COLORADO
Department of Health Care Policy & Financing

Disability Competent Care Assessment Tool

Colorado Department of Health Care Policy & Financing
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Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.
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About the Disability-Competent Care Assessment Tool

The Disability-Competent Care Assessment Tool was created to help primary care medical providers (PCMPs) better meet the needs of clients with disabilities, and to help clients with disabilities locate providers that are best able to meet their needs. The disability-competent care initiative will also make it easier for beneficiaries to find practices that are able to meet their needs.
The goals of this evolving work are to:

- Increase provider awareness and capacity to provide disability competent care
- Inform clients of practices that provide disability competent care
- Provide assistance and resources to providers to become more accessible

What does the tool assess?

The tool gives PCMPs the ability to assess a practice's ability to serve clients with disabilities in three main areas or "pillars" of disability-competent care:

- **Communication Access**. To what extent do providers offer varying methods of communication to accommodate their clients' needs? For example, are providers able to adjust their communication methods for those who are hard of hearing, or those with intellectual disabilities? To what extent do providers give their patients information about the accommodations available for those with disabilities?
- **Programmatic Access**. Are there policies or procedures in place to ensure persons with disabilities receive the same quality of care as other persons? For example, are extended appointment available and can individuals bring service animals with them? Some of these items can be answered by the PCMP, while others, particularly in the sections relating to care management and LTSS, might require input from additional parties, including waiver providers and the RAE.
- **Physical Access**. What physical barriers do individuals with disabilities encounter when traveling to and within their provider's office?

While this tool is meant to help practices identify areas of improvement for serving clients with disabilities, it is *not* intended to enforce compliance with the ADA regulations. These regulations are far more extensive than the elements covered in this assessment.

Why use the tool?

In 1978, the World Health Organization affirmed the belief that primary care services should be universally available. In 1990, the federal government adopted the Americans with Disabilities Act, setting standards for accessibility. Yet in 2015, barriers still exist in many of Colorado's primary care offices.

Over the next 20 years, Colorado's population of individuals over the age of 65 is expected to double. Accessing and using primary care is the first step in maintaining the health of this population and persons with disabilities. We must prepare our health care system to ensure all people, especially those who require unique accommodations, can access primary care services.

PCMPs who use this tool will identify ways to improve access to their clinic, learn about existing regulations, and become aware of the risks of remaining inaccessible. Improving accessibility is not only the smart thing to do, it is the right thing to do.

How does the assessment work?

The RAE works with the PCMP to decide when and how the assessment will take place. The Communication Access (pillar 1) and Programmatic Access (pillar 2) parts of the assessment may be done over the phone. A site visit is necessary for the Physical Access part of the assessment. If all three parts of the assessment are completed on site, it takes approximately two hours to complete the process.

Before the site visit, the PCMP decides who from their practice should attend. For example, a facilities manager may be the best person to answer questions about physical access, and a practice manager may be the best person to answer questions about programmatic and communication access.

What happens to the assessment results?

Once the assessment is complete, the RAE and the PCMP review the results together and prioritize which issues and gaps are most important and feasible to address. RAEs will also use the results to refer patients to clinics that accommodate unique accessibility needs. Assessment results will not be used for enforcing compliance or requiring mandatory action. Results will only be used for purposes of education and improvement.

Who created the tool?

The Disability-Competent Care Assessment Tool was developed by ACC staff at the Department of Health Care Policy and Financing, RCCO representatives from each region, providers and advocates. It is based on three existing tools: The CMS Disability-Competent Care Self-Assessment Tool, the California Physical Accessibility Review Survey (PARS) and the ADA Checklist for Readily Achievable Barrier Removal.

I would like my practice to do this assessment. What are the next steps?

Colorado is in need of physicians who will become leaders in primary care accessibility. If you are a PCMP and would like to join this important effort, please contact your Regional Accountable Entity. See the table below for contact information. We look forward to working with all PCMPs on this important statewide initiative; to serve all people of Colorado equally regardless of age, gender, physical or cognitive abilities.

Regional Accountable Entities Contact Information

Position	Contact Name	Mobile Phone Number	Email
RAE 1: Rocky Mountain Health Plan	Meg Taylor	(720) 595-1281	Meg Taylor, Program Officer Meg.Taylor@rmhp.org
RAE 2: Northeast Health Partners	Kari Snelson	(970) 397-2732	Kari Snelson, Program Officer Kari.Snelson@northrange.org
RAE 3: Health Colorado, Inc.	Gretchen McGinnis	(720) 744-5363	Gretchen McGinnis, Program Officer Gretchen.Mcginnis@coaccess.com
RAE 4: Health Colorado, Inc.	Alyssa Rose	(719) 313-8221	Alyssa L. Rose, COO, Colorado Engagement Center, Beacon Health Options Alyssa.Rose@beaconhealthoptions.com
RAE 5: Colorado Access	Rob Bremer	(720) 744 5240	Rob Bremer, Program Officer Robert.Bremer@coaccess.com
RAE 6: Colorado Community Health Alliance	Hanna Thomas	(720) 612-6732	Hanna Thomas, Program Officer Hanna.Schum@cchacares.com
RAE 7: Colorado Community Health Alliance	Amy Yutzy	(719) 278-5420	Amy Yutzy, Program Officer Amy.Yutzy@cchacares.com

Provider information and Screening

<table>
<tr><td colspan="2">Provider Name:</td><td>Name(s) of Reviewer(s):</td></tr>
<tr><td>Provider Type:
☐PCMP ☐ Specialist
☐Ancillary</td><td>Type:
☐For-Profit
☐Not-for-Profit</td><td>Date of Review:</td></tr>
<tr><td colspan="2">Address:</td><td>Affiliated Parties (e.g. Health Plan, RAE):</td></tr>
<tr><td colspan="2">City:</td><td>Phone:</td></tr>
<tr><td colspan="3">Original Construction Year of Facility (If not known, was the building constructed after 1992?):</td></tr>
<tr><td colspan="3">Year(s) of Major Additions and Renovations to Facility (If not known, were there any major additions/renovations after 1992 or since 2012?):</td></tr>
<tr><td colspan="2">Number of ACC attributed clients:</td><td>Number of MMP attributed clients:</td></tr>
<tr><td colspan="3">Is the practice open to taking additional Medicaid clients?</td></tr>
<tr><td colspan="3">Name(s) and Title(s) of Individuals from Provider Office who assisted with the Assessment:</td></tr>
</table>

