertainty of functional changes and a potential decline in overall health status. Progressive disabilities require an evolving understanding and adjustment to the change in functional limitations.
2.4. Are staff trained regarding the differences between aging with a disability and aging into being functionally disabled?
1. ***Identify functional limitations that are commonly the result of aging.*** Loss of function is a common result of the aging process, regardless of whether the individual has lived with a disability. Living with a disability for many years can accelerate the aging process. Age-related limitations can include diminished mobility, vision, hearing, balance, and memory. 2. ***Understand that individuals with long-term physical disabilities may experience age-related chronic conditions and impairments sooner than others in their age group.*** Disability-related aging risks include reduced bowel, bladder, and respiratory functions, skin breakdown, and permanent muscle or tendon shortening (contractures). 3. ***Identify secondary conditions that result from having a disability.*** Disability-related issues such as a sedentary lifestyle, tendencies for underuse, overuse, or misuse of various muscle groups due to atypical body mechanics, and decrease in energy and activity levels can all contribute to acquiring age-related conditions earlier in life.

2.5. Are staff trained regarding the common limitations demonstrated by individuals with intellectual disabilities?
1. ***Identify characteristics of individuals with intellectual disabilities (ID).*** Individuals with ID have limitations in understanding, expressing, learning, and remembering and may have difficulties with other cognitive functions. 2. ***Identify the needs of individuals with ID in terms of obtaining and directing health care services and supports.*** Disability-competent care honors the participant's desire to self-direct and express his or her needs. Individuals with ID may benefit from having a health care advocate or proxy assist them with identifying health care needs and obtaining care and support. 3. ***Identify the pros and cons of having family members serve as guardians or representatives.*** Individuals with ID and their families often prefer to have a family member or support person serve as a health care advocate or proxy, rather than having a professional guardian or representative. It is important to note that serving in such a role can impact or disrupt familial relationships and roles, whereas professionals can maintain a formal role that may be less complicated for family roles/relationships.
2.6. Are staff trained regarding the differences between intellectual disabilities and cognitive disabilities?
1. ***Define cognitive disability and understand how it differs from an intellectual disability (ID).*** Cognitive disabilities refer to mental limitations acquired during developmental years (after the age of 18), such as brain injury, Alzheimer's disease, and some mental illnesses. IDs originate before the age of 18 and are characterized by limitations in intellectual functioning (e.g., mental functioning and impaired skills). ID limitations can affect a person's understanding, memory, judgment, learning, and related information processing and communication functions. 2. ***Understand that cognitive challenges have an impact on all interactions in daily life.*** The ability to remember, process and access information, and make informed decisions can impact a person's ability to engage in many aspects of his or her life. An individual's interactions, relationships, roles, and independence can become complex when cognition is affected. It is important to adjust expectations knowing the effects of cognitive disabilities on a participant's daily life.

3. Understanding disability rights and practice implications

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities and promotes a person's ability to find and use services more easily, successfully, and efficiently. The ADA provides equal opportunities for education, social opportunities, housing, health care, employment, transportation, telecommunications, and access to viable options for services and choices.

3.1. Are staff trained in how the Americans with Disabilities Act (ADA) applies to the delivery of health care services?

1. ***Identify the key components of the ADA.*** The ADA prohibits discrimination of and ensures equal opportunity for individuals with disabilities in employment, state and local government services, public accommodations, transportation, and telecommunications.
2. ***Identify the core concepts underlying the ADA.*** Core concepts include: equal opportunity; inclusion; integration; physical access; effective communication; program modifications; and elimination of individual financial burden for accommodations.
3. ***Understand how the ADA applies to the delivery of health care services.*** The ADA prohibits discrimination against individuals with disabilities in daily activities, including accessing medical services. The ADA requires full and equal access to medical care services and the facilities where the services are provided. Access is not just physical (e.g., ramps, accessible doorways, equipment), but also incorporates communication access (e.g., large print, audio recordings, sign language interpreters) and programmatic access (e.g., extended hours, flexible scheduling, assistance with transfers).
4. ***Understand how to support compliance with the ADA.*** Identify and work to remove barriers to health care settings, modify policies, and eliminate discriminatory practices in violation of the ADA.

3.2. Are staff trained regarding the basic principles of the Olmstead decision and how it applies to accessing long-term services and supports (LTSS)?

