

## **Strategies to Stimulate and Support Participant Engagement Event 743182**

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the Disability-Competent Care Webinar Roundtable Series. At this time all participants are in a listen-only mode. Later we will conduct a question-and-answer session. Should you require assistance on today's call or if you would like to ask a question, please press star then zero. I would now like to turn the conference over to our host, Mr. Chris Duff. Please go ahead, sir.

Chris Duff: Hi. On behalf of The Lewin Group I would like to welcome you all to the second 2014 webinar roundtable session on participant involvement. As David stated, my name is Chris Duff. I'm a disability policy and practice consultant. My colleagues and I are under contract with the Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services to provide technical assistance to providers working with adults with disabilities.

First of all I'd like to introduce you to this platform for the presentation. If the slides are not advancing, push F5 on your computer keyboard. Also, please note the icons at the bottom of the screen. The blue one on the left will open a chat window, which I'll talk about in just a minute. The center icon is for technical questions, in particular. The CC icon is for closed captioning. And the green one, pointed out on the right, gives you access to the resources for this presentation.

This series consists of eight webinars. Four will be presented in succession on Tuesdays in February. We'll take a two-week break and then we'll resume with the next four starting on March 18.

Last year we published a comprehensive Disability-Competent Care Self-Assessment Tool describing the disability-competent care in three key components, individualized care coordination provided by an interdisciplinary team, redesign primary care delivery, and flexible long term services and supports.

We followed this up with nine webinars focusing on individual components of this model of care. All of the webinars are recorded and are available along with PDFs of the slides at the link at the bottom of the slide you see now.

We would like to solicit your opinion on this series as well as past webinars and resources. Please take a minute of this webinar to complete the survey.

Our goal in this series is to be highly practical using experts in each topic area with organizational examples, or first person stories to demonstrate key messages. The presentations will be about 20 minutes in length, allowing the remainder of time to explore questions or issues submitted by you.

If you click on that chat icon it will open a small chat window and the purpose of that is for you all to basically chat among yourselves, where you can make comments, you can pose questions to each other and so on. That chat box is being monitored and any questions that are placed there will be forwarded for me to handle or send onto the speakers.

You can also call in live on the phone to submit a question and you'll be instructed on how to do that after our presentation.

Beyond the chat feature though, you can submit questions and comments at any time. We will also be using instant polling to ask specific questions to help guide our presentation. To demonstrate this process, here's the first question. What type of organization are you working within? Health plan? AAA or ADRC? Consumer advocacy organization? Governmental? Or other?

Please make your choice and submit and we'll all see a tabulation of the answers shortly.

Today we are exploring the opportunities for and the values of participant involvement. Most governmental programs and all the dual demonstration projects require a formal stakeholder involvement process. Our goal today is to show specific strategies used by disability-competent plans and to spark additional ideas and suggestions from you.

Specifically our goal is to help organizations move beyond simple compliance and actually get significant value involving participants in service aspects of your program. Is it possible to go back to that slide where we saw the results of the survey? I only saw it very briefly, but what it showed is the majority of attendees are from health plans. That's similar to last week. Though I'm very glad to see that there's a lot of ADRC and AAA as well as governmental. So, we have a nice representation from across types of organizations.

On slide six our presenters today are Ben Jauregui who is a Disability Program Manager at Inland Empire Health Plan in Southern California. IEHP, as it's referenced, has been serving adults with disabilities for over ten years and has made a concerted effort to continually refine their strategies to learn from the experiences with their members and allied supporters and advocates.

I will follow his presentation with two specific activities we employed in the dual demonstration project in Minnesota. And joining us in the discussion will be June Kailes who has been a Disability Policy Consultant for 35 plus years, working with a variety of health facilities and managed care organizations as a trainer, writer, researcher, and policy analyst.

Before turning the presentation over to them I wanted to provide some context regarding the need for this training. A familiar refrain within the disability rights movement is nothing about us without us. Meeting this expectation is not just about meeting regulatory compliance, but simply good business practice. Involving your participants in the development and oversight of your plan and services has both quality and marketing benefits. As this slide shows, your participants can help your organization understand the issues they face and how your services can meet their needs. They can also provide meaningful and timely feedback on services and help refine your services.

Today we will focus specifically on the programmatic level of participant involvement. This slide shows or the previous slide shows that there are many levels of involvement from the federal government. There are advocates at the national level. All the way down to the other extreme where people are interacting with the health plan about their own individual needs. What we're focusing on is at the plan level at the local state about how they and how you all engage your consumers in the delivery of your own plan.

With that as an introduction I'll now hand it over to Ben for his presentation.