Terms and Definitions

Term	Definition
ADL	Activities of Daily Living: basic daily self-care activities that are commonly provided within an individual's place of residence, in outdoor environments, or both. Examples of ADLs include: feeding, bathing, and dressing. ADLs (like IADLs described below) are assessed using a standardized tool to identify levels of independence in each activity.
APN	Advance Practice Nurse: a nurse with post-graduate education in nursing. APNs are prepared with advanced diagnostic and clinical education, knowledge, skills and scope of practice in nursing. APNs are clinical nurse specialists, nurse anesthetists, or nurse midwives, and commonly function as primary care providers.
Care Partner	Care partners: usually unpaid close friends, relatives, or peers who are designated by the participant as a key source of physical, psychological, emotional and/or spiritual assistance, support and comfort.
CEUs	Continuing Education Units: a means for demonstrating the receipt of clinical training. CEUs are commonly a required component of licensure renewal for health care professionals and para-professionals.
DCC	Disability-Competent Care: aims to treat persons with disabilities as a whole person seeking good care rather than as a diagnosis or illness. DCC practices promote integration of services across all settings (hospitals, medical offices, residential) and types of care (including behavioral health) and support, family (informal) and paid (formal) caregivers. Being disability-competent requires health care professionals to collaborate across disciplines and engage in a meaningful partnership with the participant, and his/her identified care supporters, sharing collective responsibility for the execution of the care plan as well as the health and well-being of the participant.
DME	Durable Medical Equipment: any medical equipment designed for long-term use in the home to aid in a better quality of living. DME typically Includes, but is not limited to, wheelchairs (multiple types), canes, white canes, walkers, shower chairs, toilet chairs, raised toilet seats, oxygen equipment, nebulizer tubing and machines, and speech generating devices.
IPC	Individualized Plan of Care: a plan of care that is specific to the participant, developed in collaboration with the participant and the interdisciplinary care team. This plan should consider what is important to the participant and addresses ways to support the participant in achieving certain life changes. The plan should also indicate who should be included in the participant's circle of support (formal and informal caregivers), and how all these people will work together.
IADL	Instrumental Activities of Daily Living: tasks necessary to live independently in a community. IADLs focus on medication management, communications and other activities. IADLs are assessed using a standardized assessment tool to identify levels of independence in area activity.
IDT	Interdisciplinary Team: diverse health professionals focused on the goal of improving the health of the participant. Together, IDT members partner with the participant to maintain maximum function – health, wellness, and life in community, as the participant chooses.

Term	Definition
LTSS	Long-Term Services and Supports: assistance with ADLs/IADLs provided to persons who are unable to perform these activities on their own due to a physical, cognitive, or chronic health condition for an extended period of time, typically 90 days or more. LTSS include human assistance, supervision, cueing and standby assistance, assistive technologies/devices and environmental modifications, health maintenance tasks (e.g., medication management and ostomy care), information, and care and service coordination for people who live in their own home, a residential setting, or a nursing facility.
NP	Nurse Practitioner: a registered nurse (RN) who has completed an advanced training program in a medical specialty, such as pediatric, adult or geriatric primary care. Also see APN – Advanced Practice Nurse
PCC	Participant-Centered Care: based on the recognition that the participant is not merely a passive recipient of medical care, but rather the primary source for defining care goals and needs. Inherent in participant-centered care is the concept of the dignity of risk, which honors and respects the participant's choices even if they are inconsistent with the recommendation of the IDT. Participant-centered care focuses on what is important to the participant, how to reduce and manage risk within that context, and how to advocate for the participant by keeping them at the center of care and treatment planning.
Participant (Patient, client, consumer)	This tool uses the terms "participant" and "individual" to refer to the person receiving care. This has become an important distinction that views the participant as someone who is actively involved in the medical process, rather than a passive bystander. The issues raised in this tool aim to move the medical process away from simply providing a diagnosis and treatment, towards focusing on providing care and supports for maximum function and addressing the barriers to integrated, accessible care.
PCA	Personal Care Attendant/Assistant: provided to help with ADLs such as bathing, dressing, eating, toileting, exercising, taking medications, and moving about inside the home. They can be employed directly by the participant, or a home care agency or other provider organization.
PA	Physician Assistant: a healthcare professional licensed to practice medicine under the direct supervision of a physician. In practice, most PAs work within a clinical office setting.
Practice vs Protocol	The choice of these terms throughout this tool is deliberate. When referring to a "protocol," the attention is on whether there is a documented policy in place to address the specific topic or activity. When referring to a "practice," the attention should instead be on whether there is evidence that the protocol is actually being put into effect on a regular basis within the organization.
PCMP	Primary Care Medical Provider: see PCP – Primary Care Practitioner.
PCP	Primary Care Practitioner: In the DCC model, this term is used to include including primary care physicians, internists, osteopaths, nurse practitioners, advanced registered nurse practitioners, and physician assistants.

Term	Definition
Public Transit	Public Transit is any form of transportation that charges set fares, runs fixed routes, and is available to the public such as buses, subways, ferries, and trains. If public transportation is not accessible, the American with Disabilities Act requires, within a standard of 'reasonableness' that a Para-transit service be available where individuals who are unable to use the regular transit system independently (because of a physical or mental impairment) are picked up and dropped off at their destinations.
RN	Registered Nurse: health professional with a degree from an accredited nursing program and a nursing license.
Transitional Care	Transitional care is a range of time-limited services and guidance environments that are designed to ensure continuity of care, and avoid preventable episodes of illness, decline, or barriers to optimal functioning. Transitions can include a traditional change in institution (hospital, rehabilitation, or nursing facility), a change in living situation, a change in primary care provider or care giver/family member, behavioral health status, financial and economic eligibility, and others.

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Pillar 1: Communication Access

Focus: Assessment topics in this pillar focus on "etiquette" competencies and practices as they relate to delivering care to persons with disabilities

1.1 Disability Competencies	**1.1.1**	Is staff (office support staff, auxiliary staff) trained in disability competency? *ADA	Disability-competent organizations provide a training program(s) for staff members, such as person-first language and treating an individual's wheelchair as personal space. Office support staff should be able to communicate with participants in a disability-competent manner.	☐Yes, at on-boarding and at consistent dates thereafter ☐Yes, at on-boarding ☐Yes, at select intervals ☐No
1.2 Procedural Access	**1.2.1**	Is there a practice in place to identify, document and communicate accommodation requirements, such as:	**1.2.1.1** Making/confirming appointment?	☐Yes ☐No
			1.2.1.2 Height adjustable exam table?	☐Yes ☐No
			1.2.1.3 Assistance with transfers?	☐Yes ☐No
			1.2.1.4 Extended appointment time?	☐Yes ☐No
			1.2.1.5 Assistance with transportation?	☐Yes ☐No
			1.2.1.6 Sign language interpretation?	☐Yes ☐No
			1.2.1.7 Oral interpretation, such as lip reading, and other approaches?	☐Yes ☐No
			1.2.1.8 Assistive listening devices?	☐Yes ☐No
			1.2.1.9 Computer assisted real-time transcript?	☐Yes ☐No
			1.2.1.10 Printed materials in alternative formats, such as large print, and other approaches?	☐Yes ☐No
	1.2.1	Are other options employed to address basic communication needs, particularly for participants with intellectual or developmental disabilities?	This could include written notes, readers, and letter, word, picture, or translator boards. If Yes, please describe:	☐Yes ☐No

1.2 Procedural Access	**1.2.2**	Indicate which modes of communication are readily available to facilitate communication with people who are deaf or hard of hearing:	**1.2.2.1** Pads of paper or computers to write notes back and forth	☐Yes ☐No
			1.2.2.2 Assisted listening device worn by provider to enhance auditory signal to patient, e.g. FM, Loop, or Soundfield System	☐Yes ☐No
			1.2.2.3 Computer assisted communication, e.g. speech-to-text, or text-to-speech	☐Yes ☐No
			1.2.2.4 Sign language interpreters	☐Yes ☐No
	1.2.3	Are the participant's accommodation needs specified in the participant's health record?		☐Yes ☐No
			1.2.3.1 If Yes, is it prominently displayed in a manner that will cue staff accordingly when communicating with this participant?	☐Yes ☐No ☐ N/A
	1.2.5	Are there processes, procedures, and policies in place to provide communication access?	Processes commonly include a designated responsible individual to provide communication access, a plan for how procedures and policies will be followed, and in what timeframe.	☐Yes ☐No
	1.2.6	Are alternative forms of communication available on a non-scheduled-basis (e.g. drop-ins)?	Sign language, for example, is one alternative form of communication.	☐Yes ☐No
			If Yes, please describe:	
	1.2.7	Is staff adequately trained to utilize assistive technology when needed to effectively communicate with people who are deaf or hard-of-hearing?		☐Yes ☐No
1.3 Print Material in Alternative Format	**1.3.1**	Are printed materials offered in alternative formats upon request, such as:	1.3.1.1 Audio recording?	☐Yes ☐No
			1.3.1.2 Braille?	☐Yes ☐No
			1.3.1.3 Large print? (ex. 16-18 pt.)	☐Yes ☐No
			1.3.1.4 Electronic text/CD/flash drive?	☐Yes ☐No
	1.3.2	Is the following information available upon request in alternative formats:	1.3.2.1 Contracts, benefits, rights, informed consent, permission for treatment?	☐Yes ☐No
			1.3.2.2 Provider directory?	☐Yes ☐No
			1.3.2.3 Medications (dose, instructions for administration, side effects, food or drug interactions)?	☐Yes ☐No

