

The Lewin Group
Webinar on a Disability Competence Resource: DCCAT
December 13, 2017
2:00 p.m. EST

Jessie Micholuk: Thank you, and good afternoon, everyone. Welcome to the Disability-Competent Care Self-Assessment Tool (DCCAT) webinar, where we will be introducing our updated resource. My name is Jessie Micholuk, and I'll be getting us started today.

If you have any questions throughout the presentation, please feel free to enter them into the Q&A feature on your platform. We'll be addressing your content-related questions during the discussion portion of this webinar.

The Lewin Group, under a contract with the CMS Medicare-Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to create the DCCAT. As I mentioned, this webinar will be interactive with 45 minutes of presenter-led discussions, followed by a 15-minute presenter and participant question-and-answer session. The recording and slides will be available after the session on our website, <https://www.resourcesforintegratedcare.com/>.

This webinar is supported through the Medicare-Medicaid Coordination Office to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare and Medicaid enrollees, the Medicare-Medicaid Coordination Office is developing technical assistance and actionable tools based on successful innovations in care models, such as this webinar.

To learn more about current efforts and resources, again, feel free to visit our website, Resources for Integrated Care at the link on your screen. I'll now hand our presentation over to your moderator for today, Chris Duff.

Christopher Duff: Thank you, Jessie. I appreciate the introduction. We have a very packed webinar today, so I'll just briefly review the agenda. We will start with a quick orientation to the Disability-Competent Care (DCC) model of care, reviewing the evolution of the model and the seven pillars. We will proceed to explain how to use the self-assessment tool, which can be found at the Resources for Integrated Care website. Next, Care Wisconsin will talk about how they used the tool, and a representative from the State of Colorado and one of their community partners will talk about how they also used the tool. Then, as always, we will conclude with 15 minutes of Q&A.

My name is Chris Duff, and I will be narrating the webinar and review the model and revised tool. Chris Brieske and Elizabeth King will present on Care Wisconsin's use of the tool, and Kathleen Homan and Gary Montrose will present on the State of Colorado's use of the tool to further develop their state's disability competency.

As with the healthcare system as a whole, the field of care and support for persons with disabilities has been evolving over the last 30 years. The disability rights movement was launched by Ed Roberts half a century ago, precipitating an evolution that continues to this day. Over the years, Disability-Competent Care has come to be based on his expectation for equal access in all of its forms. The healthcare system has come to see that each individual has unique needs and are not just a diagnosis. That accessibility is multidimensional and not limited to physical access. Social determinants of health must be addressed to support self-determination and community access in order to achieve health outcomes.

As is evident throughout the model, disability is not understood in terms of a disease process, diagnosis or injury, but from the perspective of an individual's functional limitations. The DCC model evolved from a collection of promising practices and processes designed to aid organizations in the delivery of care and supports for persons with disabilities. It matured to address and incorporate changes in the healthcare system, including the expanded use and role of care coordinators, increased engagement of providers with support, training, data and accountability. Perhaps the secret sauce is the ability to integrate Medicare and Medicaid dollars and benefits to address social determinants of health, support independent living, and providing the right care at the right time regardless of payer source.

The previous version of the DCC model was developed over five years ago and had three pillars. When it was originally released, we received feedback that it was overwhelming to use, making it challenging for plans and providers to identify priorities for improvement or enhancement. Additionally, since the field is progressing quickly, it was time to update some of the content.

The current content has seven pillars, restructured to make it more accessible. It now follows a more chronological order of the delivery of care. Most of the content that was in the original tool is also in the revised version. You can see here the seven pillars.

The tool takes the DCC model of care and transforms it into a self-assessment tool. The goal here is to provide a means for plans and providers to assess their own competency, identify areas of strength and opportunities for improvement. We do not believe any one plan or provider will ever be 100% disability-competent. I know I certainly wasn't, but that it is a continual process of self-examination and improvement.

The tool consists of a series of questions within each pillar. The accompanying Evaluation Results Form tracks responses and provides a roadmap to identify strengths and opportunities for improvement. We also provided a user guide to help with the tool which is also at the Resources for Integrated Care website. As I stated earlier, it provides background information for each pillar and a brief explanation of each question.

