The Lewin Group
Webinar on New Disability Competence Resource -- DCC-START
July 25, 2017
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Chris Duff: Good afternoon, everyone. Thank you for joining today's presentation, An Introduction to the Disability-Competent Care Self-Paced Training Assessment Tool, what we will be referring to as the DCC-START throughout the presentation.

This tool was developed to help plans and providers assess the training they provide to their staff and provide resources for enhancement.

My name is Chris Duff, and I'm a disability practice and policy consultant who has been working with The Lewin Group to develop the Disability-Competent Care model and related webinars and materials.

I will be joined today by Lori Mulichak and Ellen LaSalvia from Buckeye Health Plan of Ohio. Buckeye is a managed care plan contractor with the Centers for Medicare and Medicaid in the state of Ohio to serve Medicare and Medicaid members.

Buckeye has developed expertise in working with members to improve their health status and quality of life with their number one priority being promotion of healthy lifestyles through preventive care.

Lori Mulichak is the Senior Vice President of Medical Management at Buckeye Health Plan, who is responsible for clinical operations, including case management, utilization management, and prior authorization for many of their products including those serving persons with disabilities.

Ms. Mulichak has had diverse senior level initiative responsibility for healthcare operations. Prior to joining Buckeye in 2007, she was Vice President of Clinical operations for Care Support of America in Albany, New York.

She earned a Bachelor's Degree in Psychology and Nursing from Youngstown State University and a Masters of Health Administration from Ohio State University. She's also a fellow in the American College of Health Care Executives.

Ellen LaSalvia is the Director of long-term service, support services and home community based services for Buckeye. Joining Buckeye also in 2007, she's focused on transforming the health of the community one member at a time.

One of Ellen's most notable personal and professional achievements is being a voice to assure access to the most vulnerable populations, which is those living with disabilities.

Ellen received her Bachelor of Arts degree in social work and communications from Marylhurst University and a masters in Social Work from Portland State University along with a Masters in Mass Communications and Journalism from Point Park University.

I'm honored to have the two of them join this webinar and share their experience in using this tool.

The Lewin Group, under a contract with the Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services, has partnered with experts from the field to develop technical assistance and actionable tools to support providers in their efforts to deliver more integrated coordinated care for Medicare and Medicaid enrollees.

Our presentation today, will be roughly 40 minutes in length, with the remainder of the time, allocated to questions from participants. This webinar, and all the previous webinars, have been recorded, and will be available, along with a PDF of the slides, at the Resources for Integrated Care website.

We would like to solicit your opinion on this series as well as past webinars and supplemental resources. Please take the time to complete our survey at the end of this webinar, and send us your ideas for future topics and content.

Contact information is listed at the end of the presentation if you wish.

Today, we will start by introducing you to the newly released Disability-Competent Care Self-Paced Training Assessment Tool. It has been in development for over a year and is based on the experience of two Disability-Competent Care learning communities, several health plans, as well as providers, persons with disabilities, and their advocates.

We will review the overall tool and provide guidance for getting started in your self-assessment. I will then give a demonstration of the assessment through the use of screenshots, and then hand it over to Lori and Ellen from Buckeye Health Plan who will share their experience in using the tool. We will then close with the audience questions.

First, though, I would like to provide some context for the DCC model, Disability-Competent Care model.

As persons with disabilities, especially those on public programs who are being transitioned into managed care programs, the Medicare and Medicaid Coordination Office wants to help prepare those programs to meet the needs of what was, for many of them, a new population.

To start, we developed the DCC model from the experience of several dual demonstration projects that started back in the 1990s. We proceeded to describe the components of disability-competency and created the Disability-Competent Care Self-Assessment Tool (DCCAT) in 2013.

We have since produced over 35 webinars and many supported documents and resources related to disability-competencies.

The intent of the DCC-START tool is that plans and providers will evaluate their staff training and identify current strengths and areas needed for further development.

The DCC-START consists of a series of questions based on the seven pillars of Disability-Competent Care. After answering the questions, the self-assessment users are directed to topics and resources tailored to their responses that can enhance the effectiveness and completeness of their own Disability-Competent Care training materials.

The DCC-START tool is now available on the Resources for Integrated Care website. This link, https://www.resourcesforintegratedcare.com/disabilitycompetentcare/tools/2017/dcc_start, will give you access to the tool itself as well as user technical and resource information.