Ben Jauregui: Thank you. Good morning or good afternoon. Today I'm going to be talking about our experience with participant involvement and specifically our Persons with Disabilities Workgroup. As

Christopher said we have been serving persons with disabilities for over ten years. And we've had a disability manager in place for about the same time, eight to nine years.

We have several strategies to engage participants, from members to community-based organizations, external community partners. First one is the Persons with Disabilities Workgroup. And I'll talk more about that in a bit. We also have the person with disabilities workgroup is for our members who are seniors and person with disabilities.

Our public policy participation committee is for our members who have Medicaid. And that's a separate committee workgroup of Medicaid members.

We also participate in the Inland Empire Disabilities Collaborative. It's a collaborative of professionals that serve seniors and person with disabilities in our two country area referred to as the Inland Empire. And the newest group that we have is the Coordinated Care Initiative Stakeholder Advisory Committee which includes all those organizations that will be involved in CCI from CBAS centers to IHSS, In-home support services, to public authority advocacy groups.

The Persons with Disabilities Workgroup is an advisory committee of 20 to 30 seniors and persons with disabilities. They have diverse disabilities, diverse ages, and we also select based on diverse geographic areas of the county. We serve two counties in Southern California. We serve rural areas. We serve urban areas. We serve mountain communities. We server desert area; San Bernardino County is one of the largest counties in the nation. And so we want people from diverse areas of the county, so we get their perspective of accessing healthcare in those rural areas.

We also include community-based organizations. We've had representatives from health insurance and advocacy programs. We've had representatives from the independent living centers. We've had representatives from in-home support services. But more recently we've narrowed it down to get at least one or two members from local independent living centers. We've had the directors as part of these committees, or their advocates, their [specific] advocates.

And the meetings also include directors and managers from various departments here at the health plan. We have our director of member services at the meetings. Our director of pharmacy department. Managers from marketing, directors from case management, utilization management. Someone from every department. We feel it's important that they're part of this and listen to the input that we're receiving directly from our members.

The only requirement for membership is that our members be with us, with the health plan, for at least one year. And the reason for that is because we want them to experience utilizing services, accessing services, calling our member services line, going to their doctors or specialists, accessing health education programs.

We want them to have at least a year of experience. And we also ask that they provide meaningful feedback. And I'll talk a little bit more about the recruitment process in a bit. The selection process is we take applications throughout the year. This workgroup – we talk about it in our newsletters. It's on our website. We mention it during welcome calls. We let all of our members know about this opportunity to participate in the workgroup. They can submit an application via by phone or a paper application. And then the committee scores those applications from one to five, five being best, and we select – again – 20 to 30 members to join us depending on those scores.

The questions that we ask, we ask them about their disabilities and that question is important because we want a diverse group. We want people with physical disabilities because their experience in accessing care will be different from somebody who has a sensory disability, to others with cognitive disabilities. So, we ask about their disabilities. And the selection is based on the diversity of disabilities, diversity of age, and diversity of areas that they live in.

The structure of the workgroup, there's a term of one year. And there's a two-term limit. So, they can apply again for the next year. And we typically bring back five members from the previous workgroups that way there's continuity as we move forward. Meetings are held quarterly here at Inland Empire Health Plan. And we provide a \$50 stipend. And that stipend is meant to assist our members that attend, to pay or transportation, to pay for a care giver to bring them, to pay for a babysitter. Whatever the need may be, that's there to assist them.

There are some great outcomes that we've had because of this workgroup. First one is we've learned that members do use technology to access health information. Not too long ago our assumption was that because we serve low income individuals that they may not access, have access to, or utilize technology like smartphones to access information. And through various workgroups that we've had in the past couple of years we've asked the same question at every meeting, at every new meeting when we get new members. And we've asked them about the use of technology. And surprisingly they do use technology. They use their smartphones. And at times we see them actually using it during our presentations when we're showing for example our new website, our redesigned website.

We asked them for their feedback and they were accessing the website on their smartphone. So, we learned that technology is being used and we need to rely more on technology/our website to communicate to our members, to provide information to them.

Second thing we've learned is members like our newsletter articles and the community resources that we publish in them. The challenge was to provide our members with meaningful content, relevant content, while maintaining an 18 point font on the newsletters. We publish them at an 18 point font to ensure accessibility/readability. And the concern was that it might have been too long.

Well, when we showed them our newsletters, when we asked them for their feedback they all loved the format, they loved the 18 point font, but they wanted more. And this was surprising to us. We thought that less would be better. They liked the articles. They read the articles. They're relevant to them. And they also love the community resources that we place in them. We always put three to four community resources that kind of tie in with the topic of the newsletter.