Using the Evaluation Results Form, the pillars are separated in tabs across the bottom of the Excel spreadsheet. You can also download a non-508 compliant version that can be used on paper. For each question, you will be asked to choose among five answers --

never, rarely, sometimes, usually and always. This slide defines each answer a bit further, so I won't review them at this time, but it is included in the user guide.

Once all the fields are populated in the Evaluation Results Form, the Results Summary tab calculates the average response for each pillar and subsection, presenting an overview that may help you and your organization to better prioritize your opportunity areas. This will provide a sense of where you need to begin to focus. Please note though, that the Average Response column simply provides an average and doesn't reflect the full range of responses in the section.

For example, you may indicate that you usually do the majority of one pillar, but there were a few times that you never do a few individual items. Therefore, we suggest that you quickly revisit your individual responses to each pillar to catch these gaps.

Now, I will transition into describing how we suggest you use the tool. As this webinar will show, there are many approaches to using the tool. Organizations, providers, and states need to decide which steps and processes best fit their culture, available resources and priorities. For example, some plans assigned an interdepartmental team to complete the assessment and make recommendations. Others have clinical leadership review the tool and identify areas of focus. While others have engaged an external stakeholder team or a consultant in the process.

Though there are multiple approaches to using the tool, the process we recommend is relatively uniform. Identify staff members to complete the DCCAT and its subsection. Have each of those individuals read and answer the question individually or together. Capture the results on the Evaluation Results Form. As a team, review the results and determine the priority areas. From there, obtain internal support, reviewing results and recommendations with senior management. Identify improvement team or teams, develop detailed improvement plans with goals, desired outcomes and timelines. Then, of course, periodically review the improvement efforts and progress with the larger organization for understanding and buy-in.

Again, the tool, user guide and Evaluation Results Form can be accessed or downloaded at the link on this page. The rest of this webinar will be dedicated to seeing how the tool has been used in two contexts, an individual health plan and a state.

I will now turn it over to Chris Brieske for Care Wisconsin.

Chris Brieske: Hi, thank you. I just want to start by introducing you to Care Wisconsin. We are a non-profit organization that has been in operation since 1976. We originally started off as an adult day center for elderly members in our community. In 1995, we were part of a demonstration program with our partnership program which is a fully integrated acute and primary, as well as Medicare and Medicaid program. In 2008, we expanded our services and started offering services to Medicaid participants in the home and community-based waiver systems, so the long-term care services. In 2014, we expanded into Medicaid SSI.

Our current system includes 2,000 medical health and long-term care providers and 700 employees in 2018, the majority of those being involved in care management activities. Our membership includes individuals in intellectual disabilities, physical disabilities as well as the frail elderly. They all have a complex medical history with many diagnoses, co-morbidities, and high prescription usage.

So the programs that we have on the slide right now demonstrates the funding source as well as eligibility and the type of benefits that are available to each one of those programs. For purposes of this discussion, we're focusing on our partnership program, the FIDESNP. That's where our efforts were focused in the use of this assessment tool.

With this assessment tool, we had an idea of what we wanted to accomplish and were introduced to this self-assessment tool. It helped us to identify a course of development for a program related to complex care management, utilizing our interdisciplinary care team for the partnership program that includes the nurse practitioner, a registered nurse and a care manager. They all work together to identify members for this complex care management program as well as provide a plan of care for those members.

We're fortunate at Care Wisconsin to have an executive team that's highly engaged in quality improvement initiatives, develop innovative and new ideas for our members, and provide quality care for our members.

Elizabeth King: So with that being said, there is a strong drive at Care Wisconsin to always be looking for opportunities to improve performance. The Vice President of Performance Excellence spearheaded a project to improve care management at Care Wisconsin. She called in multiple key players at Care Wisconsin. We developed a workgroup and we looked through the DCCAT activity findings and really used that to explore and drive our care improvements.