You can start the assessment in two basic ways. One approach is to begin by reviewing your current training or you can, as you will hear from Ellen and Lori, begin by asking your staff to take the self-assessment and subsequently look at your training materials.

Identify staff to complete the tool based on the scope of the training you wish to assess throughout the organization. You will see that Buckeye chose to initially focus on their Medical Management department and chose staff who had direct member experience.

Once the assessment is completed, the assessment team can review the individual results, discuss from different perspectives and identify opportunities for further development.

We also suggest you share these results, not only with those who took the assessment but also more widely in your organization to stimulate further involvement and buy-in.

Lastly, develop a plan to address your opportunity for improvement and identify a timeframe for reassessment.

As you will see, the interactive DCC-START contains four sections: demographic information regarding their plan and membership, a preliminary assessment, a comprehensive self-paced assessment, and a summary with the opportunities for enhancement.

Note that the four sections appear at the bottom of the DCC-START Excel workbook. When you first open it, you'll only see the first page but as you complete the sections, others will appear. Complete this section in the order that the tab appears, from left to right. Also note that not all questions in each tab have to be answered to move on to the next section. However, doing so will give you a more complete representation of your staff training.

At this point, I'm going to talk through several screenshots to show the assessment. The first section asks you to identify the participant population you will be focusing on in assessing your training. For example, are you just looking at staff who work with your Medicaid and/or Medicare members or staff who work with all members with disability regardless of payer source?

Other questions are about your member's health status and community of residence. What we're getting there is, for example, whether it is a rural or an urban kind of context; this include the type of residential setting in which they reside and the age distribution and identified health concerns.

Don't feel you need to do a great deal of data analysis to complete this section. I suggest you rely on what you already know. How you answer these questions will guide you to specific parts of the overall system based on applicability.

As you complete the preliminary assessment, keep in mind the member population you identified in the demographic section to help you consider which pillars of DCC are relevant to the members you identified in the previous section. Answer the questions to the best of your ability. There is no right or wrong in the assessment. If there are differing perceptions throughout your organizations, it will simply encourage further internal discussion.

The self-paced assessment itself varies in length based on your responses in the preliminary assessment. Select the responses from the dropdown to best reflect your current training. The summary will recap your responses in the demographics tab at the beginning of the tool.

The second portion of the summary features opportunities and areas based on the responses to the preliminary assessment and self-paced assessment. The opportunities are organized by the seven pillars of Disability-Competent Care and referring to the relevant individual components of each pillar.

The resource guide is a list of references to provide more information related to your individual responses. This is by no means an exhaustive list since new materials are being developed all the time. We attempted to identify resources that were relatively short and clearly understood and could be potentially useful as training materials.

To look at all the resources, you can go back to the RIC website and we have a PDF of resources for all the pillars.

At this point, I will turn the presentation over to Lori to talk about the Buckeye experience.

Lori Mulichak: Hi. Good afternoon, everybody. It is a pleasure to be here today.

Buckeye Health Plan is one of five Medicaid managed care plans operating in Ohio. We're a National Community for Quality Assurance or NCQA-accredited managed care organization and we've been operating in Ohio since 2004.

We currently have about 330,000 covered lives, and we operate in all 88 counties. Buckeye provides health services through our contracts with Medicaid, Medicare, our fully integrated duals, Advantage members and our health insurance marketplace.

According to the American Community Survey, in 2013, more than 1.5 million or about 13.6% of Ohioans experienced disabilities and about 31.8% of Ohioans with disabilities were living in poverty. So obviously, this was a very important consideration in terms of our decision to consider the assessment.

The assessment was led by our Medical Management Training department and primarily focused on Buckeye's Medicare-Medicaid plan, which serves about 17,300 members.

Buckeye's vision is transforming the health of the community one person at a time. Our mission is better health outcomes at a lower cost, and we believe that through our efforts, we're changing healthcare one person at a time.

Ellen is going to talk to you now a little bit about the DCC-START program and what our team did to implement it. Ellen?

Ellen LaSalvia: Thank you, Lori, and thank you for having me today.