		1.3.2.4	Admission, discharge procedures and reports?	☐Yes ☐No
		1.3.2.5	Follow-up care instructions, treatment, therapies, other recovery directions?	☐Yes ☐No
		1.3.2.6	Health education information?	☐Yes ☐No
		If applicable, please describe whether the provider or another entity provides the information above, and which alternative formats are available:		
1.4 Telecommunication/	**1.4.1** Are the following options offered in addition to or in place of phone communication:	1.4.1.1	Email?	☐Yes ☐No
		1.4.1.2	Text messaging?	☐Yes ☐No
		1.4.1.3	Speech-to-speech telephone?	☐Yes ☐No
		1.4.1.4	Relay Colorado?	☐Yes ☐No
	1.4.2 Is appropriate staff trained in the use of telecommunications relay service when needed?			☐Yes ☐No
1.5 Other Communication Accommodations	**1.5.1** Is appropriate staff trained to schedule longer appointments when the participant is identified as needing additional time to communicate with the provider, transfer on/off or position on medical or diagnostic equipment?	Additional time is commonly needed when working with participants with intellectual, speech, or hearing disabilities.		☐Yes ☐No
	1.5.2 Does the provider's website meet accessibility guidelines?	Websites should be designed and maintained to adhere to the Web Content Accessibility Guidelines (WCAG) Level 2.0 AA For example, the provider's website should be useable to people who are visually impaired or have difficulty using a mouse for navigation.		☐Yes ☐No

Pillar 2: Programmatic Access

Focus: Assessment topics in this pillar include questions on how the provider can achieve participant-centered care management, responsive primary care, and comprehensive long-term services and supports (LTSS). Some of these questions will be best answered by the primary care medical provider (PCMP), while others, particularly in the sections relating to care management and LTSS, might require input from additional parties, including the health plan and the RAE.

	Topic	Criteria for Assessment	Responses
2.1 Respo	**2.1.1** Is there sufficient primary care capacity to serve the enrolled members *(based on State-specific criteria)*?		☐Yes, consistently ☐Yes, most of the time ☐No

	Topic	Criteria for Assessment	Responses
	2.1.2 Are the primary care practitioners (PCPs – including physicians, nurse practitioners and physician assistants) trained to serve persons with disabilities?	Disability-competent organizations often provide a training program for staff members and may contract with disability-competent organizations to provide in-service training and networking opportunities. Continuing Education Units (CEUs) may also be provided. Training may include a wide variety of topics related to etiquette, technology, and best practices to assist individuals with disabilities.	☐Yes, at on-boarding and at consistent dates thereafter ☐Yes, at on-boarding ☐Yes, at select intervals ☐No
	2.1.3 Are there practices in place to facilitate timely and routine communication between primary care and behavioral health practitioners?	Integration of behavioral health with primary care and LTSS can take many forms, including co-location, integrated of full access to the health record, or regular participation in care team meetings.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.1.4 Do the PCPs have access to and knowledge of a network of medical sub-specialties experienced in serving persons with disabilities?		☐Yes ☐No
	2.1.5 Do PCPs follow clinical protocols for the identification and treatment of key secondary conditions of disability?	Disability-competent organizations should have clinical protocols for the ID and treatment of skin breakdown, urinary tract infections, upper respiratory infections, bowel impaction, depression, and other secondary complications.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.1.6 Are PCPs available 24/7 for both diagnosis and treatment?	Some disability-competent organizations have opted to hire or contract with PCPs who agree to make home visits and take call from participants. Others have opted to hire or contract with NP's who make home visits and provide 24/7 coverage while working in a partnership with a broader PCP network.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	Topic	Criteria for Assessment	Responses
	2.1.7 Are PCPs available to provide care in the community (clinical, urgent care or place of residence)?	Community- or home-based care is often necessary, as transportation can be difficult to arrange and is a key barrier to accessing timely care.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.1.8 Are the PCPs schedules flexible enough to be able to provide same-day episodic care?	Disability-competent organizations commonly augment clinic-based primary care physician services by having NP's available for home visits or consultations.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.1.9 Does the PCP providing after-hours or on-call coverage have access to the participant's comprehensive health record (including IPC)?	Coverage may be provided by a PCP who is not familiar with the participant. As such, having access to their health record and IPC can minimize the need for ER or inpatient assessment or treatment.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.1.10 Are there practices in place to assess for the need for medication management and to provide it as needed (addressing poly-pharmacy usage and medication follow-through)?	The PCP on the IDT should assume responsibility for having the medications reviewed and managed.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.1.11 Are clients and caregivers/personal care assistants provided with health promotion and self-care education specific to their needs?	The IPC should include a health and wellness plan, including: accessing primary care; routine health prevention services; management of conditions associated with existing disabilities and chronic illnesses; prevention of secondary conditions of disability; and participant and caregiver self-care for chronic conditions.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	Topic		Criteria for Assessment	Responses
	• Does the PCMP office perform Care Management? ☐ Yes – please continue with the questions in section 2.2 ☐ No – please indicate which parties perform this service (e.g. RAE, health plan), and skip to Section 2.3 Care management services provided by: _____ ☐ Don't know – if unsure, please complete the following questions with the PCMP to the best of their ability			
2.2 Participant-Centered Care Management	**2.2.1**	Is staff trained to provide participant-centered care?	Participant-centered care is based on the recognition that the participant is not merely a passive recipient of medical care, but rather the primary source for defining care goals and needs.	☐Yes, at on-boarding and at consistent dates thereafter ☐Yes, at on-boarding ☐Yes, at select intervals ☐No
	2.2.2	Is staff trained to eliminate medical and institutional bias?	Medical and institutional bias often impedes providers from addressing the whole individual, including his or her unique abilities, limitations, and preferences for social and community participation.	☐Yes, at on-boarding and at consistent dates thereafter ☐Yes, at on-boarding ☐Yes, at select intervals ☐No
	2.2.3	Is care management provided by an Interdisciplinary Team (IDT)?	Disability-competent care is interdisciplinary team-based care with core competencies in primary care, behavioral health, long-term services and supports (LTSS), and nursing. Operating in close communication with the participant and external providers, the IDT is responsible for ensuring the participant receives the care and supports he/she needs to achieve his/her goals and maximize independence.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	Topic	Criteria for Assessment	Responses
2.2 Participant-Centered Care Management	**2.2.4** Does the IDT include individuals with competency in primary care, nursing, behavioral health and LTSS?	Primary care practitioners might include physicians, nurse practitioners (NP), or physician assistants; NPs might include Advance Practice Nurses, Registered Nurses, or Licensed Practical Nurses; behavioral health practitioners might include social workers, psychologists, chemical dependency specialists; LTSS practitioners might include social workers, mental health therapists, and community health workers.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.5 Are practices in place designating one person as 'lead' with each individual participant?	One individual team member should have final responsibility and accountability for both the IDT and the Individualized Plan of Care (IPC).	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.6 Are participants able to designate a family member or close friend to be involved in IDT related communications?	Other individuals might include caregivers, friends, community supports, and other clinicians such as fitness coaches and massage therapists.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.7 Are practices in place to ensure timely communication and responsive follow-up?	The need for timeliness will vary depending on the urgency of the situation. In some disability-competent organizations, IDT members maintain flexibility on their daily schedules to be able to address emerging concerns on a same-day basis.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.8 Are all persons screened to assess need for in-person assessment and/or follow-up?	The initial assessment provides a key opportunity for the IDT to establish a relationship with each participant and to building the trust needed for successful, ongoing care and care management.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	Topic	Criteria for Assessment	Responses
	2.2.9 Is the above screening used to adequately prioritize staff time based on the individual needs of each participant?		☐Yes ☐No ☐N/A
2.2 Participant-Centered Care Management	**2.2.10** Are all participants assessed annually or upon significant change in status?		☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.11 Are there practices in place to assess the nature and amount of care management to be provided with each participant?	It is important to discuss the frequency and amount of care coordination contact they will receive so that their participant's expectations are identified, discussed, and met.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.12 Are assessments comprehensive and multidimensional, incorporating all aspects of the participant's life?	The following elements should be considered when assessing care management needs: participant strengths, goals, and priorities; demographic, contact, financial, and eligibility information; medical diagnoses and history; functional assessment [ADL's and IADL's]; behavioral health screening; health-related services; long term services and support use; health risks; and community participation.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.13 Do all participants have Individualized Plans of Care (IPC)?	The IPC is the guiding document that identifies all the care, services, and supports of each participant. It is a living document, referenced and revised over time depending on the needs of the participant.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	Topic	Criteria for Assessment	Responses
	2.2.14 Do all IPC's include participant goals, action steps and interventions, with timeframes and accountability identified?	IDT members need to be trained in working with and guiding participants and identifying their personal goals – medical, social, or other.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.15 Does the IDT have the ability to modify the IPC based on the unique context of the individual or a specific change in condition (either temporary or long-term)?	The IDT needs to be able to alter the scope, intensity, and frequency of care delivery, supports, and services when warranted.	☐Yes, consistently ☐Partially ☐No
	2.2.16 Are there practices in place to facilitate IPC oversight and coordination?	Ongoing oversight and review of the IPC is needed to ensure the plans are effective and being followed, that preventive strategies are in place, and that revisions are made based on the participant's changing needs.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
2.2 Participant-Centered Care	**2.2.17** Are there protocols in place for management of transitions?	Many disability-competent organizations provide protocols that may be used for different types of transitions. Others may employ a universal checklist of actions required for all types of transitions. Transitions can include traditional change in medical institution, change in living situation, change in primary care giver, and change in health status, among others.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.18 Does the IPC identify and specify all services and supports in place?	The IPC should contain specific documentation on what care and support services are being provided, by whom, and when.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.19 Are participants encouraged to have advance directives, including a living will,	Many disability-competent organizations include a question or section regarding advance directives in the initial and recurring assessments.	☐Yes, consistently ☐Yes, most of the time