1. ***Understand the implications of the Olmstead Decision.*** The Olmstead Decision of the U.S. Supreme Court requires that services for individuals with disabilities be provided in the most integrated setting appropriate to their needs, giving participants the right to choose services and where to live.
2. ***Understand how the Olmstead Decision applies to LTSS.*** Governmental entities are required to provide home- and community-based services for people with disabilities who would otherwise be entitled to institutional services when:
   a) Such placement is appropriate;
   b) The affected person does not oppose such treatment; and
   c) The placement can be reasonably accommodated, taking into account the resources available to the state and needs of other individuals with disabilities.

   In practice, eliminating institutional bias requires access to home- and community-based services and other supports, including accessible housing, transportation, personal assistance, technology, and home modifications.

4. Understanding and providing access

Achieving competency in disability care can include removing barriers to timely and appropriate health care. Disability-competent care focuses on providing care and support to maximize function and addresses barriers to integrated, accessible care. Barriers can be classified into three overlapping categories: structural (i.e., attitudinal, physical, and communication), programmatic, and financial. Though these are primary concerns in accessing medical services, individuals with disabilities may require other services and supports that meet their health care needs.

Barriers to access include:

1. ***Structural***
    - *Attitudinal* barriers include stereotypical perceptions and biases toward individuals with disabilities.
    - *Physical barriers relate to the architectural characteristics of medical offices and the accessibility of the equipment utilized for medical examinations and diagnostic procedures.*
    - *Communication barriers include language (e.g., written, spoken, visual).*
2. ***Programmatic*** barriers include aspects of how providers' offices operate, the responses of practice staff to individuals with disabilities, the absence of physician and allied health professional expertise regarding the provision of health care, and long-term services and supports for individuals with disabilities.
3. ***Financial*** barriers relate to coverage limitations for medications, durable medical equipment, mental health treatment, referrals to specialists, and treatment for chronic conditions. These barriers also include limited social opportunities, poor nutrition, and limited access to transportation.

4.1. Are staff trained to consider how biases and experiences may influence attitudes regarding individuals with disabilities?

1. ***Identify negative perceptions that can affect interactions with and provision of services to individuals with disabilities.*** Negative perceptions (e.g., stereotypes, biases, beliefs, prejudices, fears) may include: individuals with disabilities are unhealthy, asexual, of limited intellect, need help, or do not need to exercise.
2. ***Identify how to manage these perceptions so that they do not affect interactions with people with disabilities.*** Being aware of personal perceptions and working to identify biases improves comfort and understanding when caring for individuals with disabilities.
3. ***Understand the importance of participant-first language.*** Language and terms used can reflect biases. Using precise, objective, neutral, and participant-first language instead of negative language can foster positive dialogue. Examples include: replacing 'wheelchair-bound' with 'wheelchair user'; 'stroke victim' with 'person living with the result of a stroke'; 'retarded' with 'person with an intellectual disability'; and 'crippled' with 'person with a mobility disability'.
4. ***Understand that people with disabilities can experience common health challenges that others experience.*** Providers should consider discussing the same set of preventive concerns with all participants regardless of disability status. For example, lack of exercise commonly results in weight gain, smoking reduces respiratory capacity and increases susceptibility to many other health conditions, drug or alcohol use commonly results in poor judgment, and unprotected sex increases exposure to sexually transmitted diseases.

4.2. Are staff trained to address and accommodate physical and equipment access?
1. ***Identify the elements of physical access.*** Physical access encompasses transit, parking, exterior approach, entrance, interior approach (e.g., elevators, lifts), and interior (e.g., reception area, toilet, exam rooms). It is important to assess the accessibility of referral sites and referral services. 2. ***Identify the elements of medical equipment access.*** Medical equipment access encompasses exam tables, weight scales, diagnostic equipment, and procedural equipment (e.g., radiological equipment).
4.3. Are staff trained to identify and address communication barriers commonly experienced by individuals with disabilities?
1. ***Identify the types of accommodations that can affect access to health care services.*** Communication access accommodations include auditory (e.g., use of sign language, assistive listening devices), visual (e.g., use of Braille, large print, electronic, audio formats), comprehension and expression (e.g., use of pictures, simplified language), and memory (e.g., notes, lists, reminders). 2. ***Understand the importance of clear communication, on an individual's ability to obtain health care.*** Clear communication aids in the process of achieving successful outcomes, including the delivery of information, the receipt of information, and the understanding and use of information. 3. ***Identify how to improve a participant's understanding and use of health information.*** Obtain, document, and routinely update participants' communication needs and their preferred communication accommodations in their health record.
4.4. Are staff trained to identify and address procedural access issues, such as scheduling and appointment duration?
1. ***Understand the importance of embedding disability competencies into practice and culture.*** Continually assessing and improving processes, procedures, protocols, policies, and trainings builds the organization's capacity to accommodate individuals with disabilities. 2. ***Understand that training and defined practices can result in consistent programmatic and procedural access.*** Establishing a practice to accommodate access followed by continued training and attention to detail can support efforts to achieve consistency of programmatic and procedural access. 3. ***Understand that planning ahead can provide access to care by removing disruptions, long wait times, and delays.*** Documenting and updating participant-specific accommodations in his or her health record can help provide guidance in scheduling. This may assist in reducing avoidable disruptions, long wait times, and other delays. Documenting the participant's accommodations can also help with the accessibility of referral sites and referral services.
4.5. Are staff trained in understanding how financial challenges may affect individuals with disabilities?
1. ***Understand that challenges are disproportionately experienced by individuals with disabilities who have limited or inconsistent income.*** Challenges include reduced options for housing, nutrition, transportation, social opportunities, and basic necessities. 2. ***Identify how participants can obtain help with financial challenges.*** Accessing both formal financial supports (e.g., food assistance, subsidized housing) and informal supports (e.g., relying on volunteers, food banks or pantries) are key methods by which participants can obtain assistance with financial challenges.