As the managed care plan with a diversified product line that crosses the age and ability spectrum, the DCC-START afforded our Buckeye Medical Management Training team an opportunity to evaluate our current training curriculum and support planned enhancements for on-boarding, continued professional growth and development along with the implementation of a preceptor program within our Medical Management Training department, utilizing the adult learning theory and understanding that adult learning is self-directed and autonomous. It utilizes knowledge and life experiences. It is goal-oriented. It's relevancy-oriented. It highlights practicality and encourages collaboration.

Early on, we determined that the DCC-START would benefit us most if we targeted completion of the self-assessment across Medical Management and compiled the results into departmental findings. In order to assure a diversified mix of employees, Medical Management Training sent email communication to Medical Management employees and requested volunteers to participate.

The email outlined what DCC-START was, the goal in Medical Management Training completing this, and the next steps. Once responses were received, an outbound call was made to each volunteer to review the expectation of their participation and answer any questions the volunteer may have.

Once the call was completed, the two-week window for completion started for the volunteer. All volunteers were afforded the option of completing the DCC-START either electronically or in paper format. All volunteers completed the DCC-START assessment electronically and this was our preferred method of completion. Medical Management Training then reviewed and compiled the results for an overall departmental final report.

Medical Management Training then brought the volunteers together to share the final report, share experiences in completing the self-assessment and dive into the findings. From the findings, this group identified and prioritized opportunities and created some draft timelines for action. Ultimately, it is the responsibility of the Medical Manager in training to implement.

All parties agreed that a six-month reassessment could benefit our Medical Management Training department as continued evaluation and opportunities emerge. We want to ensure we are not losing ground where are strong and are gaining ground in areas of opportunity.

Our final report shows that Medical Management's current training curriculum and materials provide a good foundation for the understanding of disabilities and opportunities in integration along with additional information on participant accessibility and incorporating the experience of having a disability.

From a lessons learned perspective, while our results varied across the Medical Management volunteers, there were commonalities as well. The varied results were drilled into and the root rationale was primarily based on the volunteer employee's role within the Medical Management team. Our volunteers consisted of care managers who come from licensure background of an RN or LCSW; program coordinators who have a licensure background of an LPN or LSW; and community health workers who are certified through the Ohio Nursing Board as certified community health workers; and members of our leadership, so our supervisors, managers and directors.

It was easier to compile all the results created in order to create the final report. Then, we've also seen an opportunity in utilizing the DCC-START in other departments within Buckeye. For example, our Member Services and our Grievance and Appeals department who are member-facing as future opportunities for the DCC-START.

I'm now going to turn it over to Chris for Q&A.

Chris Duff: We've gotten a few questions in, but let me start with some questions that I had prepared. Could you give me some examples of how you chose the volunteers? So you just sent out a general request and see who responded? What was the rough number of people who did the assessment?

Ellen LaSalvia: Certainly. We sent out a general email to the entire Medical Management staff for our dual demonstration, and so that was roughly approximately around 140 employees.

We got a wealth of respondents that were willing to complete the assessment, so took a minimum of six individuals from each discipline within our care management teams. We had from the list, six care managers, six program coordinators, six community health workers, and then we also leveraged two supervisors, a manager and then also a director.

Chris Duff: That really shows, the quality of Buckeye that you had that many people who are that interested in participating in this process and improving the work that you all are doing. I'm glad to hear that level of response.

Can you give us more detail on training opportunities that were identified as a result of this? Can you give a specific example? Were there a couple of areas in particular you're going to work on? Were there some low-hanging truths that'll be just pretty easy to kind of pick up whereas others are a little more involved?

Ellen LaSalvia: Certainly. Well, we had numerous opportunities that emerged. We did begin by targeting three. One was enhancing current curriculum to focus training on functional limitations as compared to medical diagnoses and then linking that with the difference between medical necessity and functional necessity. So it would be the addition of explanation and education on functional necessity in combination with medical necessity.

Second was to increase the robustness of training related to common limitations demonstrated by individuals with intellectual disabilities. Specifically in Ohio, our individuals with intellectual disabilities became eligible for the demonstration, approximately a year and a half after going live. It identified areas that we could enhance that particular education for our staff, and then globally, the view of participant demographics in trainings, training offerings and how specific trainings impact this area. So it's really identifying from each of the trainings that we have within our curriculum, who they impact and how they impact.

