

The Lewin Group
Introduction to DCC and Disabilities
February 8, 2017
2:00 p.m. EST

Christopher Duff: Good afternoon, everyone. Thank you for joining today's presentation. Please take a minute to Orient yourself to the screen. Virginia gave us a bit of an orientation but I want to review it one more time. If you have a question, please use the chat function in the lower left side. Technical questions will be addressed as they come in, and content questions will be addressed towards end of presentation. If you would like to download the content of this presentation, please use the triangle icon on the top right. Live closed caption is available at the bottom of the screen.

My name is Chris Duff, and I am a disability practice and policy consultant who has been working with The Lewin Group on the development of Disability-Competent Care and related trainings, webinars, and materials. On behalf of The Lewin Group, I would like to welcome you to our 2017 Disability-Competent Care webinar series. The Medicare-Medicaid Coordination Office, at the Centers for Medicare and Medicaid Services, has contracted with Lewin to develop technical assistance and actionable tools to support providers in their actions to deliver more integrated and coordinated care to Medicare and Medicaid enrollees. This series will consist of seven webinars running on consecutive Wednesday at this time through March 27th. All the webinars will be recorded and are available along with a PDF of the slides at the Resources for Integrated Care website with the web link on this page.

In 2013, we published a comprehensive Disability-Competent Care self-assessment tool describing Disability-Competent Care, and we have since produced 25 webinars on the topic and numerous supporting tools and documents. These are also on the RIC website. The DCC material has recently been revised to be more assessable to users and reflect the further development of the field. It is now structured in seven pillars of Disability-Competent Care.

In this series, we are introducing the seven pillars in separate webinars. We will be allowing at least 15 minutes at the end of each for discussion and questions. We would like to solicit your opinion on this series as well as past webinars and supplemental resources. Please take 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 this presentation.

Today, we will present an overarching definition of disability and some background information to inform your understanding of the population of adults living with disabilities. We will define disability and its impact on those who live with the disability. We will be hearing from a couple of persons describing their experiences and interfacing with healthcare providers. We will follow that with an overview of the seven pillars of the DCC model. Most people have used disability as a medical condition such as blindness, medical injury, and others. Over the last couple of decades, this definition has evolved to reflect the one on the screen focusing instead on the impact upon those living with a disability. The DCC model is based on looking at disability from a function-based perspective understanding and addressing the eliminations experience.

If you know one person with quadriplegia, the next one you meet with quadriplegia will certainly be different. We all vary by age, gender, gender identity, race, ethnicity, socioeconomic status, sexual orientation, function and other factors. Disability-Competent Care requires that we understand the participants as individuals. Each will experience their disability different. Each has varying disability and chronic conditions, and each will have different functional limitations to their disability.

Functional status identifies the impact of the disability whereas diagnosis identifies the cause or source of the disability. Functional limitations are identified using a standardized tool assessing activities of daily living commonly

referred to as ADLs or instrumental activities of daily living referred to as IADLs. You will hear of these throughout this webinar series. These are standardized tools that have been in use for many years and serve to provide a foundation for identifying the specific supports a person needs. As you can see on this slide, ADLs include self-care tasks such as feeding, bathing, and dressing. IADLs include tasks that enable an individual to live independently in the community such as using telephone or communication device, homemaking, meal-prepping, and others.

For example, a diagnosis of Spina Bifida doesn't indicate what an individual can do. Physical capability and capacity, along with the living environment, are indicative of varying levels of functional dependency. Thus, the need for ADL's and IADL's assessments. Disability types are commonly broken down into four clinical categories usually for purpose of service and program eligibility. These are most quickly accessed when analyzing medical records or claims history. Examples of physical disability are a spinal cord injury, multiple sclerosis or other mobility impairment. Examples of intellectual or developmental disabilities are autism, cerebral palsy, or other intellectual impairments. Examples of sensory impairments are vision or hearing limitations. Examples of behavioral impairments are major depression, behavioral limitations, and chemical health challenges.

It is also important to understand the differences of being born with a disability and acquiring a disability later in life. For persons born with a disability, that is all they have known, and it is quote on quote, normal to them and their family. Understanding and self-acceptance is seldom an issue. Conversely, for those who acquire a disability after they and their family have begun to establish their identity is a very different issue. These individuals often struggle to understand and integrate this change into their life and self-image. Lastly, it is important to note that individuals rarely fit into one category. For most, they experience components of one or more. Sometimes the co-existing or co-occurring disability is a direct result of a primary disability. An example of this would be depression or anxiety a person with a physical disability may develop due to challenges interacting with the healthcare delivery system or even friends and the broader community.