	Topic	Criteria for Assessment	Responses
	power of attorney, and/or a funeral plan?		☐Yes, some of the time ☐No
		If yes, are these documents recorded in the health record?	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No ☐N/A
		If yes, is the importance of these documents discussed at least annually?	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No ☐N/A
2.2 Participant-	**2.2.20** Are participants routinely engaged in a discussion of their desire to have a care partner?	A care partner can provide assistance to the participant who has complex care needs or cognitive limitations, such as accompanying the participant to medical appointments. The care partner can coach the participant to ask questions during the appointment, assist with adherence to the care plan, and provide support while the participant is accessing care.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.21 Is there a centralized health record for each participant?	A comprehensive health record is composed of many elements, including assessment(s), the IPC, medication lists, referrals and authorizations, care management notes, and other information as appropriate.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	Topic	Criteria for Assessment	Responses
	2.2.22 Is the health record accessible to all members of the participant's IDT, including coverage staff?		☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.2.23 Is staff trained to modify services, teaching materials, and documents for individuals with learning, intellectual and/or cognitive disabilities?		☐Yes, at on-boarding and at consistent dates thereafter ☐Yes, at on-boarding ☐Yes, at select intervals ☐No
	2.2.24 Are materials and documents provided to participants who may only be literate at a sixth grade level?	Beyond communication, these materials should cover any documents that go hand-in-hand with services provided.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	Topic	Criteria for Assessment	Responses
	• Does the PCMP office coordinate LTSS? ☐ Yes – please continue with the questions in section 2.3 ☐ No – please indicate which parties perform this service (e.g. RAE, health plan), and skip to Pillar 3. LTSS provided by: _____ ☐ Don't know – if unsure, please complete the following questions with the PCMP to the best of their ability		
2.3 Comprehensive Long-Term Services and Supports (LTSS)	**2.3.1** Are practices in place for mobility and seating assessments?	Participants should be given access to customized equipment and equipment modifications based on their needs.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.3.2 Is there an adequate network of durable medical equipment (DME) providers to ensure choice and timely access to needed equipment, modifications and services?	Due to the importance of equipment and supplies, many participants may have preferred providers who are best able to meet their individual needs.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.3.3 Are practices in place to provide timely repair of DME, with back-up options if necessary?	Timeliness of repair request will vary depending on the equipment (e.g. respiratory and cushioning malfunctions versus a cooking or hygiene aide).	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

2.3 Comprehensive Long-Term Services and Supports (LTSS)	**2.3.4**	**Are participants given a choice between an agency-model and a self-directed model for their personal care attendants?**		**☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No**
	2.3.5	Are practices in place to ensure for emergency and caregiver backup plans?	These plans have two components: actions to take in an emergency; and plans for coverage if a caregiver is expectantly unavailable.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.3.6	Are practices in place to provide participants a reasonable choice of providers and settings of care?	Since care is commonly attached to the residential setting, it is important to offer as wide a choice as possible.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.3.7	Are participant transportation needs assessed and addressed at least annually?	The assessment includes physical as well as communication and cognitive requirements. The participant's IPC should specify the type of equipment and assistance that is needed while being transported.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

2.3 Comprehensive Long-Term Services and Supports (LTSS)	**2.3.8**	Are support and/or training in the use of transportation services available to the participants?	Disability-competent plans ensure the participant understands how to access transportation for all needs (daily as well as episodic and urgent).	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.3.9	Are individual home and community support needs incorporated into the IPC?	The participant's goals and priorities, as identified in the assessment and care planning process, must drive the development of his/her community-based support plan.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.3.10	Are participants able to maintain existing relationships with LTSS providers when feasible?	Continuity of care with LTSS providers is a cornerstone of disability-competent care. If a participant's previous provider is not in the network, disability-competent organizations may provide an option to use the out-of-network provider for a determined period of transition.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No
	2.3.11	Is there adequate network capacity to ensure participant access to the full range of needed LTSS?	Disability-competent organizations may consider hiring or contracting with LTSS providers or community providers.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