We do a really good job at identifying these are the individuals that we have the honor of serving, but tying that back to a specific training so people can connect the full global picture of how the trainings that they're participating in and actively engaged in are thus coming over into the work that they do day-to-day with our members.

Chris Duff: That's great. Thank you very much. I appreciate that response.

I'm going to go to a question we received. Many insurers continue to insist on cheapest DME and home medical equipment available rather than recognize that right equipment is needed to optimize functional independent self-care. Presently, a more expensive model is easier for users and caregivers alike. Is this issue addressed in the toolkit or is it viewed as a larger policy debate outside your charter?

Let me get a start on that, and then Lori or Ellen can respond also. There's certainly an issue that comes up frequently in all the DCC work. We've certainly addressed it, we've done some webinars around that, in particular that you can find at the RIC website. If you look at material under Disability-Competent Care, some of the questions in this would relate to what you're talking about. You ask questions around training that relates to long-term care services, and so it's here a bit. Then, you will be given links to further resources that you can look at, but I think what you're really talking is a broader issue that needs to be trained based on the policy of the individual plan and how they approach it. I think all plans do approach cost-effectiveness, as Lori spoke of at the beginning, but cost-effectiveness and a longer-term focus can easily be addressed.

That is kind of my shot at it. Lori or Ellen, do you have a response to that question?

Ellen LaSalvia: Hi, this Ellen. I think from a plan perspective, we certainly embrace our ability to go above and beyond in certain areas and have a distinct ability to assess, individualize the needs of any one unique member. It's certainly something that we embrace in choosing the DME that most fits the need of the individual and also any of those individuals that are wrapped around that person to help them be as independent as possible.

Lori Mulichak: Right, I would agree with Ellen, and also include the fact that we make our determinations based on medical necessity and we make our determination within a scope of a multidisciplinary care team or interdisciplinary care team approach. I certainly understand where the individual who asked the question is coming from, but we really focus on the medical necessity aspect of it.

Chris Duff: Thank you very much. We had a couple webinars that we did earlier on around this issue also.

There's another question that came in. Do you have a health acuity tool that could help determine nursing support hours for individuals with disabilities? It is unclear whether it's nursing support hours at the plan in terms of care management/ care coordination versus home-based care.

Again, most plans, and this is required by most states, use the standard functional assessment tool, which is the ADL and IADL. There are more trainings on that in the website. This tool, if you answer the questions related to this, it will certainly give some further resources to the health acuity assessment.

Lori and Ellen, how do you guys handle that?

Ellen LaSalvia: Hi, this is Ellen. Internally at Buckeye, we have a developed tool called the HCBS Functional Tool and speaks specifically to personal care attendant support through home- and community-based services. So it is actually a functional tool that we collaborate with the member on completion that gives us a guideline for identified amount of hours to meet those functional needs. So we use that objective-based tool to give us guidelines from which to start.

Chris Duff: Great, and that makes sense. Can you expand on functional necessity? Is it functional independence? Is functional independence an integral part of this model and tool? What is the difference between the two?

The way we look at that in the entire body of disability-competency, that obviously Buckeye has really implemented well, is that we will be more focused on functional capacity than diagnostic disability. A quad is a quad but some quads are very functionally independent and some quads need a lot of assistance.

So what we're interested is how do they function in their life and what kind of support do they need to be as independent as possible.

So if you do your assessment, you do your staff training, and then it does go back to, as I believe it was Lori who said, goes back to the interdisciplinary team, to talk that through. When I was doing the work, there was some C5 quads, for those of you who are nurses especially, who needed a little bit of home care but not that much, and then there were some who needed a lot. Now, some of it was dual diagnosis issues, some of it was chemical health issues, and some of it was involved mental health issues, but that's the kind of thing that you can find with the assessment but then the team needs to talk about it.

Lori or Ellen, do you have comments on that?

Lori Mulichak: Right. It's exactly as you state it. We have our medical necessity criteria in that focus but we certainly take all considerations to the interdisciplinary care team, and also include the member and the caregiver and the provider in those decisions as well.

Chris Duff: Great. Will this program be initiated in other states?