Through this process, Care Wisconsin decided to focus on a subgroup of high-risk individuals with frequent hospital admissions. This was our target group because they seemed to be ones that pose some increased risk both to themselves and also to costs. It's certainly something that the care management group could increase their attention to. So the plan was to identify ways to enhance the care management for this particular population subgroup.

The result was the creation of a complex case management program. Through this, members received a different level of care management and care coordination. The IDT, which again was the nurse practitioner or physician assistant, the VP of Performance Excellence, and the medical director could identify the individuals or participants that would be involved. Their workgroup met frequently and tried to identify strategies to enhance the problem-solving around the care that these individuals needed. That was really the focus of the program.

It quickly was obvious to all of us that we needed leadership. The key feature was to have people who were able to both step up at the highest level both organizationally and at the member level. We identified that these were people who would be willing to step up. They would have to be trained in some way and able to meet this higher level of care management. They needed to address the high-risk member group in sort of a unique way, not the same as what we had done under care management, which is something we're pretty well-versed on.

At Care Wisconsin, we decided that would be our NP and PA group. We identified these as the individuals to start that conversation and to provide the structure around complex care. The NP and PA's job was to lead the mission to engage the member and all of the players involved. This was a process that helped us drive what we call a community care plan and community care team. We looked at who was involved in the members' care and what the issues were. We gathered data and collected information and resources. We looked at who was involved in the care, the supports, the primary care physician group, and anyone who could be a pharmacist in the medication aspect. So we engaged every single player to be part of this process to make improvements in this particular group of care.

Through the outreach, member data was gathered, the care plans were created and this community care plan identified members and their variables, including systems issues, access issues, mental health issues, and we created a write-up or a care plan for all of the individuals who worked with this individual. We created a care plan organized in a way that was adaptable; it included the social determinants of health, and it helped us come up with a care plan that was useful, that we could take into the community, and take into any aspect of care and use it to make the care better.

So once the plan was tested and success was identified, the members' care returned back to the routine level of care management. The key concept is that it was a different place than where we were before. We were using a higher level care management. There were a lot more variables that were considered in this particular group's care plan. It was our mission to make the care better. Through the process and through the issues identified, we were able to make success through this.

So some of the things we learned in doing this and using the DCCAT included the need to be more open and flexible in considering new ways of doing things. Not doing it the same way, recognizing that there was something unique about this group, and that we really needed to do something different in order to make a change and make it better.

We also needed buy-in at the highest organization level. We needed buy-in at the individual level. We needed numbers of participants to buy into it, and we also needed some community buy-in. It is important to have at least one person who is willing to step up and champion better individual member care. It seemed to make a difference. Success leads to improved respect across the board, better care management, and better care access.

Other providers, including the primary care providers importantly, did want to be involved. What they could offer made a difference in terms of how things turned out. So never underestimate the involvement of others in terms of making improvements as well.

Finally, member engagement can be a challenging aspect, but there is something absolutely pivotal about success in this area. So that is not something to be underestimated.

There was trust gained through the process, which helps members engage, but we are still working on creative ways to strengthen engagement. Complex case management resources are consuming, so the number of participants need to be limited so that it can be effective. Skill building and tools to improve efficacy are needed. Finally, tools to effectively evaluate how we are doing are needed. Is what we are doing making a difference? That is really important to us with the goal of reducing member risk.

So in summary, involvement in the DCCAT motivated Care Wisconsin to explore and create complex strategies and helped us refine our care management for those with unique needs.

So I'm going to pass this on now to Kathleen Homan and Gary Montrose. Thank you.

Kathleen Homan: Thank you, Elizabeth. Greetings from Rocky Mountains. I'm Kathleen Homan, representing the Colorado State Department of Health Care Policy and Financing, the State Medicaid Office. I'm here with Gary Montrose, Advocate and Stakeholder Representative Lead on the DCCAT project and work in our state. Let's jump right in.

Colorado utilizes a managed fee-for-service system where we rely on our Regional Care Coordination Organizations, RCCOs, to utilize their own care coordinators or network providers to deliver all care coordination services. The state provides oversight, guidance and monitoring of the RCCOs, and the RCCOs are tasked to implement all initiatives and projects within our Accountable Care Collaborative, the ACC.