	2.3.12 Is there the capacity to develop specific services not readily available in the community that are specified in the participants IPC?	If the local community lacks any specific services required by the participant, other community-based organizations or social agencies may be engaged in developing the needed services.	☐Yes, consistently ☐Yes, most of the time ☐Yes, some of the time ☐No

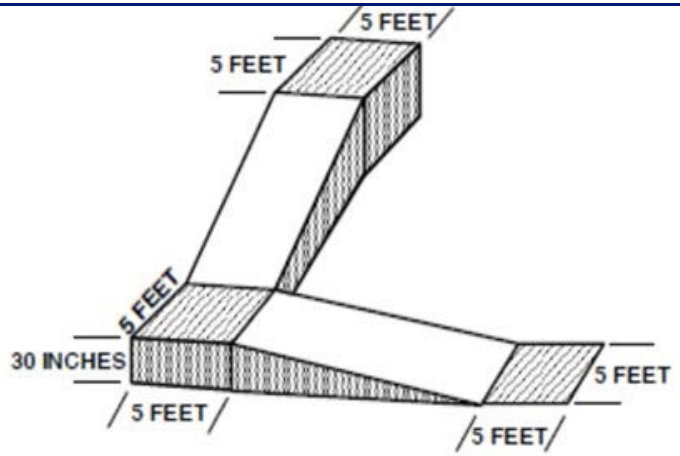
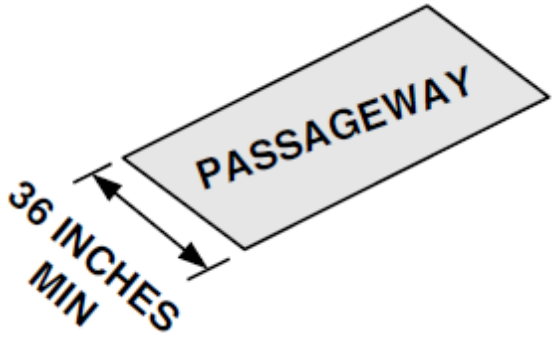
Pillar 3: Physical Access

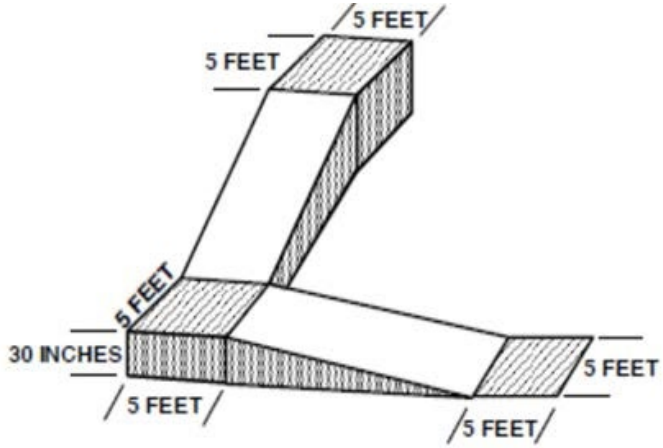
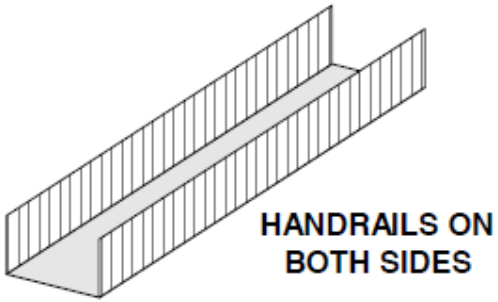
Focus: Assessment topics in this pillar address physical barriers that individuals with disabilities may have traveling to and within their provider's office.

Section I – Arriving at the Provider Site

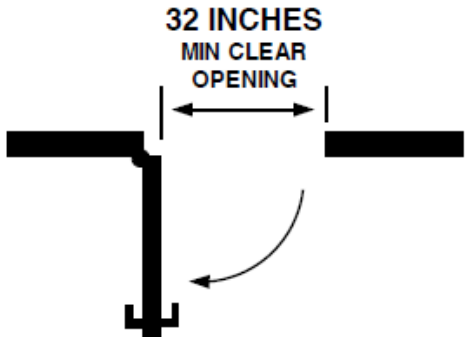
	Topic	Criteria for Assessment	Responses
3.1 Transit Access	**3.1.1** Is public transit within 0.25 miles?		☐Yes ☐No
		3.1.1.1 If Yes, is the public transit accessible (accommodates persons with wheelchairs and scooters)?	☐Yes ☐No ☐N/A
		3.1.1.2 If No, is there another form of accessible, non-emergency transportation available? Please specify these below.	☐Yes ☐No ☐N/A
		Please specify:	
	3.1.2 Is there an accessible location for participants to be dropped off and picked up?	Drop-off/pick-up locations with curb ramps if needed.	☐Yes ☐No
3.2 Parking	**3.2.1** Is off-street parking available?		☐Yes ☐No If No, skip to question 3.3
	3.2.2 Are accessible parking spaces available?		☐Yes ☐No
		3.2.1.1 If Yes, is it clearly marked? Accessible parking spaces should have a vertical sign posted with the International Symbol of Accessibility.	☐Yes ☐No ☐N/A
	3.2.3 Are the correct numbers of accessible parking spaces provided?	If there are 25 total parking spaces or fewer, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required. This should be prorated for larger areas so that there is one accessible space for every 25 total parking spaces.	☐Yes ☐No

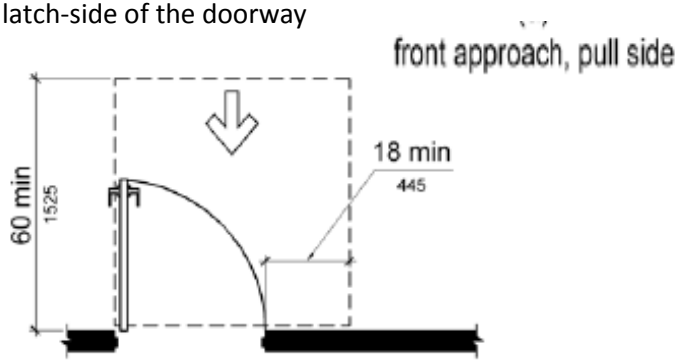
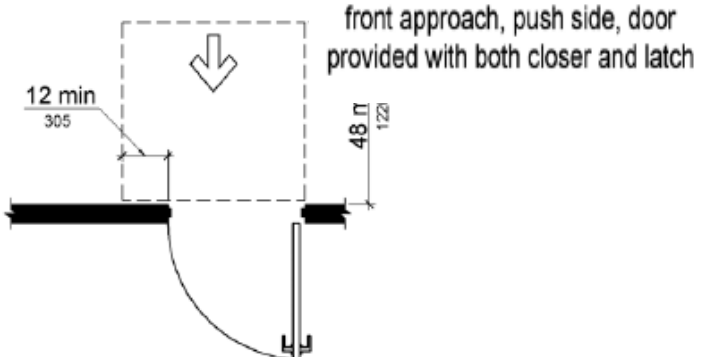
	Topic	Criteria for Assessment	Responses
	3.2.4 Is van-accessible parking provided?	One van space for every six standard accessible spaces should be provided, and not less than one.	☐Yes ☐No
		3.2.4.1 If Yes, is it clearly marked?	☐Yes ☐No ☐N/A
	3.2.5 Are the accessible parking spaces closest to the accessible entrance?	The accessible parking space(s) should be located nearest the accessible route to the accessible entrance.	☐Yes ☐No
3.3 Approach and Entrance to Site	**3.3.1** Is there signage for the accessible approach and entrance?		☐Yes ☐No
	3.3.2 If main entrance is not accessible, is there another accessible entrance?		☐Yes ☐No ☐N/A
		3.3.2.1 If Yes, is there signage indicating location of accessible entrance? Signage should be legible with appropriate size, fonts, and color contrast. 	☐Yes ☐No ☐N/A
	3.3.3 Is the exterior accessible route barrier-free for the following means of approaching the site, including the presence of curb cuts or curb ramps when needed?	3.3.3.1 Parking?	☐Yes ☐No
		3.3.3.2 Public transit?	☐Yes ☐No
		3.3.3.3 Public sidewalk?	☐Yes ☐No