All of the work of The Lewin Team, not just the Disability-Competent Care work, but other areas that are supported by this contract with the Medicare and Medicaid Coordination Office, are tools to let all providers and states work with. Which ones to pick up and which tools, that's really up to them. We've worked hard throughout the Disability-Competent Care work to not be proscriptive because then you get into issues of benefits and that's something that we are not trying to do. It is up to the state and the feds to kind of deal with it as they see fit.

So we're just trying to throw resources, train people on them, and encourage utilization. So it is available for any state plan to use, however they wish.

So here's an interesting question that I don't have a response to but hopefully someone from Buckeye does. Can you talk about what it might look like to implement the DCC-START in appeals and grievance processes?

Ellen LaSalvia: Yeah. When we look at taking the DCC-START, it looks and evaluates the competency of the staff in terms of having the education and knowledge necessary to critically think about things that come through.

So in the grievance and appeals department, it would actually be the frontline staff who are processing that information, taking the particular assessments, and then taking that final report and seeing where there are questions that may remain about in essence to their competency and understanding disabilities. I think that ties in nicely with the very first question that we have from the audience in terms of the best equipment for the person.

Having competency in that area allows individuals to critically think about requests coming through and provides them the opportunity to make impactful decisions in that particular area of operations.

Chris Duff: One thing that we encourage in the overall Disability-Competent Care model is that the decision authority remain as close to the people who know the individual member as possible. In other words, remain with the team that is working with a member. The team needs to be able to have the flexibility to respond to that now, that kind of thing. Again, that's the stuff that we really encourage; that the decision and the discussion happen as close to the member as is possible.

Another question here is, I know you started with Medical Management and in conversations with you, you talked about taking it to some other departments within your plan. Can you talk about where you plan to go next and your rationale for beginning to look at some other areas?

Ellen LaSalvia: Yeah. One thing that we heard from doing the program and doing the assessment in Medical Management is that it netted some great objective results on current training curriculum and then future opportunities. One such opportunity that as an organization we were able to identify is placing our employees in a position where they can fully understand the experience of a member, to the extent possible.

We, as an organization, have committed to giving that to our employees, organization-wide.

We started this through holding COPE trainings for our staff to allow everyone that experience and through the completion of the DCC-START. It has also opened up an additional opportunity and communications with our centers for independent living and specialized training they have specific to disabilities in that particular experience.

From a forward movement standpoint, building off of the results from Medical Management in implementing the actual completion of the assessment in other departments, and seeing what those results show, and then seeing our initiatives either at a departmental basis, or at a more global organizational basis, much like you see in the COPE training that I previously mentioned.

Chris Duff: Thank you very much. I'm really excited because what you keep talking about is stuff that we view as the core principles of this Disability-Competent Care, such as understating the lived experience of the member and understanding their perspective.

Again, diagnosis doesn't give you that fully. That's a part of it, but it doesn't fully give you that. How was the experience? What are the social factors in their life? What are their familial issues? Other health conditions? All of those are just very important, and so the closer you can get to the individual and understand some of the experiences of dealing with the disability, the better you are able to serve the people. So I'm very excited to be hearing your responses along the way here.

The question that we had is from when you first decided to take on this tool, and again we thank you, how long did it take you to pull together this team, get them started, pull together the results, and then move into developing a plan? Can you kind of talk a bit about the chronological, the process and the timeframes for those steps?

Lori Mulichak: Yes. I would say from start to finish, it took approximately seven weeks so we allocate at a 6- to 8-week timeframe to complete the process. There were some prep-work that was completed first, a leadership based understanding of what the DCC-START was, so we were well-informed and educated on what the tool was, and it what offered our organization.

From there, we worked specifically with Medical Management Training about a deployment tactic that would work for them and would also net us some meaningful results in order to take actions on. We then allowed staff, because this would be done in addition to their day-to-day duties, two weeks to complete the actual tool. Then we took an additional two weeks, as a Medical Management Training department, to take all of those results, compute them, refine them and get the final report and then to coordinate schedules so everybody can sit down and go through the final report and discuss the action plan.

This first round looks over the course of the next six months since we did identify a six-month marker for us to then go into the assessment again to see if our results remained the same or if they changed. Ideally, we'd like to see them change and new opportunities emerge and then we gain ground in areas that we didn't have opportunities in before.

So startup was identified 6 to 8 weeks, it took us 7 weeks, and then we have had our action plan related to those final results mapped out in a sixth-month increment because we selected to redo it at the sixth-month mark.