4.6. Are staff trained in documenting and making information regarding provider access available to both participants and care coordinators?

1. ***Understand the importance of having both the provider and participant know essential information regarding access.*** Providing detailed information about individual provider access can assist participants and their care coordinators to arrange for and obtain accessible care.
2. ***Identify methods for providing accurate information regarding access to participants and their providers.*** Methods of providing information include incorporating accessibility indicators into provider directories and databases, establishing databases of provider access that can be referenced by participant services and care coordination staff, providing participants access to the information via a web-based portal, and collecting feedback on the experience of participants (e.g., via surveys, workgroups, advisory committees).

5. Understanding and providing care coordination

An interdisciplinary team (IDT) with core competencies in primary care, behavioral health, long-term services and supports, and nursing can support the provision of coordinated disability-competent care. Operating in close communication with participants and external providers, the IDT is responsible for ensuring that participants receive the care and support needed to achieve their goals and maximize their independence.

The purpose of care coordination is to ensure continuity of care for participants and to address participants' immediate needs. Care coordination requires person-centered care, including cultivating a relationship with the participant, seeing participants as people and not as their diagnoses, and recognizing that participants are often the best source of information. Person-centered care is based on the recognition that the participant is the primary source for defining care goals and needs rather than a passive recipient of medical care. The concept of dignity of risk is essential in person-centered planning. Dignity of risk honors and respects the participant's choices even if they are inconsistent with the recommendation of the IDT.

5.1. Are staff trained regarding the concepts of dignity of risk and self-determination?

1. ***Define dignity of risk.*** Dignity of risk is the concept that adults with disabilities are competent and have the right to make their own choices about their health and care, even if health care professionals believe these choices may endanger the person's health or safety.
2. ***Identify care coordination strategies that respect self-determination.*** Respecting the participant's choices begins with a discussion of his or her goals and priorities. The participant may need to be coached to state and develop a plan aimed towards fulfilling these goals. Care coordination strategies involve partnering with participants to educate and reduce or manage risk within the context of what is important to them.

5.2. Are staff trained regarding the importance of establishing a trusting relationship with the participant?

1. ***Identify ways to foster and support trust between the participant and the IDT.*** An effective care coordination relationship requires trust and starts with a discussion. Explore ways to establish and support a trusting relationship such as through active listening and engaging in discussions about the participant's goals and priorities.
2. ***Understand how communication and trust impact service outcomes.*** Consistent in-person contact between the participant and the same staff can build trusting relationships that may improve adherence to individual care plans. In-person relationships also have added benefits when identifying and addressing needs and barriers that may not be recognized through the use of telephonic care coordination.