They are tasked with three priorities. First, the coordination of care; second, practice support; and third, network development. The RCCOs must develop their provider network and establish a beneficial working relationship between the state and their primary care medical providers, PCMP.

Here is a visual representation of our structure. The state is involved in all elements but you can see the touch points between the RCCOs, providers, the quality performance metrics which are outlined in RCCO contracts, and our data management system.

Gary Montrose: Speaking on behalf of the advocacy and provider community of the LTSS providers, I'd like to jump here and say Disability-Competent Care is a concept with a major priority, and it was able to express itself through the Medicare-Medicaid duals demonstration project

As part of that project, Colorado stakeholders had very strong appetite for improving access to providers for people with severe disabilities. Our DCCAT development work occurred during 2015 and 2016. Some of the most influential stakeholders included a former ADA regional office director, one of six or seven regional offices around the country which happened to be housed in our geographic area. Executives from a very mature, robust independent living center that provides LTSS services to people with severe disabilities and advocacy support. As well as our seven RCCO partners across the state that Kathleen has just described to you, they performed the care coordination functions across the state Medicaid system.

Colorado Medicaid advocates and stakeholders worked extremely well together. It was an amazing collaborative experience. It's something that actually is quite common in Colorado and especially in the healthcare environment where the department reaches out to consumers, advocates, and stakeholders to solicit our input on virtually every major decision. It's a wonderful working environment that we have.

So they were able to put together a stakeholder workgroup that was responsible for the design of the Disability-Competent Care clinic survey, which was the output that we were able to generate after the time we spent together during 2015 and 2016 with all the various stakeholders. The work had robust participation and significant research and technical assistance from a number of providers and partners, including technical assistance from The Lewin Group. Our clinic survey was built on the three pillars of the Americans with Disabilities Act, and that is addressing physical accessibility, communication accessibility, and programmatic accessibility.

Kathleen Homan: Thanks, Gary. Ultimately, Colorado chose to focus on access and primary care for our survey, especially since our managed fee-for-service structure relies on the RCCOs and their ability to leverage their provider network. Access in primary care was seen as a gate for starting Disability-Competent Care conversations in medical offices. So focusing on physical communication and programmatic access within primary care delivery systems was the best way to manage and administer the clinic survey tools for us here in Colorado.

Care coordination and patient engagement pillars in the DCCAT are elements of our RCCO system, and they are addressed within our survey but not specifically as a separate pillar. Thus, Colorado strayed from the original DCCAT but only in practice, not in conceptualization, energy, and overall intended outcome.

Gary Montrose: So the survey tool that we developed drew heavily from other assessment tools, and I think it's important to mention that, but we were just standing on the shoulders of the giants that had preceded us in the advocacy world. The two surveys that we most leaned on was from California, the California Physical Accessibility Review Survey, and then the ADA Checklist for Readily Achievable Barrier Removal, a tool that was developed out of the ADA center in serving the New England states.

Our survey development process looks, as Kathleen mentioned, on primary care. We realized that engaging PCPs would be a challenge. We designed the tool therefore to be as user friendly as possible, framed as an assistive and helpful device for our PCP provider community as a way of meeting the needs of the especially vulnerable populations.

Our goal is to improve practice accessibility for people with disabilities through our DCCAT clinic surveys with as many practices participating as possible on a voluntary basis.

Once the survey was rolled out, it was provided to our RCCOs as a screening tool to be used in their provider support toolkit. Our aspirational goal was to have all seven RCCOs across the state complete six to eight provider practice surveys over a one-year period of time.

The RCCOs has a discretion as to how aggressively they chose to implement the clinic survey. Fortunately, one RCCO was willing to enter into a contract to fund performance of 12 clinic surveys. That was a really key turning point in the evolution of our experience here in Colorado. That RCCO partnered with a very mature, independent living center in Colorado Springs with ADA subject matter experts. This team managed to complete 10 surveys of PCP offices in two different RCCO regions of the state focusing on physical accessibility to and within clinic offices.