Chris Duff: Great. Will you have different teams be doing the action plan or that would be done by your training department? How are you going to manage the six months here?

Lori Mulichak: So that will actually be part of the strategic plan for our training department. They will actually own the particular action plan and then in our standard meetings report out on those results, and feed that information out to our global demonstration staff so they can see the progression of the actions taken. Outlining and spelling it in a verbal way and also visually so staff can see that the active participation that they willingly agree to resulted in some fundamental modifications, changes and enhancements into the program that they participate in and rely upon for their professional growth and the support that they need as they're working to coordinate care for our members.

Chris Duff: That's a nice loop in your quality management there. I appreciate that

How much consistency did you find in the responses that you had from the volunteers that you ended up selecting to do the assessment?

Lori Mulichak: Yes. So we've seen consistencies, but we're also seeing differences. We found the most consistency in individuals that had similar positions. So our care manager's consistency amongst one another was much higher than consistencies that we've seen between a care manager and a program coordinator. When we drove into those in our discussion with all the volunteers, fundamentally, it came back to what the roles and responsibilities are on the team. Taking it from the perspective of their onboarding experience, the work that they do day in and day out, and then secondary to that, were any previous work experiences that individuals had prior to bringing their talents to Buckeye and our members.

So those were really the differences that we've seen and it also played back into frequency of use. Our community health workers assist the team in going out in identifying very individualized members' specific tasks such as maybe linking with a lifeline phone that they may need. They're very distinct, and we were able to trace back through that discussion that it was dependent upon the roles and the functions they complete within the care management team.

Chris Duff: Great. Can you give some specific examples of your action plans?

Lori Mulichak: Yeah, I touched on this one a little. Specifically one of the biggest areas of feedback from action planning is really the experience of those with disabilities and how that would be, so that was a finding. In our discussion groups, individuals begin discussing the COPE training that we, as an organization, are already far into the process and have already been implemented and having staff go through. That resulted in somebody else mentioning the Centers for Independent Living.

Post the meeting, we had somebody assigned to make outbound calls to the Centers for Independent Living to see which centers could offer that particular service. We had a meeting set up, and now we are at the proposal stage for offering that training specific to disabilities for our staff.

So that is one example of the particular action steps. We identify a desire and an opportunity to get hands-on experience with experiencing those disabilities through discussion, and we were able to identify a resource for that and also based upon current curriculum we have in place. We were able to assign somebody to make that outbound call, that outbound call was made, it looped back to the group, we were able to have follow-up conversations and now we're in a proposal format.

Chris Duff: That's great, and I feel like I keep fawning over you, but everything you're saying is just so heartwarming to hear, and so on the mark with the model that we've been trying to promote along the way here.

Going back to June Kailes, where this question came from, she used to run a Center for Independent Living for many years, and she also does disability training in Southern California. So, she would certainly be an advocate at partnering with community resources in Centers for Independent Living.

So I'm really glad you're doing that. If nothing else, they can also be an advocate for your staff, if they're working with someone they just don't know what to do. Even the team is kind of left scratching their heads. If they start having more relationships with community people such as Centers for Independent

Living, they can seek them to help figure out how to best meet the needs of that individual. So I'm really pleased that you are doing that.

Another question here is, were there any lessons or tips that you learned that you plan to use when you do the reassessment in about six months?

Lori Mulichak: Yeah, at the six months increment, the volunteers that we utilized this time around were seasoned staff who had been with us and have established roles, responsibilities within their positions. So they are aware of our trainings.

At a six-month mark, we would actually like to re-assess at that level but then maybe also start anew with doing some evaluation of our on-boarding program or on-boarding training, I should say. We've recently evaluated that and started a new process that is actually a very structured six-week on-boarding process and are working to then tie that into preceptor program.

We would like, at the 6-month mark, to do a sampling of a established, shall we say, seasoned staff and then also our new staff so we can see potentially the difference between somebody on-boarding and somebody seasoned. Then, we can see the difference between an on-boarding training need and then just from an ongoing to see if there's any gaps between those two and opportunities that may reside there.

Chris Duff: Very interesting. I would not ever even have thought of that. That's great. Thank you very much.

How often do your teams meet?