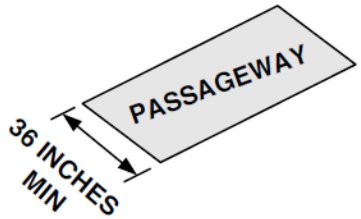
	Topic	Criteria for Assessment	Responses
	3.3.4 Ramps		
3.3 Approach and Entrance to Site	3.3.4.1 Are ramps required to access the building?		☐Yes ☐No If No, skip to question 3.4
	3.3.4.2 Is each run (leg) of the ramp no longer than 30' between landing(s)?	 The slope of the ramp should not be any steeper than a 1:12 ratio; for every 1 inch vertical increase, the ramp should not be less than 12 inches long.	☐Yes ☐No
	3.3.4.3 Are all ramps at least 36" wide?		☐Yes ☐No

	Topic	Criteria for Assessment	Responses
3.3 Approach and Entrance to Site	3.3.4.4 Are landings a minimum of 5' wide and 5' long?		☐Yes ☐No
	3.3.4.5 Are handrails provided on both sides of ramp that are mounted between 34" and 38" above the ramp surface, if it is longer than 6'?	If ramp is not longer than 6 feet, check N/A 	☐Yes ☐No ☐N/A
	3.3.4.6 If needed, are there curb cuts/ramps available throughout the accessible approach route?		☐Yes ☐No ☐N/A

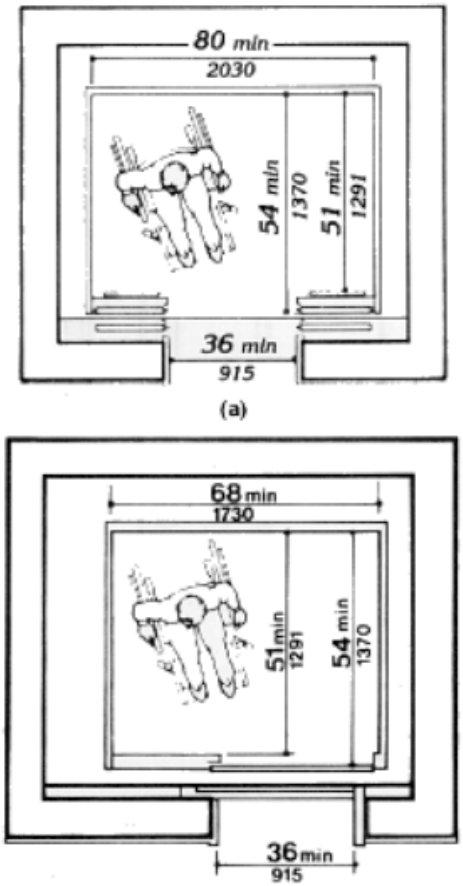
Section II – Entering the Provider Site

	Topic	Criteria for Assessment	Responses
3.4 Building Entrance	**3.4.1** Do doors have an opening at least 32” wide (at the narrowest point below the opening hardware) when opened at 90-degrees?	 When measuring double doors, measure the opening with one door open to 90°.	☐Yes ☐No
	3.4.2 Are power assist doors present?		☐Yes ☐No If Yes, skip to question 3.5

	Topic	Criteria for Assessment	Responses
3.4 Building Entrance	**3.4.3** Is space available for a wheelchair user to approach, maneuver, and open the door?	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices, to open the door safely and independently. Examples: • Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway on the latch-side of the doorway  • Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway  	☐Yes ☐No

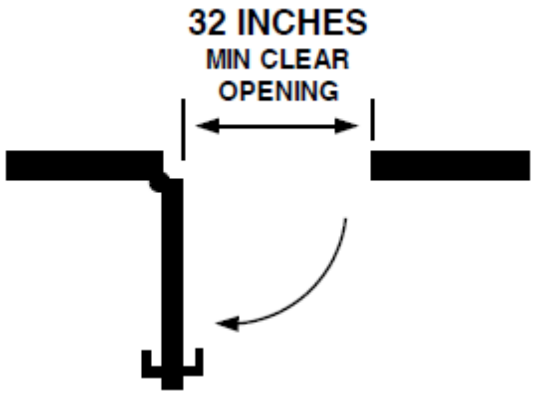
	Topic	Criteria for Assessment	Responses
	3.4.4 Do entrance doors have handles that can be opened without grasping, pinching or twisting of wrist?	Someone with a closed fist or fully open hand should be able to open the door. Door knobs, for example, cannot be used in this manner.	☐Yes ☐No
3.5 Access within Site	**3.5.1 Does the site have an interior route prior to accessing the provider's office?**	Some medical offices are accessed directly from the street or parking area rather than being located within a larger office building or complex, therefore they do not have interior routes.	☐Yes ☐No If No, skip to question 3.5.4
	3.5.1.1 If there is an interior route to the medical office, is it accessible?	Accessible includes, but is not limited to, the interior route having no stairs or steps.	☐Yes ☐No
	3.5.1.2 Is the interior accessible route at least 36" wide?		☐Yes ☐No
	3.5.1.3 If there are stairs, are there handrails on each side?		☐Yes ☐No ☐ N/A
		3.5.1.3.1 If No, is there one handrail on either side of the stairs?	☐Yes ☐No ☐ N/A
	3.5.1.4 Are there signs that provide direction to, or information about, interior spaces and locations?	Signs should be legible with appropriate size, fonts and, color contrast.	☐Yes ☐No
	3.5.1.5 Does interior signage include raised letters and Braille, where appropriate?	Signs designating restrooms, permanent room numbers, floor numbers, and exits (e.g., stairways) should have raised letters and Braille. These signs should be located on the wall on the latch side of the door between 48" to 60" above the floor. All other signs should be legible with appropriate size, fonts and, color contrast.	☐Yes ☐No