Another interesting thing we learned is that the health risk assessment that we conduct on our members, we found out that many of our members had confidentiality concerns in filling out those surveys, in answering phone calls, questions over the phone. We learned that one of the questions specifically that asked about a drug use or substance use, most of the group told us that that's probably a question that they wouldn't answer on paper. But they might be more willing to answer in person, or via a telephone survey. They might feel more comfortable doing it over the phone than putting it on paper that they have a substance use or alcohol problem.

We also learned that our members want providers/doctor's offices to understand people with disabilities and their experience. And we've learned this through when we were asking them about our

disability awareness training that we have here at the health plan. We provided them with the videos, the content, and they really liked them and enjoyed them. And they wished that everybody that they come in contact with was trained on disability awareness, including their providers because they pointed to that, that doctors sometimes are not aware of the experiences of a person with a disability, the barriers that they may face.

And the last thing we learned is that many of our members have transportation challenges, especially in this large geographic area that we serve. Like I said, we have some mountain communities. We have some desert communities where it's very rural. No transportation to and from the rural to the urban areas. And it's a challenge. It's something that we look at and consider all the time. In fact, we do provide transportation to our members who request it to attend our Persons with Disabilities Workgroup. If they ask assistance in transportation, maybe the \$50 is not enough to cover the transportation. Maybe it's an hour away via public transportation. We will provide a cab or wheelchair accessible transportation if requested upon request.

I think that's it for my slides.

Chris Duff: Thanks again. I appreciate. One quick question from Lucy from the [Tennessee] Commission on Aging, "Is the stipend you provided on a quarterly basis or an annual one?"

Ben Jauregui: A quarterly basis. A quarterly basis. And one thing that we also learned is that there were some folks that are concerned about accepting a \$50 stipend and preferred grocery gift cards. And so we also offer that as an option. We'll provide them with a \$50 grocery store gift card if they have a concern about accepting a \$50 stipend.

Chris Duff: Thank you. What I really appreciate about your presentation is the debunking of the myth that many of us have had for years around people on Medicaid not being able to have access to technology. And I think what you're saying is they do. They may not have it in their own home, or everyone may not have a smartphone, but they do find ways to have access to technology and we need to build that into our plan. So, that was interesting to me.

I'm going to talk about the Member Advisory Workgroup that we had at AXIS Healthcare which is part of the Minnesota Disability Health Options program. We actually approach it in a very different way. And I'm going to explain to you about that. Neither way is right nor wrong, it's just different. Ours is far less formal. Our workgroup met monthly and was open to any participant who wanted to attend.

Our staff informed the participants in the first month or two of their enrollment with us. And we generally had between 25 and 35 people attend each of the meetings. Of that number about half were fairly regular attendees and they also invited their personal attendant or primary care giver to join them.

I, as the CEO, moderated the meeting and senior managers were expected to attend as well as all new staff sometime during their first six months of employment. We thought it was important that they experience the workgroup.

We dedicated the first half of the meeting, the entire hour, to an open mic format where we talked about anything the participants desired. Sometimes complaints. Sometimes compliments. And many suggestions.

I was responsible for assessing what comments were unique to one participant versus a common experience. The unique ones, after I quickly redressed it to the participant, I redirected the participants by asking them if I could have their care coordinator follow up with them after the meeting. If it was a more common experience I used it as an opportunity to further understand their experiences and to begin to explore ways we could improve. I would follow up with these in our next management meeting.

For example, the person who talked about their neighbor being hurt while riding a van on their way to an appointment and asking others if they had seen or experienced similar problems, several indicated that they had. As we drilled down further on this we learned two things. One is our transportation providers have relatively sloppy procedures for tying down wheelchairs in their vans; and secondly that many of the newer models of power wheelchairs that we're providing were incompatible with the conventional van tie-down. So, both issues that we followed up with the providers on.

The other strategy I wanted to talk about was that we employed what we referred to under the very professional title of How Are We Doing survey and a copy of this was sent out with the slides or a link to it was sent out with the slides for today's presentation. As you can see on that there are 13 score-able questions and three open-ended questions.

(Technical difficulty) questions – it gave us the opportunity to focus on some key quality indicators, such as access to their care coordinator and obtaining needed services, dental, transportation, and others. This survey was sent out to everyone three months after they joined the program and if they didn't return it we actually employed some people with disabilities who would call them and ask the questions over the phone. Through this process we achieved consistently 95% completion.

The individual concerns that were identified were forwarded to the team supervisor for follow up and the tabulation of all those surveys were shared with governance, leadership staff, the Member Advisory Workgroup, and quarterly all staff meetings.

The tool provided us with quick feedback and early identification of issues or problems. We used it to track key programmatic changes to see if they were being effective, such as the transition to the new Part D drug benefit that was initiated in 2006.