5.3. Are staff trained regarding the role of the interdisciplinary team (IDT) and the importance of working as a team?
1. ***Understand the role of the lead care coordinator in the IDT.*** The "lead" care coordinator is usually responsible for the assessment, care planning, and reporting outcomes of the individualized plan of care (IPC). The lead care coordinator is in close communication with the participant and other medical providers and community resources and modifies the IPC as needed. 2. ***Identify the best individual to serve as the consistent communication link between the participant and his or her providers.*** One team member is selected to serve as the consistent communication link. Commonly the team member with the greatest rapport and level of trust is selected. 3. ***Identify a strategy for addressing conflict among team members.*** Team members should be prepared to address conflicts and disagreements that may occur among the team or in regard to the participant. Providing the opportunity and structure for direct, open communication while keeping the participant at the center of focus is a good strategy to prepare for potential conflicts.
5.4. Are staff trained regarding the need to focus on functional limitations as compared to medical diagnoses?
1. ***Understand the difference between medical necessity and functional necessity.*** Medical necessity is the traditional criterion used to determine eligibility for medical benefits or services that are based on a diagnosis. Functional necessity determines the need for long-term services and supports and begins with an assessment of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which identify functional needs.
5.5. Are staff trained regarding the components of a comprehensive participant assessment?
1. ***Identify the range of components included in a comprehensive assessment.*** There are three key components to providing a comprehensive assessment: a) Identifying age-appropriate preventive care needs and how they need to be modified based on the participant's health history; b) Understanding that all persons, regardless of disability status, can experience common health challenges that need to be addressed; and c) Understanding how a participant's cognitive status may impact the assessment process and implications for the participant's IPC.
5.6. Are staff trained regarding the key components of an individualized plan of care (IPC)?
1. ***Identify the key components of an IPC.*** Key components of an IPC include participant goals, plans for achieving goals (specifying 'who' does 'what' and 'when' with target completion dates), progress/status reports, and key outcomes/results. 2. ***Understand how to help a participant identify what is important.*** Coaching, motivational interviewing, health education, open discussion, and listening, while encouraging the participant in self-direction (i.e., self-advocacy) can help participants prioritize their goals.

5.7. Are staff trained to assess and support the participant's ability to self-direct?
1. ***Identify why coaching is an important care coordination component.*** Coaching helps participants identify, state, and prioritize their goals. Coaching also helps participants advocate for their needs. 2. ***Identify how participants are coached to contact their care coordinator and when.*** Materials can help participants identify their immediate needs and obtain timely assistance from care coordinators to address them. 3. ***Identify methods to prepare and support participant self-advocacy.*** Examples of participant self-advocacy include filing a grievance either formal or informal, complaining, venting, respecting differing opinions, and advocating for physical, communication and equipment access. 4. ***Identify a strategy for addressing conflicts with a participant.*** Conflicts and disagreements may occur. Addressing conflicts involves acknowledging the participant's right to have his or her own opinions and allowing for discussion on issues of potential risk while promoting and modeling respectful communication.
5.8. Are staff trained regarding transition plans and the unique needs they may serve for individuals with disabilities?
1. ***Define disability-competent transitional care.*** A specific transition plan identifies areas of risk and plans for timely intervention, especially regarding medications and home-based supports. This plan can help prevent avoidable hospitalizations or emergency department visits. 2. ***Identify common transitions experienced by individuals with disabilities.*** Examples of common transitions include admission to and discharge from a facility, using new equipment, moving to a new home, encountering a new medical condition, changing caregiver support, and changing from pediatric to adult providers.
5.9. Are staff trained regarding the differences between formal and informal supports and their value to the participant?
1. ***Identify benefits of using informal supports.*** Informal supports offer certain benefits including choice, access, flexibility, cost effectiveness, and decreased personal expense. The IDT, with the consent of the participant, can leverage those supports to be the "eyes and ears" of the IDT.
5.10. Are staff trained to identify and address potential signs of abuse for individuals with a disability?
1. ***Identify why individuals with disabilities may be at greater risk for abuse.*** Individuals with disabilities, especially individuals with physical and cognitive limitations, may be at greater risk for abuse. This is due to the person's dependency on personal care, fear of addressing any discomfort, fear of being abandoned, and confusion regarding boundaries. 2. ***Identify indicators of potential abuse.*** Symptoms of abuse include being withdrawn, depressed appearance, isolation, bruising, expressing fear or intimidation, and change in appearance. 3. ***Understand how to follow up if a person is identified as potentially at risk of abuse.*** Serving participants who are potentially at risk of abuse involves orienting staff to consumer protections, including state and provider policies and procedures to address all concerns of potential abuse.

6. Understanding and providing long-term services and supports

Long-term services and supports (LTSS) include an array of community-based services and supports that help participants maintain or strengthen their ability to live in the community. LTSS can include home health care, transportation, behavioral supports, independent living services, adult day programs, foster care, home delivered meals, home modifications, and others as identified by the state.

6.1. Are staff trained to support the participant's choices related to independent living and long-term services and supports (LTSS)?