Some 12 targeted surveys were completed in the Colorado Springs area, the second largest population center in Colorado. Although our goal included addressing a communication and programmatic access pillars, we discovered that the practices did not have the bandwidth or willingness to engage in that level of clinic assessment without some level of pressure from some government entity, such as the state or Office of Minority Affairs while avoiding the threat of litigation for ADA incompliance.

Kathleen Homan: Ultimately, the survey was distributed as a voluntary measure, rather than mandatory, as the state felt we did have the jurisdiction to enforce the ADA. The voluntary aspect of the tool was the biggest challenge that we faced. There's little leverage for the state and the RCCOs with providers to complete the survey. The length of the survey and the provider and RCCO capacity to administer the tool is another challenging factor as well as the flexibility and discretion that RCCOs had to implement as much or as little as they saw fit. We had many key takeaways, but those were the primary challenges.

Of our key lessons learned, we saw the collaborative nature of the survey as a key success as well as having a DCC expert, content expert, subject matter expert, or champion as crucial for the DCC clinic surveys to be rolled out within our provider delivery system. It's not just a do the survey and you're done, but an ongoing mindset change and upfront education about disability cultural competence. With that, we were able to see some increase in engagement.

Continuing here in Colorado, we're not giving up on our survey. We funded and produced seven training videos for how RCCOs can use the survey at the practice level. You'll see the link here on the slide. We love our videos. We think they're excellent, and they provide a great deal of narrative and member experience to how important this survey tool really is.

We wanted to also provide intrinsic motivation as well as practical application material and support for how to use the surveys. We included a webinar video directly for our RCCOs, for options and the flexibility for maybe how they can present that within their RCCOs. The videos elaborated on the importance of implementing the tool with provider and focused on provider education and training.

We hope to participate in further webinars to provide details on our two years of experience and our approach to implementing the survey tools and videos here in Colorado. We are officially rolling our videos out across the state in January. So although they have been completed, we have not had any experience with the reception of the videos yet, but stay tuned.

So with that, on that note, I'll turn this back over to Chris.

Christopher Duff: Thank you Gary and Kathleen. I appreciate it.

I'm going to address some process questions we've had. Someone asked where they could have access to the Colorado tools, and I just wanted you to know, it was on the last slide.

An attendee wants to know how she can share some of the resources they developed on disability competency. We would love to see a lot of that stuff, and we would love to partner with you in getting some information out. Please contact us at RIC@Lewin.com, and we can have a conversation and figure out how to do that. So thank you for reaching out and wanting to help us make use of your valuable material.

Then there's a comment that's less of a question; I'll read it exactly as is. Usually, when one addresses disabilities, their first thought is physical. As an advocate for cognitive disabilities and dementia patients, I have to say that understanding and accommodations for dementia lags behind these disabilities that are visible disabilities.

I totally think you're right. I agree. When we started this, we needed to figure out how we could possibly address all the variable forms of disabilities. Now there's so many different dynamics, so we chose instead to focus on people with functional limitation, not diagnosis. We're not focusing on age because really one's disability doesn't appear once you turn 65. So a disability can start early on and can go until very late life. So I agree with your comment. It's just within our body of work, we haven't addressed that.

There is some other material that you can find at the Resources for Integrated Care website that will address some of the other things you're talking about such as persons

with IDD, geriatric population, dementia, and so on. So I encourage you to spend some time on that website looking at some of the other resources.

Thank you for those three questions or comments. They were very helpful. I'm going to put forward these questions in terms of which organization it references. For Care Wisconsin, how did you get past the normal to resistant to change in your organization?

Elizabeth King: In our organization, we are about change. So that is part of our culture. We embrace that, and we move with that every day.

So that wasn't so much of an aspect for us. It was really trying to answer all the questions that we had to try to make the improvement. I think most of our group was very flexible with the change.

Christopher Duff: That speaks to the culture issues. I've actually known Care Wisconsin for probably 15, maybe 20 years, and I can vouch to that. They have amazing values, and you see that in the depth of their work and the creativity of their work. That's great that you have found how to do that, and if you have any advice for others on that more secret sauce and how you keep that kind of environment, that would be helpful to share.