Ellen LaSalvia: So just for clarity, we're talking about an individual member's team that supports them, which we call interdisciplinary teams.

First and foremost, it's based on members' needs. It will depend upon the assessment that our chair manager is doing. At minimum, we ensure that they are recurring on an annual basis with the entire team, but our IDTs are set up, so that they receive information updates at time of engagement into care management so they have input into the HRA completion, the care plan development and, for our home- and community-based members, their service plan development.

At any point in time, there may be a change to either the care plan that the member develops or the service plan that's developed; we would then work and tie in the IDT team.

So it's very member-specific, but we do have a minimum requirement of annually.

Chris Duff: Got it, so you do your HRA and assessment annually and discuss them with the team annually. If changes occur, such as a hospitalization or a health status change, they come back up at your next team meeting, I mean, you'll do communication outside the team, but they'll come back up with the team meeting to discuss if anything needs to change?

Ellen LaSalvia: Correct.

Chris Duff: Great. That is something I know a lot of plans kind of struggle with.

Does the tool need to be used in its entirety or can a specific area of focus be done? Let me take a shot at this. Once you go through the first section, you don't need to do it in its entirety. We encourage everyone to do that because it gives you an umbrella picture of your work. When you get to action plans, at that

point, then you can zero in. So we do encourage its entirety but that is not necessarily the tools that require that.

What would Lori and Ellen say to that question?

Lori Mulichak: I would say upon completion of the tool, you could focus on any particular pillar and get some results that are produced. From an initial standpoint, it is worth completing the entire tool, so you have an understanding of where you stand from the seven pillars and not necessarily assuming that one pillar is your problem. So that involves going into it with no assumptions and utilizing the tool to guide you with the results. Then from the results, identifying an area of impact, one of the pillars that you have the capacity for which to address that at one time might be effective, but I think the global picture is what we found to be most beneficial.

Chris Duff: Thank you. Would you have an estimate of how long it took anyone of your staff members to complete the assessment tool?

Lori Mulichak: Yes. Because we did not tie a review of training materials in with the completion of assessment, I do believe that led us to go at a quicker pace. So I would say that on average, it took our team approximately 20 to 25 minutes to complete it.

Chris Duff: That's great. It's actually a learning for me here because your process actually makes it more accessible for plans since they don't have to spend a lot of time upfront. Individual people can take half an hour to complete the assessment, so I really want to support and endorse what you came up with. I think that's a really nice approach to it. My compliments to you.

Were there any big surprises in what you heard from your staff who did the assessment or any of you as leaders or managers?

Lori Mulichak: I don't think anything came across as a huge surprise. I think one of the elements that we found the most interesting was the difference and the desire of the staff to more thoroughly understand medical necessity versus functional necessity. I think that is an element that we have some opportunity in our trainings, and our staff was able to identify that, but it was really putting the language around it and the ability to communicate on a level that maybe we didn't have the words for previously. So I think that was probably the most interesting finding.

Then when we found that out, it impacted other areas of our findings because when we're talking about understanding and providing care coordination, so maybe access to any physician's office that you're working to coordinate an appointment with somebody, that medical necessity versus functional necessity really plays in and gives us another language in which to utilize. That was the finding that then impacted several other areas.

Chris Duff: Thank you very much, and what you just said is totally consistent with the questions we've got in here because that seems to be what the audience has been struggling with also. So it's quite interesting and that's an example of I think some further training that we can focus on in our work to help other plans with those very issues.

Who provided the leadership for your assessment within your plan?

Ellen LaSalvia: I did.

Chris Duff: Okay.

Chris Duff: Thank you.

So with that, I'd like to thank everyone for all your questions, and we had a lot of them. They were great questions. We're going to wrap up the presentation now. Please send any feedback you have to RIC@Lewin.com and answer the survey that will appear at the end of this webcast.

Your input, as well as the discussion we've had along the way here, will help us develop and provide you with material to optimally serve your participants with disabilities.

Again, I'd like to call your attention to the resources that we have outlined at https://resourcesforintegratedcare.com/ and through the Disability-Competent Care Self-Assessment Tool.

I would like to again, thank Lori and Ellen and the Medicare and Medicaid Coordination Office, at the Center for Medicare and Medicaid Services, for sponsoring this webinar and the entirety of the Disability-Competent Care work.

Thank you very much for attending.