Most all of us will experience some decline in function as we age. For me, I need glasses and find myself needing to write things down for recall. Of course, while I am still in denial, I've been told I am losing my hearing acuity. These are not commonly disabling when they first present. They become functional impairments as they become more severe.

Lastly, it is important to understand the distinction between visible and invisible disabilities. Visible disabilities are those that are readily evident to others such as spasticity or the need to use a wheelchair. Invisible disabilities are those that are not as readily evident to others. They can include hearing loss, diabetes, arthritis and many mental illnesses. Because many live with invisible limitations, it is extremely important to inquire, of the individual, whether they have any disabilities or limitations they would like you to know about. Alternatively, you could ask if they have any accommodations. This is especially true when interacting over the phone when you don't have the benefit of a visual image. In 2015, an estimated 14% of noninstitutionalized male and female of all ages and races, ethnicity and education levels in the United States reported a disability. These statistics were calculated by Cornell University using the U.S. Census Bureau 2015 American Community Survey. Upper governmental estimates have the number as high as 20%. Therefore, between 40-50 millions of persons in the United States live with a disability.

Looking at this from a different perspective, there are 7.5 million dual eligible individuals under age 65 in the U.S. most of whom are dually eligible due to disability status. Let me clarify here, by dually eligible, I mean they are eligible for both Medicare and Medicaid. It is also important to look deeper than just the incidence of disability. Research has shown these individuals experience material hardship including difficult in paying rent, or utility bills, food and security, limited access to medical and dental services, limited options for transit, under-employment or unemployment, family and social relationships, social opportunities and meaningful activities. They are also disproportionately represented in racial and ethnic groups, and are growing in number as the population ages. Building upon the last slide, research has demonstrated that persons with disability experience significant health disparities. They experience worse outcomes and are less likely to receive recommended care. They experience

delays and barriers in receiving necessary care. They have lower levels of receiving recommended health screenings such as breast and colon cancer screens, and cholesterol and diabetes care. Many have not had an annual dental visit, which is commonly due to accessibility issues. They have limited knowledge and access to sexual health information and others. It is our hope and intention that this, and related Disability-Competent Care trainings, will begin to address these disparities.

The National Academy of Science, Engineering and Medicine are about to release a report on social risk factors and their impact on Medicare and Medicaid costs. As the government moves from fee-to-service payments to a variety of value-based payment models, it has been demonstrated that social factors need to be accounted for in value-based payments for diagnosis alone does not fully reflect the cost of care. This report identified five domains of social risk, which have certainly been well known for years by those with a disability or those of us working with the population. The Star Quality metrics and measures are one strategy being used to address this concern. Along with the social factors, it is necessary to be aware of disability-related biases. These biases can often inhibit listening to and learning from the participant. Together you and the participant can develop plans and strategies that will result in the best care and minimize adverse health outcomes. This will be addressed in much greater detail in the third webinar of this series. At this point, we are going to show a short video. Please remember to turn on your computer sound. These vignettes that we are going to show in this webinar and some of the others were developed by DREDF from California. They show people talking about their experiences interacting with the healthcare system. The first is Jim LeBrecht who was born with Spina Bifida. He grew up outside of New York and went to college in Southern California. Jim moved to the east bay of Northern California to take a job with the Berkeley Repertory Theater as a sound engineer. He has recently opened his own business serving the film industry. In this clip, Jim is referencing the biases we all bring to working with people with disabilities. He is asking us to listen to his experience and be a participant and together build a plan of action.

Jim LeBrecht (video): Here's the key here I think. There's many ways to deal with certain situations and but your patient that has a chronic illness has been dealing with it 24/7 and you're there rolling into your or walking into your room and it's like – and if you knew how to trust their judgment versus your years of experience in medical school and collaborate with them. I think you'd get much better results. If all of your knowledge about kind of the world and techniques of dealing with folks has been based in medical school and has been based basically on people who were bipeds, you know, people who are walking around who don't really have any active disability going on, then you're missing out on some really important information. I think that looking at your patient with a disability as a resource and not a problem would be a really great place to start. Ask them and learn from them and then share that information.

Christopher Duff: I think Jim explains the situation well. I think this is also a good point for me to reference some language issues. Jim used the word patient at one point in this video. I tend to use the word participant. Client is also used in the field. What people with disabilities generally prefer is a more active reference. So being a patient kind of implies passive; passive to the professional who's telling them what they need. We use participants to reflect their active involvement with their care team.