Another example, one of our lowest scoring questions was how often do you talk to your coordinator, where the largest percent of response was that they didn't talk with their coordinator as much as they wanted. This was a hard one for us. We often felt that our staffing was never going to be able to meet their expectations.

What this led us to do was add a component to our initial assessment where our staff was asked to talk with each participant about their expectations and need for ongoing contact. This would lead to a very productive and successful discussion, often identifying a timeframe for ongoing contact. We then entered this information in our care management program software and it triggered reminders for the coordinator at the identified time.

This gives you a sense of a couple strategies we used at AXIS. Now, before we get to questions I'd like to go ahead and push out this second question we have which is how does your organization involve participants. If you could check all that apply.

Now, I'll turn it over to June Kailes for her thoughts and comments and questions.

June Kailes: Yeah, thanks to both of you, Chris and Ben. I think you give quite a few strategies to consider weaving into participant involvement options.

So, I have two questions. Ben, can you talk more about the benefit of why you include advocacy organizations like the independent living center regularly in your disability workgroup? And then can you tell us more about how you score those applications you talked about that are used for people applying to become a member of your workgroup?

Ben Jauregui: Sure. The purpose of the Persons with Disabilities Workgroup is to help us to improve the delivery of healthcare service, to improve communication, and to improve access. And when we think about access, when we think about communication, when we think about healthcare services we also think about community-based organizations and the value that they bring to our members and so that was the reason why we included them because we thought they could absolutely help us and add to the Persons with Disabilities Workgroup.

And one thing that I have found is that when members talk about individual issues and the director of the local independent living center hears these things, they're able to translate that into, okay, this member is talking about physical accessibility or this member is talking about the lack of accessible transportation in that part of the county. So, they bring an understanding, they bring an awareness of the issues that people with disabilities may face in accessing healthcare, so they've been a valuable tool and a resource.

The second part of your question was about how we rate the applications. Basically we're looking for individuals that have – that can bring something to the table. That can actively participate and help us to improve. That's the whole goal of the committee – help us improve our health plan – always looking for ways to improve the health plan. And so we asked them what is your interest in serving in this committee? That's one of the questions on the application.

And we get great responses to that. We get folks that have been a part of the in-home support services advisory committees before. They've served on commissions. They've served on boards. Or they have a long history with us. Maybe they've been with us for five, ten years and they have a lot of experience and they can bring that to the table and share their experience in accessing services.

Some of them are fairly new, and so we also look for that, also. If we see that somebody has been with the health plan maybe two years and they have some great suggestions we rank those at a bit higher. And so we rank them based on their answer, on their interest, why they want to serve on the committee, and just overall do we think this person is going to contribute and help us.

And we do rate also when we see something that maybe somebody wants to bring to our attention in a complaint, we also see that as an opportunity. So, just because somebody may have some negative things to say about us doesn't disqualify them. We will absolutely consider them. In fact, we welcome those opportunities to hear the challenges that they may be facing in accessing healthcare.

Chris Duff: Thanks Ben.

June Kailes: You have a lot more applications – you have more applications than you can accept?

Ben Jauregui: At times we have and there's times – last year we did not receive enough applications. So, what we did is I got a list of 500 members who matched the requirement of being with the health plan for a year, had a disability, and we called them. We made outbound calls and informed them about the Persons with Disabilities Workgroup, asked them if they wanted to be a part of it. And we came up with about – of the 500 I'm thinking we got about 50 or 60 good applications that we were then able to pick about 20 people to join.

So, sometimes the recruitment that goes on in our newsletters, on or our website is not enough, and we have to send out letters. We have done letters in the past, also. We've sent out letters recruiting new members. We've made outbound phone calls. And so we'll try to get anywhere from 60 to 100 applications to review each year.

June Kailes: Oh, thanks. Chris, back to you for a bit.

Chris Duff: Yes, as you saw on the last survey, it was interesting that the respondents all showed that you're using many of these ways to involve participants. Largest number is advisory committee. So, many of you, or almost half of you have those in place. Interesting volunteer activities is higher than I expected, and other ways. Two things from this. One, I would hope that people could submit in their chat other ways that they involve consumers that give you some value. I think that would be good for us to learn about. And then the governance or board committee, I think that's interesting, 22%.

There was one question that was submitted to us that I wanted to have both Ben and I respond to. At AXIS Healthcare we had some people with disabilities on our board. It's a somewhat different structure that I don't need to kind of get into. So, we had some people with disabilities on the board, but we did not have any actual members or clients on the board. So, I think that was something that we were weak on that we tried to compensate through some other structures, but we at AXIS did not do that.

Ben, at IEHP do you have participants participating on the board or committee in governance?