Elizabeth King: So yes, I think that is an issue. It's an aspect that we all need to consider. Change is something that you have to embrace, and if you don't embrace that, it's not comfortable here. I would encourage people to start thinking outside of the box and embrace change; the more you do it, the more you want to do it.

Christopher Duff: That's great. Thank you very much. I love that attitude very much. How do you identify people for its science or your CCM program?

Elizabeth King: I appreciate that question. We started looking at data, and we were thinking that the data had all the answers. Then we realized that you could actually throw the question out to the team and say, "So who is it that you would identify or could anticipate?"

From our lengthy experience, our culture of change, and our culture of problem solving, we have a sense of intuition. So for us, we could easily identify through just intuition that this one was either there or was heading in that direction. If we could use that data and combine it with the studies and the other data that we gathered, it was actually quite impressive how much they match. That was something that was in vain for us.

Christopher Duff: Thank you. I appreciate how you tried to combine those.

Let's go to the training. Did you do any additional training for other staff who were doing CCM? If so, what kind of training was it?

Elizabeth King: So there was a variety of different things. We found that those who were told they were going to do this was a little more uncomfortable than those who were excited about this and saw this as an opportunity. Both ways worked if you provide some tools; one of the tools that we used was the Wisconsin star method. That was one way to conduct a member-centered exploration of members' issue, cares, care barriers, mental health issues, and really just a holistic view of the individual.

By using a variety of different tools, we could get to the ultimate goal. That was the care plan that helps eliminate barriers and set up a better way to manage the situation.

Christopher Duff: Makes total sense. We have a question here from, "seems like a lot of information for an MCO to start to. Am I really seeing this self-assessment tool that's 46 pages?"

Well, yes, you are seeing it as 46 pages. We kept trying to provide higher level detail, so that's why we split it up from three to seven pillars. I believe it was Care Wisconsin that said they wanted to focus on access and primary care. So that's another thing you can do instead of looking at all of your organization, you can look at a couple components.

In actuality, when I completed the tool within the last several months, I completed it in an hour or hour and a half. However, completing is one thing. The second thing is making sense of what you see in the results and then thinking out what you're going to do about it. So it's a bit of a process. Some organizations completed it differently. One asked to put together a work group to do it, and one organization asked one individual to do it and then come up with recommendations and then a workgroup came up with ideas to build a quality improvement program around it.

So there's a variety of ways you can make it functional. You do not have to do every single piece of it. We are assuming that most area organizations will see it. Most every organization in this space has some degree of competency.

On the other side of that, they're never going to be 100% competent in everything. So you need to figure out where you're going to start and that will then make it much more doable.

Gary Montrose: The fact that there are these seven different pillars within the self-assessment tool, it provides a great opportunity to leverage the major lesson learned in Colorado over the past several years of trying to do this work. To get practices to become ADA compliant in the three concepts that we talked about, program, physical and communication accessibility require a lot of work and expertise.

Our major lesson learned was that disability cultural competency needs to come first. They need to understand what disabilities are, and what we mean by disability cultural competency to treat people with respect and dignity and address the physical challenges that they face, which are all addressable.

Most practices just don't know, and they don't even know that it's an issue. So starting off with low-hanging fruit, with some small steps, easy wins, and just having people understand what the issue is, seemed to be the right place to start and hence the development of the educational videos that the good state of Colorado Medicaid has funded and is now available for everybody to use. So that was our major lessons learned about where to begin in the seven different pillars.

Christopher Duff: Thank you, Gary, very much. I appreciate that. I would also ask everyone if you can, download the full DCCAT from the RIC website and complete the survey related to that. We would love to get as much feedback on it as with disability competency, within a provider or plan setting. We are never fully competent in the disability-competent care model, so we would love more feedback from you as we go along here.

Another question came in. We have care coordinators function in many of the pillars. Why did you separate care coordination into its own pillar? I think that's a question for me.

Care coordination, more than anything, was across most all of these because that's generally the person who touches the individual participant the most. We didn't want it to get lost under a primary care or access or LTSS or behavioral health, so that's why we folded it out into its own individual pillar.