As most of you know, there are many challenges in the existing healthcare delivery system. This slide describes a few challenges and their results. Care is commonly reactive and proscriptive. It is fragmented exemplified by the fact that most persons with a disability see multiple specialists who have limited access to experienced primary care. Many settings of care are inaccessible, to some degree, from getting into the building to as simple as being able to maneuver within them. Lastly, care is increasingly becoming standardized and uniform. While this is often good, being based on extensive studies and research, most persons with disabilities have extenuating situations or issues that may require modifications from this standardized care. A result of this care is extensive avoidable costs both financial and personal. Poor care results in avoidable costs and often misery on behalf of the participant. Payment incentives are misaligned leading to transfer of costs to other payers, providers, and even the participant. Lastly, as mentioned earlier, there is a very limited available of experienced primary care practitioners willing and able to see

persons with disabilities.

At this point, I will move into the Disability-Competent Care Model itself. As the statement says, it is designed to meet the needs of this participant and address their resulting functional limitations not just their diagnoses or condition. This slide describes the basic components of the model of care. This is participant-centered and delivered by an interdisciplinary care team. It focuses on maintenance of health, wellness, and life in the community as the participant chooses. The model recognizes and treats the individual as a whole person not just a diagnosis or another descriptor. It is designed to respond to the participant's physical and clinical needs while also considering emotional, social, intellectual, and spiritual needs.

This slide is another way of demonstrating those basic tenants. The DCC model calls for a shift in attitude from the traditional medical model, where the professional knows best, to the DCC model which is also known as the person-centered model. For example, the problem is not the person's impairment, but the results from the attitudes and environmental barriers. That moves the locus of the problem from the individual to the environment. The solution to the problem changes from fixing the person, for most cannot be fixed, to barrier removal. The individual is not viewed as a patient or client, but as a participant, consumer, or user of service. Lastly, but very significantly, the control is shared between the professional and the participant with the final choice lying with the participant. If you reflect back to the vignette of Jim LeBrecht, I think you will see all of this referenced in his comments. At this point, we would like to show another video and, again, turn on your sound if you would like to listen to her talk. We will hear from Karen Schneiderman. She is currently the Director of Advocacy at the Boston Center for Independent Living. As with Jim, she was born with Spina Bifida. She grew up on the east coast and went to college on west coast and then returned east for work.

Karen Schneiderman (video): I mean there are two classes of people. There are the professionals and there are the patients. And it doesn't matter who you are, what you are, and in fact, I think that if you express either a strong opinion or you appear to be intelligent, I think sometimes that's used against you because it's like you're engaged in a warfare with the medical community. I understand the need for medical expertise, but I think that there are some areas where the person with the disability needs to be consulted and trusted to have the best either solution or something that will prevent things from getting worse or some new problem arising. They do not understand that they have certain skills and those skills are to be respected but that people with disabilities have their own skills as it comes to, using—experiencing their own body, working with their own body, taking care of their own body. And if we don't work collaboratively, the healthcare will break down.

Christopher Duff: I hope you are getting the point we are trying to model here listening to the participant. They are the ones that are living with it, who have the history, and often bring very important insight into where to go from here in terms of what their needs are. I think these vignette, and the future ones we will show most of whom will be from the DREDF website, help model this interaction.

The DCC model evolved from a few pioneering programs in the late 1990s. These programs matured and revised their model. Components were adopted more broadly by health plans and health systems. This model has evolved into what has become known and recognized as best practices. The DCC model was developed by those involved in the pioneering organizations and was released in 2013. Following input from subjects matters and experts and field testing by several health plans. It has been revised to reflect the experience from the last several years and further development of the field and practice.

This slide contains a diagram of the core values of the DCC model. I won't go further into being participant-centered as I've been addressing this throughout the webinar. Respect for participant choice and dignity is sometimes challenging for providers. Most of us were trained in a skill or a profession and have gained specific knowledge. We have been expected to impart that knowledge on people telling them what we think is best for them. But that often backfires resulting in frustration for all involved, a breakdown in trust, and we reflect a

disrespect of the individual participant. Most important, it seldom brings about the best outcome. We have provided some webinars in the past on this subject, which you can find on the RIC website.

Thirdly, elimination of medical and social bias is also a hard concept. What we are addressing here is a judgment or an honest belief that an individual may best be taken care of in a certain setting such as a nursing home or a group home. While that may, in fact, be true from a purely medical perspective, it will certainly not be successful and if it's inconsistent with the goals and expectations of the participant.