Ben Jauregui: The Persons with Disabilities Workgroup reports up to the Quality Management Committee who our Chief Medical Officer is in charge of that committee. And then he again responds to the board. Our governing board, because we're a local initiative, is comprised of supervisors from the two counties that we server, board of supervisors from the two counties that we serve, two from each county, and three members of the public. I don't believe we have members on that board, but the Persons with Disabilities Workgroup does report to the Quality Management Committee which then reports to the Governing Board.

Chris Duff: It's a really interesting question. I know it's a challenging question for many plans and organizations. Some states actually require a certain number of the plan's members actually be on their board of directors or board of governors. But I think it's something that we need to keep learning more about. And a webinar I'm going to tell you about later on in today's presentation perhaps will follow up on that a little further.

At this point I'd also like to put forward the third polling question we have for you which is if your organization surveys your participants beyond the annual CAHPS survey or annual standard satisfaction surveys, how much value do you get from the surveys you use? Do you get significant, moderate, minimal, or you don't currently participate, you don't currently survey your participants? That would be helpful for us to learn.

So, I'm going to turn it back to June for a question or two.

June Kailes: Sure, you know, for both of you – one thing that seems to be a common issue is there always seem to be a few member of these advisory groups or workgroups that dominate the discussion, the conversations, and how do you handle that situation without being discounting or disrespectful? What have some of your strategies been? Ben, you can go first maybe.

Ben Jauregui: Sure. We have some guiding principles of the group that we go over at the first meeting of every year, where we talk about the purpose of the group, we talk about the goals, the outcomes we'd like to see, and we'd also talk about their participation. We encourage them to participate. That's why they're there. We welcome comments that may be – are not always positive and that's fine. We welcome all of their comments.

We do ask them to limit their comments to general comments and not so much personal items that they might be going through, but just general comments on healthcare, on access, on doctor's offices, on durable medical equipment. And that tends to help; just a brief reminder at every meeting that we welcome your input, but please try to keep it general and not on issues that are specific to them.

And one way to – another thing that has helped us is that at every meeting we have our member services representative there to assist our members with personal issues at the end of every meeting. When the member walks into the meeting they have a slip they can either fill out or at the end of the meeting they can sit with a member services representative that can help them with anything that might be personal. And so I think that helps because they may come to the meeting wanting to share about their personal, very personal experience. We have somebody there that can help them at the end of the meeting, which then helps them not to bring it up necessarily during the meeting.

June Kailes: Interesting technique. Chris, anything you want to add?

Chris Duff: Yeah, I think, and Ben I like what you said. That's totally on the mark and lord knows we've all been on committees where there is one or two people who tend to dominate a lot. And it's a frustration for both the organization as well as other committee members.

From my perspective, Ben's strategies are absolutely the right strategies. And it really boils down to the skill of the person who is leading the meeting. The only thing I would add to what Ben had to say is I would commonly say, "So, we haven't heard from you yet, what do you have to say on this?" Try to pull in other people, especially people who tend to be a little quieter, so, by example, trying to redirect away from a person who is more dominating over to another person.

I love the strategy of having a member services person in the meeting to follow up right away because that's also a really respectful way of saying we really care what you have to say but we also want to give other people an opportunity to participate, so I think that's great.

Well, one person asked us here I noticed, Anna, about how are we defining disability. And, June, why don't you take that one if you would.

June Kailes: How are we defining disability? Well, you know, I always can answer that classically by we've got the definition of the ADA in terms of people with disabilities and census says that represents

20% of the population. And then we have our states that have different definitions under our contracts that define disability. But I always like to look at it broadly as not only the protected class under our Civil Rights legislation like the ADA, but also the huge or the bigger group of people where they just have access and functional needs that are indeed disabilities, whether they're related to mobility, or seeing, or hearing, or reading, or learning, or remembering in understanding. So, I always like to think of the group broadly in terms of what we're doing here really, being a benefit to a great many more people than maybe defined by any of the variety of definitions that we're dealing with at the state or federal level.

I don't know if that's what you were looking for Chris, but--

Chris Duff: Yeah. I think that does get to – the two things that keep coming to my mind on that is first how do people present themselves. Do they consider themselves disabled? That's first and foremost. Secondly is the whole issue of we don't look, from our perspective in the model of care, it's not about the diagnosis or the medical condition a person has. We look at functional limitations. And look at the functions. And that then leads to the definition of what their needs are and so on. So, we take a functional perspective versus a medical perspective.

June Kailes: Chris, if I could just add to that comment. I think it is an important issues because there are probably many more people who don't identify as ever having a disability for a variety of reasons, but they will tell you they just don't walk too well, or they just don't hear too well. But they don't use the D word and that's a whole other conversation, the D word being disability.