1. ***Understand how to support community integration.*** Self-direction is an important participant skill in supporting integration in the community. Creating opportunities for increased presence and participation in the community can help individuals live comfortably and feel valued. The interdisciplinary team should encourage and support the participant's choices to actively pursue valued adult roles in life.
2. ***Understand dignity of risk as a right of participants.*** Dignity of risk is allowing participants to make informed choices as well as respecting the participant's right to make decisions even though they may put the participant at risk.
3. ***Understand the provider's role in supporting participant choices related to independent living.*** Supporting participant choices related to independent living involves identifying and reviewing viable options for participants that include risk reduction plans and community-based supports.

6.2. Are staff trained regarding the differences between formal and informal supports and their value to the participant?

1. ***Define informal and formal supports.*** Informal (i.e., unpaid) supports can include family, friends, volunteers, church members, and community program contacts. Formal (i.e., paid) supports can include personal care assistants, home maintenance and house workers, and others.

6.3. Are staff trained to enhance the participant's functional capabilities through the use of equipment and environmental modifications?

1. ***Understand functional necessity.*** Activity limitations can be identified with functional assessments. Activity limitations can be addressed by implementing environmental modifications and alterations, providing equipment and personal assistance.
2. ***Understand how enhancing mobility allows people to gain independence, including access to the community.*** Enhancing mobility (i.e., through the use of equipment or environmental modifications) and reducing physical "hassles" enable the participant to increase participation in community activities.

6.4. Are staff trained in accessing local community resources?

1. ***Identify how community resources can help meet the participant's needs.*** Creating resources or linking a participant to resources to meet his or her needs can decrease isolation and improve health and quality of life. Community resources can provide the participant with opportunities for work, education, volunteer experiences, and decrease social isolation.
2. ***Understand the importance of connecting the participant with resources.*** The interdisciplinary team should work collaboratively to identify, partner, and share responsibility for connecting the participant with resources that can help prevent susceptibility to other health conditions and support participant success in achieving his or her identified goals.

7. Understanding and integrating behavioral health care

Behavioral health (BH) encompasses mental health as well as chemical dependency, behavior challenges, and substance abuse. BH care may be integrated with primary care, to ensure continuity with the interdisciplinary team and the participant's individualized plan of care.

7.1. Are staff trained to identify and address mental health issues?

1. ***Identify signs of serious and persistent mental illness (SPMI) disabilities and how they can affect a participant's overall functioning.*** SPMI (e.g., schizophrenia, schizoaffective disorder, delusional/psychotic disorders, bipolar disorder) and other mental health issues (e.g., depression, anxiety) can impact various aspects of an individual's life and safety such as performing activities of daily living and instrumental activities of daily living.
2. ***Understand why individuals with disabilities may be at a greater risk of experiencing mental health issues than the non-disabled population.*** Individuals with disabilities are potentially at greater risk of experiencing co-occurring mental health issues due to isolation and an array of barriers to accessing health care. These barriers can include living on low or fixed income, limited employment opportunities, increased risk of medication interactions, the presence of progressive disabilities, adjusting to changing functional abilities, and societal attitudes toward disability.

7.2. Are staff trained regarding the differences between chemical dependency and substance abuse?

1. ***Understand how chemical dependency varies from substance abuse.*** Chemical dependency and substance abuse involve mind-altering substances, including alcohol and drugs. Chemical dependency is long-term, which may or may not include active, current use while substance abuse is commonly episodic or situational.
2. ***Identify the indicators of chemical dependency or substance abuse.*** There are several indicators of chemical dependency and substance abuse, including changes in appearance, increased health conditions, missed health care appointments, and poor adherence to individual care plans.
3. ***Understand how the negative stigma of mental health and cognitive disability issues can impact pursuit of health services.*** Reluctance to expose oneself to labels and diagnoses can adversely impact an individual's willingness to access or pursue necessary health services.

7.3. Are staff trained regarding behavioral issues, mental illness, substance abuse, and chemical dependency?

1. ***Identify what encompasses behavioral issues.*** Behavior is a form of communication, which may be exhibited with or without the participant's intent. Usually, there are triggers that result in a behavior with positive or negative consequences. For example, frustration related to reduced physical function may cause the participant to become verbally aggressive or abusive, resulting in conflict with caregivers providing support.
2. ***Differentiate behavioral issues from chemical dependency or substance abuse.*** Behavioral issues can be independent of or a direct result of any chemical or substance abuse. For example, increased depression may stimulate a participant to use chemicals to alter mood.

7.4. Are staff trained regarding the recovery approach to mental health?

1. ***Identify the concept of recovery learning.*** The recovery model focuses on learning to live with a chemical dependency or mental illness, as compared to a finding a cure or providing treatment. A core component of the recovery model is community, akin to Alcoholics Anonymous.