In summary, people with disabilities have unique needs and challenges with the healthcare delivery system. The DCC model requires a change in mind-set and in practice and serves as a tool to help providers meet the unique needs of the population. Based on user feedback and the experience and the development of the field, we have restructured the DCC model into seven pillars of disability-competency. As you can see, they start with the basic tenants of the model to participant engagement, access, primary care, care coordination, long-term services and supports and behavioral health. I will briefly go through them in the remaining slides giving a little more attention to each pillar.

We have focused on this pillar throughout this webinar, so I will not go through it any further at this point. The second pillar focuses on participant engagement. To build trust, we suggest starting off by asking the participant to describe themselves and their life. Ask what is important to them and what they want and need. Participant engagement is not just limited to sets of communication with the participant but also with the participant's family members and other caregivers. This very seamlessly leads to a comprehensive assessment with a level of trust that will facilitate open discussion. The third pillar focuses on all aspects of access, which is perhaps the greatest barrier to care experienced by persons with disabilities. The DCC model describes access in the following terms: attitude, biases or stigmas associated with disabilities, physical (that's the most obvious access barrier and follows the requirements of the ADA), equipment access (that's exam tables, scales, and x-ray and radiology), communication, (that is interfacing with the participant such as using interpreters for those who are hard-of-hearing or deaf), service access, which refers to referrals and need to ensure that those who are the source of the referral also will be able to meet the needs of individual. An example of this would be referring someone to an ophthalmologist, and that ophthalmologist's office needs to be accessible and their machinery needs to be used by someone who is in a chair. Lastly, programmatic; that is ensuring there are no systemic barriers to receiving appropriate care in a timely manner.

The fourth pillar focuses on the provision of primary care. Disability-Competent primary care is the key component: enhanced primary care with home-based episodic care provided by a physician or a nurse-practitioner, the focus of that is to capture avoidable episodes of illness. The focus on early intervention to prevent exacerbation of chronic condition. 24/7 access of informed and knowledgeable clinician with electronic health record capabilities. Ability and willingness to partner with the care team, and inpatient management with transition planning and follow-up. As we all know, that's often where the greatest difficulties will occur. And lastly accessible physical facilities to ensure appropriate adaptive equipment and flexible scheduling.

The fifth pillar is care coordination. Relational care coordination is a practice recognizing the participant is a primary source of identification of care goals and priorities. Key components of this pillar are dignity of risk, requires informed decision-making, team-based care with competency and primary care, nursing, and mental health and community-based services. Note here, I'm not necessarily naming people's professions. I think what is important is that they have the competency in that area. So primary care. A physician, nurse practitioner, physician assistant are all possibilities. Sometimes some IDTs have a community-based service professional who offers expertise in mental health. So, that could be one person. So, the issue at hand here is that it is team based care with those competencies. Comprehensive and timely assessment and reassessment. Reassessment is based on anytime a change and condition is experienced by the participant. Personalized plans of care incorporating the individual healthcare goals and preferences. Lastly, perhaps among the most important

components, is management of all transitions with clear communication and accountability of rules.

The sixth pillar focuses on the provision of long-term services and supports requiring flexibility and care planning. This pillar includes ensuring participant choice in where and how they live, personal care services using either person-directed or agency modeled, equipment purchasing, fitting, seating, training and maintenance clinics, enhance independence by a medically or functionally necessary equipment and technology, and flexibility to use alternatives in lieu of traditional home-based supports.

Lastly, the seventh pillar is focused on identifying and addressing behavioral health needs and is considered an integral component of comprehensive disability-competent care. Including in this pillar are mental health issues and their impact on the participant, substance abuse, and chemical dependency.

In conclusion, disability-competent care is just like any other care. It additionally requires understanding of the experience of living with a disability. With this understanding, practitioners and plans can establish a relationship with each participant and together they are able to develop a course of action. I worked with a medical director in Minnesota who said the most important tool brought to our services is the relationship we are able to establish with each and every participant. He said without it, we would not be able to meet their needs. With it, we can together accomplish goals they have identified.

In summary, the DCC model requires interacting with the participant as a partner and treating them as an individual, not a diagnosis. It is participant centered, eliminates medical and institutional bias, and respects their dignity of risk. Becoming proficient in understanding the experiences of the individuals we work with is the first step to becoming disability competent. We would now like to open up the presentation to your questions. Please use the chat feature on the lower left-hand side of your screen to any questions about the content of this presentation. I'm now going to turn this over to Jessie Micholuk from the Lewin Group to bring us the first audience question.