Chris Duff: The person who asked that question wants to know specifically, and I think Ben will answer, "How did you come up with those 500 names? How did you figure out of your members who were the ones with disabilities to know who to contact?"

Ben Jauregui: The easy way to do that is by Medicaid [Aid] codes. If you are a person with a disability qualified for Medicaid based on your disability you're assigned a unique Medicaid Aid Code. And that's how we pulled that numbers. If they have an Aid Code that starts with a 1, a 2, or a 6, that identifies them as a person with a disability.

Chris Duff: Caution people in some other states: different states have different reliability with their data. When I was in Minnesota that was not a reliable way for us. And it really boils down to how the state manages the data and puts on the system. So, that is a question I think you really need to answer and think about and figure out how you handle that internally.

Ben Jauregui: And that's the technique that we use because we needed to find a quick way of finding folks. But, if somebody calls and they want to join the committee they're absolutely welcome to. In fact, we've had parents come, parents that have children with disabilities. They come on behalf of their child or adult son or daughter and they come to the groups as well.

Chris Duff: Interesting question from a colleague of mine, Judy, in Illinois. Of course she asks among the toughest of questions. "Illinois requires managed care organizations to create consumer advisory boards of 'randomly selected Medicaid enrollees.' How can we ensure maximum engagement of a randomly selected membership group who may not be interested in being on the committee?" So, how do you ensure random diversity on your committee when it's a voluntary process? Ben, do you want to take a shot at that, or June?

June Kailes: Well, Judy, what comes to mind is that if you throw out a big enough net, even if they're randomly selected, then you would still be able to employ some of the strategies that Ben talked about in terms of narrowing down the group to a workable size group. So, random – I am assuming that doesn't necessarily mean you have to take everybody that's randomly selected, that you could still do some further application processes from there.

Ben Jauregui: Several years ago we used to accept just anybody who would call and want to express interest. We would sign them up and they would be part of the workgroup. And we did find that we were getting folks signing up but maybe not actively participating. And so that's why we moved towards having an application where people have to show more of an interest and really show interest in just being active participants. That's one of the requirements we ask for: willingness to actively participate in discussions. And that's helped a lot to ensure that people are contributing at the workgroups.

Chris Duff: You mentioned in going through the applications you had, Ben, you mentioned that you tried to get a geographic representation. You tried to get age representation. Did you try to get representation of different disabilities, or persons with disabilities? Or how did you handle – was there other criteria that you looked at in reviewing the applications?

Ben Jauregui: So, first we looked at the response. What is your interest in serving in this committee? That was the first thing that we looked at. The second thing we looked at was once they're all rated, then we look at diversity in disability, diversity in age, and diversity in geographic area. So, let's say we have, you know, ten people that got a five, a score of five. We then would look for five people from one county and five people from another county, as opposed to just taking the top people. We would look for that age, geographic area, and diversity of disabilities.

June Kailes: I wanted to pipe in here with an underlying question that always seems to be under the rug in these conversations and that is for both of you, what kind of criteria do you apply to make sure that the involvement of members or participants is really meaningful engagement and not some kind of tokenistic gesture or token engagement?

Ben Jauregui: One thing that I do is if we have a presenter, let's say I have somebody from case management come and talk about a new program that we have. And they may ask some questions from the group. And they get their questions answered and we ask further follow up questions. I moderate/facilitate the workgroups, and so I always interject and ask for more explanation of the answer. Why do you feel that way? Or what do you think we could do to improve that? And just ask for more clarification so that way they're really just expressing themselves fully. They really are providing meaningful instead of just yes or no, we like it, or we don't like it. Well, why do you like it? Just digging deeper, I think, it really makes it more meaningful when we ask folks to dig deeper into their answers.

Chris Duff: I agree with what Ben is saying. The one thing I kept telling myself, and this is myself as a highly verbal person, is to shut up at these meetings. That basically I think it's important to listen, especially where most of our role in those meetings is to listen. And I try to keep the agenda brief so we didn't like fill them with all sorts of information and details. So, that was one thing was to make sure that we consistently listened and we always tried to get a couple people weighing in on every subject that we were discussing.

Another thing is we kept a log of issues that were brought up in one meeting and we always reported back to the group what we did with it in subsequent meetings. Sometimes it was resolved in the next meeting. Sometimes our report was still working on it. This is the stuff we're trying. And we'll bring more information back to you when we have it together. So, I think there's some accountability to the group for what they've brought to you, that we owe them some responsibility back with what we're doing with that information. So, that's the other piece.

I think that's why sometimes attendance is a problem is they don't feel they're being listened to or getting a lot of value out of it.