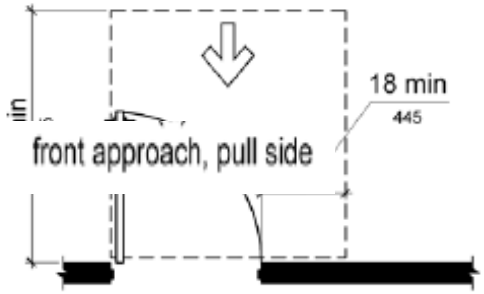
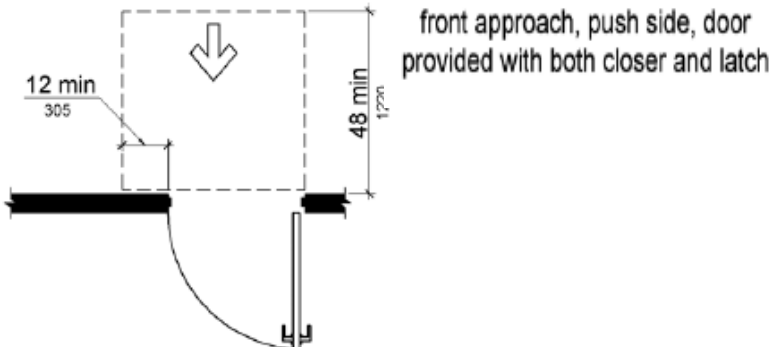
	Topic	Criteria for Assessment	Responses
3.5 Access within Site	3.5.1.6 Do all interior doors require less than 5 pounds of pressure to open?	For interior doors, labor force to open a door should be ≤5 lbs. Measure the weight of the labor force of the door after the door is unlatched; push a door pressure gauge until the door opens and read the weight of the force. This excludes fire doors.	☐Yes ☐No
	3.5.2 Is the path through the medical office free of any objects that stick out into the circulation path more than 4"?	Obstructions could include fire extinguishers, drinking fountains, and signs that protrude more than 4" into the path. If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.	☐Yes ☐No
	3.5.3 Is an elevator or lift needed to access the provider's site?		☐Yes ☐No If No, skip to Question 3.5.4
	3.5.3.1 If needed to access medical office(s), is the elevator/lift available for public use during business hours?		☐Yes ☐No
	3.5.3.2 Is the elevator(s) equipped with both visible and audible door openings/closing and floor indicators?	A visible and audible signal indicates which car is answering a call. An audible signal would be a "ding" or a verbal announcement.	☐Yes ☐No
	3.5.3.3 Is there a raised letter and Braille sign on each side of each elevator jamb?	Please refer to question 3.5.1.5 for signage criteria.	☐Yes ☐No
	3.5.3.4 Are the hall elevator call buttons no higher than 48" from the floor?		☐Yes ☐No
	3.5.3.5 Is the elevator car large enough for a wheelchair or scooter users to enter, turn to reach controls, and exit?		☐Yes ☐No

	Topic	Criteria for Assessment	Responses
		 The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide, or 54 inches long and 68 inches wide, depending on where the door is located.	
	3.5.3.6 Do the buttons on the control panel have Braille and raised characters/ symbols near the buttons?	Please refer to question 3.5.1.5 for signage criteria.	☐Yes ☐No

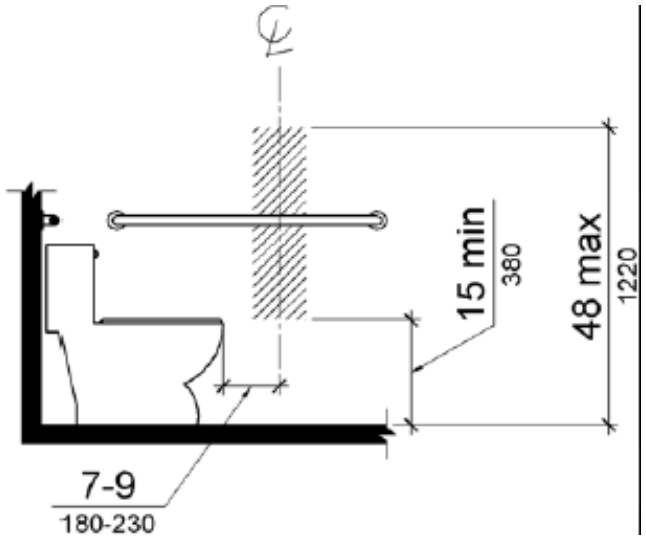
	Topic		Criteria for Assessment	Responses
3.5 Access within Site	3.5.3.7	Is the elevator emergency communication system usable without voice communication?	The safety of people with hearing or speech impairments could be jeopardized if the emergency communication is dependent on voice communications alone. Visible signal requirement could be satisfied with a button that lights when the message is answered, indicating that help is on the way.	☐Yes ☐No
	3.5.3.8	Is the emergency intercom or alarm system identified with raised letters and Braille?	Signs designating restrooms, permanent room numbers, floor numbers, and exits (including emergency intercoms or alarm systems, which facilitate emergency exits) should have raised letters and Braille. These signs should be located on the wall on the latch side of the door between 48" to 60" above the floor. All other signs should be legible with appropriate size, fonts and, color contrast.	☐Yes ☐No

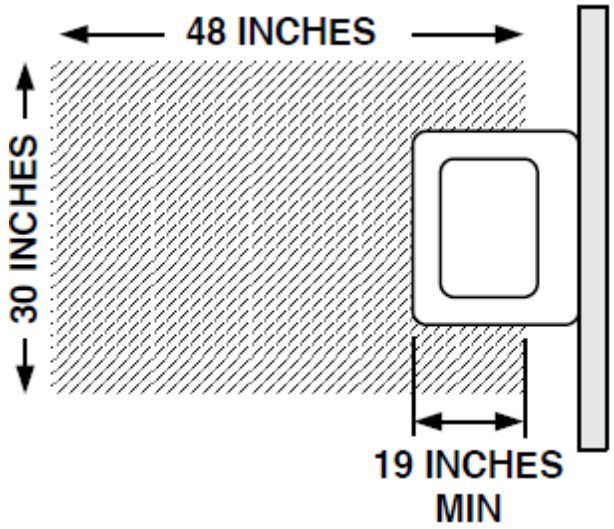
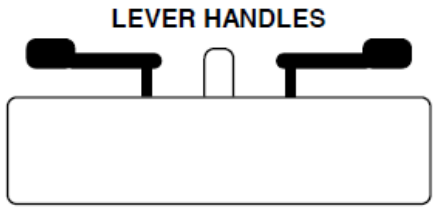
Section III - Entering the Reception and Common Areas of the Provider Site

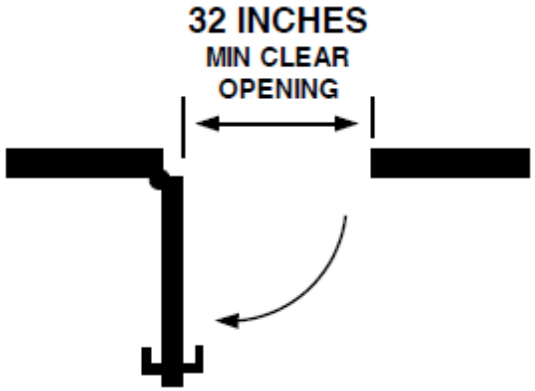
	Topic		Criteria for Assessment	Responses
3.5.4 Reception/Waiting Area	3.5.4.1	Do doors have an opening at least 32” wide (at the narrowest point below the opening hardware) when opened at 90-degrees?	 When measuring double doors, measure the opening with one door open to 90°.	☐Yes ☐No
	3.5.4.2	Are power assist doors present?		☐Yes ☐No If Yes, skip to question 3.5.4.5