Jessie Micholuk: Thank you, Chris. So, we had a couple of questions come in throughout the presentation. First here, going back to the beginning of the presentation, what clinical category does cognitive disability fall under?

Christopher Duff: That would depend, traditionally, that would depend on if, depends on how you look at it. We look at it from a functional perspective. How is it getting in the way of the individual, the ability to function? Traditionally, it could be in the category of persons with developmental or intellectual disabilities. It could also be subsequent to a brain injury, but again, we are trying to move people away from thinking about diagnoses and move towards thinking about the “so what” part of it. What is the impact of that limitation on the person's life? That, then, is our job in helping them be functional.

Jessie Micholuk: Thank you. Okay, the next question we have that came in here is asking about an example of home-based episodic care capacity.

Christopher Duff: That's a great question, and that's among the hardest to put into practice. I have several examples that, I think, would get at that. So, the individual, let's say it is an individual with quadriplegia. The individual is noticing that their urine is getting cloudy. So, that's a sign. They've lived with their disability for several years, so they know that likely means they are getting a urinary tract infection. So, the usual way to handle that, they would call their care team or their primary care doctor. And hopefully, they would get an appointment; likely that would be days off, and then they have to try to get transportation to get there. Often for a quad, the cost of transportation is several times more than cost of the care. And so, the other factor in mind is with people with quadriplegia, often they are going from being stable to a systemic infection, could easily be 24 to 36 hours. While many of the rest of us who get an UTI can push through it and do our home remedies and all that. We are not as, we don't go south as fast shall we say. So, what we need in this case is to get care to the

individual quickly. That can be done a couple of different ways. One way would be a primary care practitioner going out to the house to diagnose and begin treatment. Another way would be to have an arrangement with a lab that the lab or nursing or skilled home health agency would go and get a sample within 24 hours. Get it tested very quickly, and that the physician or the primary care practitioner would look at the results and then order an antibiotic and get that to them, so they start treatment within 24 hours. That last alternative avoids a primary care doctor needing to go to their home. That is one example of home-based primary care. What the issue is here is that we have to know the person. One more example with UTI that we did in Minnesota, many people with spinal cord injuries would get repeated UTIs. Usually, it would be the same -- they would need the same prescription as a result of the UTI. So, what we would do is give them a supply of the antibiotic to keep in their house. We would then ask them to not to take it we got the lab results back to confirm they are taking the right antibiotic. Then we are saving all the time of getting the prescription to the pharmacy and getting the pharmacy to deliver it to the individual.

So, those are all examples of primary care intervention that keeps the person, a) out of a primary care clinic that may, or may not be, accessible and timely, keeps them out of the ER because the infection has become much more serious. As we all know, once you get into an ER or hospital, it often becomes more problematic.

Jessie Micholuk: Thanks. Just a very quick follow-up to that question you were just answering. It is a little bit specific, but the home-based care that you were just describing, is that Medicare-Medicaid billable?

Christopher Duff: If the provider is in a capitated plan, they can enter codes and all of that. If they are in fee for service Medicare, it depends on their license, the state they are in, and the contract they have with the pair, whether it's the state or the health plan. So, to bill straight Medicare or Home-based care, it won't reflect the added cost of delivering the care at home because obviously it is more expensive to get a practitioner off to the person's home than to have all of these people lined up in the practice to be seen.

Jessie Micholuk: Great, thank you. Next question we have here is could you further discuss adherence to a treatment plan and the dignity of risk?

Christopher Duff: Yeah, you know, if you go to the RIC website, you will actually see webinars where we talk about that that are just dedicated to the dignity of risk. We also have a couple of first person stories. One is John, and I can't remember the other person's name. They also talk through that very concept. Let's take an obvious one. One of the two we have up is around diabetes, and another one may be around smoking. Let's take the obvious one: smoking.

We all know smoking is not good. For a doctor or a care coordinator or mother or a spouse to tell the person, it's not good for them and they should stop, is likely not going to have much of an impact. So, what we are talking about here, is not that we say, "oh, well, okay, that's the way it's going to be and ignore it." We keep talking to the person about it and keep engaging them with it. Not in the initial visit or the subsequent visit, but over time. Next time they get a cold, maybe bring it up then, you know, the way the cold is lasting longer than for others could be related to your smoking. Obviously, the same for pneumonia and bronchitis. More about education and engagement is what's that is about. We try to stay away from the term "compliance" because it goes back to we know what's best for you, and with a lot of people, I know another person with a disability who was -- who needed a surgery. The person smoked a few cigarettes a day. We are not talking a large amount. The surgeon, and it was a minor surgery, says I will not provide surgery until you have been off of cigarettes for six weeks. There is a correlation to nicotine and healing. This person also struggles with a severe mental illness.