This might be a good time to go back to the results of that last push poll that we sent out. And it's interesting that only 7% of you found that there was significant value in the survey that you guys currently use. 41% said moderate/minimal. And almost as many, almost 40% said they don't currently survey your participants.

I guess I would really encourage organizations if you don't survey or if you're not getting much value out of it to step back and say why are we doing this. Some of the surveys are mandatory in order to compare some of the cross plans and so on, but one of the main purposes or how are we doing surveys was so that we didn't have that lag time between when they joined us and when they may first get surveyed.

Another idea would be just to do some random calls. We actually hired members. And anyone who would get a call from one of our members, they would always get a letter in the mail before the call was placed telling them that a member would be calling them and that if they're not going to talk to a member they should say that at the very beginning. And in the phone calls they acknowledge that. I don't think we ever had any member who said they weren't comfortable talking with another member. They actually liked that. The problem was keeping the conversations on topic. The problem is they can be quite involved.

So, I think if you're finding no benefit or moderate benefit I would encourage you as an organization and ask yourself are the questions wrong, are we missing the mark, what is it? Because I think what we're being challenged to do by our participants as well as our payers is to make sure that we do listen to the participants and that we learn from what they're having to say and apply what we are learning.

June Kailes: Chris, June here. I have to ask with your survey, you would initially send it out and then the people were, if you didn't hear from people you would call. Is there a breakdown of who would respond to the call who didn't respond to the survey? And the reason I ask is that currently with what's going on in our healthcare is that people are getting bombarded with things in the mail. And we always wonder about who even looks or can read or can access the information that they get in the mail. So, do you have any sense of the response rate from your mail versus the response rate when you reached out and called them?

Chris Duff: That's great. A quick response to that was a majority, probably about 50/50. 50% returned it in paper, probably even less. Most of the surveys were completed as a result of the phone call.

June Kailes: So the phone kind of increased the accessibility?

Chris Duff: Yes. And I think some of it also gave a connection that they liked having to someone to connect with with the organization who wasn't their direct care coordinator. And, Ben, you can comment on the last survey.

Ben Jauregui: Yes, I just wanted to say the CAHPS survey, one way that we make the results more meaningful is that we actually get the results from the CAHPS surveys and we actually kind of do a survey in front of the group. We ask them the same questions that the CAHPS survey asks and then we ask them for their feedback on why they answered that way. And that really helps us to understand the results because it's great to get the results, we see what our members are thinking, how they're rating us, and what they think of their healthcare, but it just gives it more meaningful, it's more significant when we ask them why do you feel that our members answered this question this way. Why do you think we are rated lower on this or higher on that? And to be able to go back and say can you help us understand this more clearly. It just gives them more – makes that more significant survey results.

Chris Duff: That's really nice. So, you're taking one, listening to the member's strategy, and bringing it to another to help you understand it?

Ben Jauregui: Yes.

Chris Duff: That's great. I really like that. I think that's very good. Judy from Illinois asks again whether we allow people to participate telephonically and we certainly did. And we always had between five and seven people who participated by phone. Sometimes there are some sound quality problems, but generally that worked pretty well. Do you, Ben?

Ben Jauregui: No we have not. We've never done that. It might be because we provide a good lunch for folks! There's an incentive. I believe they also like the interaction and perks. And they get to meet other folks and really just to interact. And it just I think in person is more meaningful. And because we provide transportation, you know, getting to the meeting is not a challenge where they have to call in. But, we're definitely open to that if necessary.

Chris Duff: Great. Ben, can you talk about any other community activities that you or your staff participate in? And then how do you get – and I'm thinking community fairs or whatever – and how you get what you hear from these community activities back to your internal staff?

Ben Jauregui: Absolutely. Our disability program staff are very involved in the community. I participate on many commissions and boards. I'm on the IEHS Advisory Committee for our county, local country here. Just various committees that I serve on. And the purpose of that is, of course, to build a relationship with our community partners, but also to get feedback. And I get great feedback any time I'm at a community fair, any time I'm at an advisory council. The topic of healthcare comes up and they look to me for questions, concerns, comments, and it's a good opportunity to meet our members, to meet the community organizations that are serving our members, or family members and just get continuous feedback throughout the year on how we're doing or what's going on in their lives.

And I bring that back and share it with internal workgroups and committees and always looking for ways to improve the health plan by taking that feedback from multiple sources, not just that member workgroup, but other workgroups that I've mentioned. Inland Empire Disabilities Collaborative is a great place to get feedback from service providers, professionals in the field. The CCI Stakeholder Advisory Committee includes everybody who is a part of CCI as I mentioned earlier, from CBAS center, to the CSS,

to the public authority. All of these groups come and they're going to help us develop CCI, that we've been meeting for awhile now and they're helping us to guide and to shape the CCI product. And it's been valuable to get feedback from multiple sources.