Gary or Kathleen I think you talked about the advocate's role in the process and identification of the priorities. What is the role of the RCCOs in continuing to administer the surveys, and what is the role of the stakeholders either as a group or individually in continuing to work for this disability competency?

Kathleen Homan: I'll address the RCCOs side of it, and Gary, if you'd want to address the stakeholder and advocate side of it, let's do that. So the RCCOs have three main tasks, and they are tasked with the priority of coordination of care, practice support and network development. We really allow as much as flexibility as we can for each RCCO across their region to amend and adapt to their provider's needs and also to support their providers in their practices.

So there has been quite a bit of leeway that we have provided the RCCOs for how to do this. Again, it was a voluntary measure, so we are hopeful with the videos that this will continue the DCCAT conversation that started two years ago and really encourage the RCCOs and providers.

So the RCCOs provide support and oversight and the providers feed from that. That's where they're getting the state message. We have very clearly outlined that this is a priority, and the RCCOs know that it is a priority. So it's part and parcel of the work that they're doing.

Ultimately, we know that sometimes the burden of care falls on the providers themselves. So in our videos, we tried to outline specific tasks or activities that providers could do themselves. It might not need the RCCO support in order to just look at the videos, and we encourage our providers to do that themselves if they feel that they can.

So the clinics are really able to get feedback and support from the RCCOs, but they're also very able to go outside of that relationship to get their needs met and especially if they're meeting the needs of their members as best as they can. So that was the RCCO part of that. Gary, do you want to speak to the stakeholder?

Gary Montrose: It's important to call out that the relationship between the RCCOs and the state involves a contract. That contract says that the RCCOs must comply with all state and federal regulations. That would presumably include the Americans with Disabilities Act, but the fact that the state and no one else feels that they have the legal authority to enforce that, means that nobody is obligated to really become fully accessible.

So we as stakeholders try to keep our foot on the gas pedal, pumping it all the time and putting pressure on the state and the RCCOs to remember that there's a vulnerable population that is not getting the kind of healthcare they need and deserve. So those are the real obligations between the state, the RCCOs and the stakeholders. It takes all three of us working together to get some kind of positive movement in this challenging issue.

Christopher Duff: Thank you both. I appreciate that. Also, I'll note that I believe it's one of the early webinars in our next series which will be starting in February. We're going to be actually talking more about Colorado's experience with their tight survey and be learning from a few other places on this very issue. So stay tuned please.

Okay. Before handing this back to Jessie, I would like to make a few concluding remarks. First, the tool is not meant to be proscriptive, but suggestive. Users need to bring their own judgment to the assessment.

Secondly, the DCC model is conceptual in nature. It needs to be adapted locally based on your capacity, priority and population.

Lastly, we don't believe any provider or plan will ever achieve total disability competency. Instead we see it as a process, and we're challenging people to continually focus on it. Some gaps will be able to be addressed fairly simply, while others will take a major quality improvement initiative.

So at this point I'm going to turn it back to Jessie to wrap up.

Jessie Micholuk: Thank you, Chris. Thank you to our presenters today, and thank you all for attending and your contributions to our discussion. Please feel free to continue to send any additional questions either via the chat in the platform or to our email address. It will be posted at the end of presentation, and we'll be sure to follow up with you.

As Chris mentioned, we are excited to announce our new DCC webinar series. That will begin in February 2018. We'll be doing a deeper dive into the DCC model concepts and bring in new leading practices from experts in the field. Registration information will be sent to your inbox for all those who registered for today's webinar and of course they'll be posted on our website <https://www.resourcesforintegratedcare.com/>.

As always, your input is essential in developing new trainings and resources. Please answer our brief survey that will appear automatically on your screen when this webinar ends. Again, you can send any additional comments to our inbox, RIC@Lewin.com.

And finally, you can access the DCCAT and many other resources on our website. Please visit <https://www.resourcesforintegratedcare.com/>, and you can see all of our disability-competent care resources posted there.

Once again, thank you for attending today's webinar, and have a great rest of your day.