So, going off cigarettes for that person while they are facing the surgery and struggling with serious mental illness, the greatest risk was cold turkey from the main coping mechanism that individual had for their severe depression. So, that's another example of the engagement with the person. In that case, we talked directly with

the surgeon, explain the situation, and he said, I understand, I will schedule the surgery immediately.

Jessie Micholuk: Great, thanks, Chris. We have another question that came in here from the audience. Do you see primary care practices or primary care physicians having to add staff or changing their structure significantly to effectively do this, do disability-competent care, and do you think they will be open to this change?

Christopher Duff: Yeah, and our experience is, and we have a webinar and a Medicaid medical director from Aetna is going to talk about this, it is about engaging primary care. I understand the question, and there is no easy answer. Our experience, and I have been doing this for 20 years around primary care, is that the practitioners want to. They to want provide care to the people who need their care. The issue is that all the systems around them interfere with that. An example is someone with a speech impairment, it takes a lot longer to do a physical than it would on me who can talk very sound. That's just one example, so it does take some accommodations. We will be talking about that in webinar 3.

It does engagement of physicians, you need to try to develop a lot of support mechanisms to help with that. We have a brief, on the RIC website, on engaging primary care. May I refer you to that? But another example is in the dual eligible plans that are growing in this country, the issue becomes one of -- what you need is you need the glue between the primary care physician and the care plan. Who is going to make that happen? Physicians don't have time to do that. The question is, where does that care plan -- care coordination sit? Many places it is sitting within the primary care practice. So, they are either hiring the care coordinators themselves or the health plan is giving them additional money to hire them or the health plan is placing people in key primary care practices.

One common thing that we did when we started this 15 years ago, is we looked at who are the practices that feed the most people with disabilities? In other words, we try to follow our members. Where do they go? They are going there for a reason. It may be as simple as its accessible or it may be that they like the person; it doesn't matter. Then, we make a connection there. The goal is to have champions within that practice and you need two kinds of champions. You need a physician champion. Not that that physician will take everyone with a disability because their capacity to serve people will shrink because they take longer and are harder often, but someone who can serve as a resource to other physicians in that practice or practitioners. Other person you need as a champion is a manager there because a lot of work that needs to be done in primary care practices is around making sure you track accommodations. When you're scheduling an appointment for the person, make sure you observe the large exam room with the up-down exam table. When the person arrives, you can actually serve them. That system stuff that you need engagement from a clinic manager or someone on that side of the shop to build that in to their practice pattern. We will talk about that a lot more in the third webinar here.

Jessie Micholuk: Thank you, Chris. I think we have time for one more question here before we wrap it up today. So, we have one more that came in through the chat. How does care coordination for persons with disabilities vary for care coordination for other populations?

Christopher Duff: Yeah, in some ways, I would look at it. How does that -- I'm not sure what the person means by other populations. I guess it's something for geriatric or someone who has Alzheimer's. If you start at -- I, an adult, don't need care coordination because I'm capable of doing that myself. For other populations, the issue is you need to first of all stop and understand who they are and what their needs are and then accommodate those needs, whether it's Alzheimer's, whether it's -- whatever the other issue going on, care coordination is care coordination. Your competency, you may need to understand a little more about certain things. I do not understand dementia very well. I would need to bone up on that if I wanted to be a care coordinator with that population, but the foundational skill set that I would need to bring is the same that I would bring within the Disability-Competent Care model.

Jessie Micholuk: Thanks, Chris. So with five minutes left, we have enough time to wrap it up with remaining the slides then.

Christopher Duff: Great. In conclusion, the Disability-Competent Care model is just like any other model, but additionally requires an understanding of living with a disability. With this understanding, practitioners and plans can establish a relationship with each participant and together develop a course of action.

Virginia: Thank you, Chris.

Christopher Duff: I think we are at the end of our time. In closing, we appreciate everyone's questions and we're going to send this back to RIC and the narrator. I would like to call your attention to resources that we have online including the disability competent care self-assessment tool. I hope you will join us a week from today for the second webinar, Disability-Competent Care Participant Engagement. Again, I would like to thank the Centers for Medicare and Medicaid for sponsoring this webinar and the entirety of this work. Thanks for attending