June Kailes: And Ben I just want to translate the abbreviations for the non-Californians. So, help me out. CBAS is Community-Based Adult Services.

Ben Jauregui: Formerly know [Adult Aid] Healthcare Centers.

June Kailes: Yes. And IHSS is the California public program for personal attendants or personal assistants.

Ben Jauregui: Correct.

June Kailes: CCI, Ben is?

Ben Jauregui: The Coordinated Care Initiative. That's bringing together Medicare and Medicaid benefits under one health plan.

June Kailes: In California?

Ben Jauregui: In California.

June Kailes: Well I think we've got all those abbreviations. Thanks.

Ben Jauregui: Sure.

Chris Duff: Thank you for that and I wanted to acknowledge to people and apologize for not opening the phone lines. We had so many written questions that came in. We just stuck with that. And we have time for one more question, but while we're queuing that up what I'd like to do is go towards the end of the PowerPoint presentation, go over some of the resources that are on slide, I believe eight, slide 19. Resources and References. First is a brochure that was put together by Community Catalysts. It's a great brochure. And it highlights several mature disability-competent plans and some strategies they have. And it addresses the issues from Judy, I believe, about board representation. One plan does do that and talks a bit about that. So, I encourage you to look at that.

We have the How Are We Doing Survey from AXIS. And then some material that was actually developed by one of our presenters, June Kailes, on the effect of including people. And I would encourage you to download those documents and look at them after this presentation and glean information from it.

And then I also wanted to suggest that you look at slide 23 and talk a bit about Community Catalysts. Community Catalysts has a project going where they're funded, they're a Boston-based organization that is funded to work with a variety of local stakeholder groups, and I think it's five or seven of the demo demonstration states. So, they actually have workgroups that get together. They make phone calls. They have various meetings. And they are actually – they have a great website and that's the material that I would encourage you to look at, but they're actually doing a webinar on this very subject in about a month. Well, two months, in April. So, I encourage you to look over that. If you go to their website, it's at the bottom of the slide, I'm sure it will give a link to obtaining information about that.

I've participated in several of their webinars and I've attended several of them and they do a great job, so I wanted to give a shout-out to them.

So, do we have one last question from June or anyone else? Okay, if that's the case, I think what I would like to do is call people's attention to a few other things. First is the satisfaction survey that we have provided a link to. I believe that's slide 16. I would encourage you if you have a minute at the end of this presentation to fill that out. It would really give us feedback, not only about how this presentation went, but also about future topics. We're always trying to make sure that our topics are meeting the mark of what people are struggling with today, not just what we think they're struggling with, so the more you put down in there the more helpful it is. You can also feel free to contact any of us at the emails provided on slide 19.

And I also wanted to encourage you to spend some time going around the resources for Integrated Care Website. That's slide 21. And there you can download the Disability-Competent Care Self-Assessment Tool and a whole variety of other materials related to the demos. We'll be putting – all of the webinars are put up there for your reference. All the materials with the webinar is also there. And as we prepare further materials they'll be posted there. So, I encourage you to periodically go to that website to obtain more information.

With that, I wanted to remind everyone that next week we have a webinar on wheelchair – I'm trying to get the exact title here. Just one second. On Mobility, Seating, and Seating Assessments, and Equipment Procurement. People in the dual demonstrations the plans are not being expected to assume responsibility for sometimes simple, sometimes complex mobility and seating needs. And so we've engaged a person who is really a national expert and has developed a lot of the assessment tools to present next week on what you need to think about and why is it important for people with disabilities to have the best equipment. And so we will be talking about both the assessment process as well as procurement.

And then the last, the fourth webinar in this first four series was going to be on wheelchair training. So, it's not just getting the right equipment, but it's also training people on how to use their equipment and charge at night, that kind of thing, but also maintenance, what are some good maintenance standards for electric wheelchairs, power chairs. And thirdly issues related to repairs. Many people with disabilities rely on their wheelchairs just to function in life, so if the chair is on for a couple days there needs to be an alternative available. How do you work that out? It's not as easy as just getting a loaner, because many of these wheelchairs are specially equipped to meet the positioning needs of individuals. So, we'll be discussing some alternatives along those lines.

With that, I wanted to thank everyone for attending today's webinar and I do hope you'll spend some time looking at the resource material and filling out the evaluation and giving us your ideas for the future. Thank you very much.

Operator: That does conclude our conference for today. Thank you for your participation and for using AT&T Executive Conference Service. You may now disconnect.