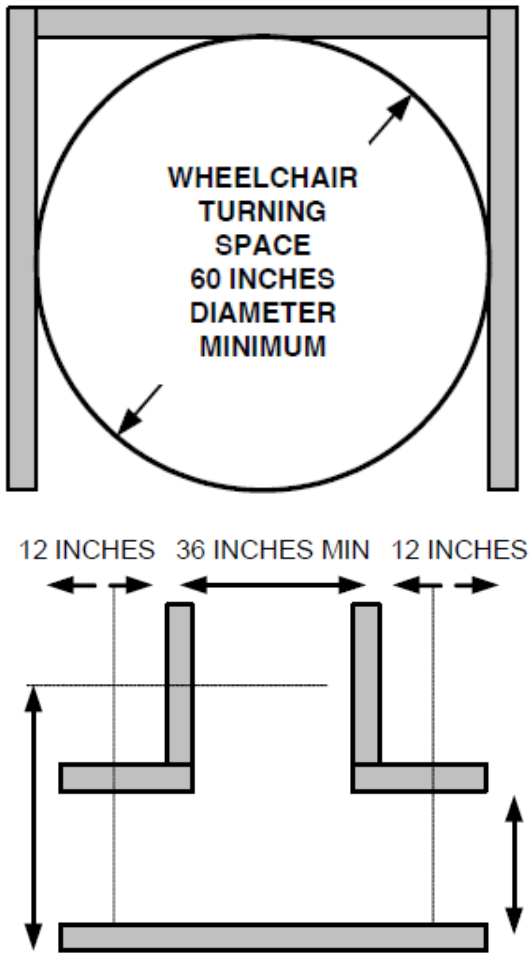
	Topic		Criteria for Assessment	Responses
3.5.4 Reception/Waiting Area	3.5.4.3	Is space available for a wheelchair user to approach, maneuver, and open the door?	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices, to open the door safely and independently. Examples: • Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway  • Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway  	☐Yes ☐No
	3.5.4.4	Do entrance doors have handles that can be opened without grasping, pinching or twisting of wrist?	Can the door be opened by someone with a closed fist or fully open hand? Door knobs, for example, cannot be used in this manner.	☐Yes ☐No

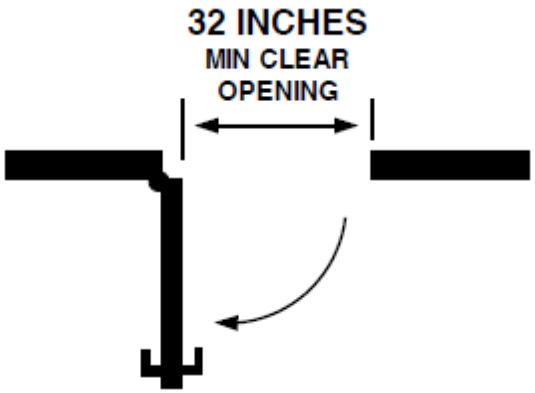
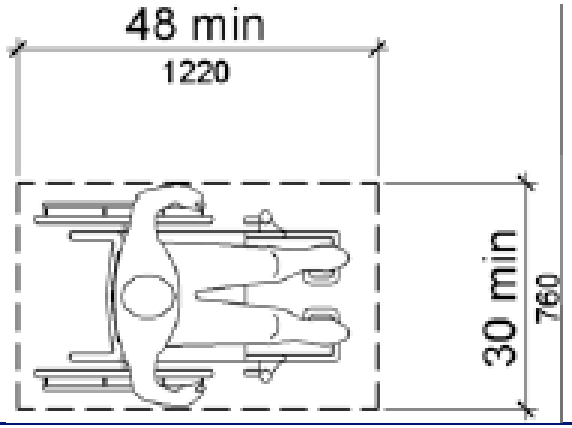
	Topic		Criteria for Assessment	Responses
3.5.4 Reception/Waiting Area	3.5.4.5	Is there a space, at least 30" wide by 48" long, for a wheelchair or scooter to park in the reception area without being an obstruction?		☐Yes ☐No
	3.5.4.6	Is a portion of the reception counter/sign-in no more than 34" high and no less than 36" wide?	This does not apply to areas designated for pick-up/drop-off of materials.	☐Yes ☐No
	3.5.4.7	Do signs identifying permanent rooms and spaces include raised letters and Braille?	Please refer to question 3.5.1.5 for signage criteria. This does not apply to employee-only areas.	☐Yes ☐No
	3.5.4.8	Are all person-operated controls (call buttons, self-service literature, and hand sanitizers) mounted /accessible between 15" and 48" from the floor?		☐Yes ☐No ☐N/A
	3.5.4.9	Are all person operated controls operable with one hand without grasping, pinching or twisting to operate?		☐Yes ☐No ☐N/A
3.5.5 Toilet Rooms	3.5.5.1	Is the height of the toilet seat accessible?	The height of an accessible toilet seat should be between 17" to 19". The center line of the toilet should be between 16" to 18" (a horizontal measurement) from the side wall.	☐Yes ☐No
	3.5.5.2	If not all toilet rooms are accessible, is there directional signage to the accessible one(s)?	Signs designating restrooms should have raised letters and Braille. These signs should be located on the wall on the latch side of the door between 48" to 60" above the floor. All other signs should be legible with appropriate size, fonts, and color contrast.	☐Yes ☐No ☐N/A
	3.5.5.3	Does the interior door to the restroom require ≤5 lbs. of pressure to open?	For interior doors, labor force to open a door should be ≤5 lbs. Measure the weight of the labor force of the door after the door is unlatched; push a pressure gauge until the door opens and read the weight of the force.	☐Yes ☐No

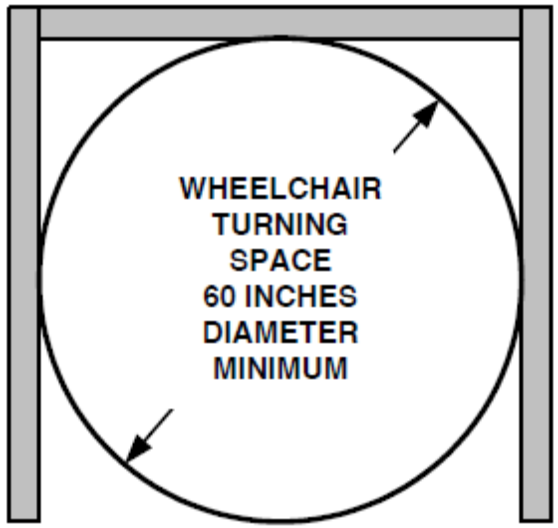
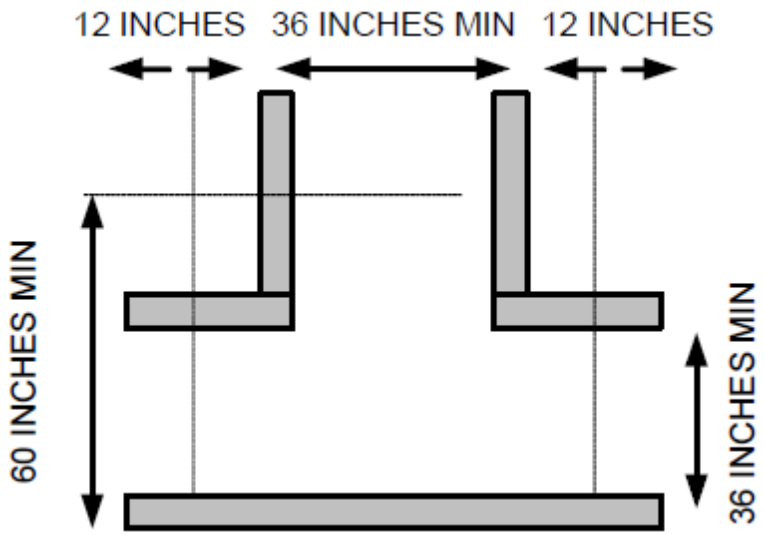
	Topic		Criteria for Assessment	Responses
3.5.5 Toilet Rooms	3.5.5.4	For toilet rooms, with and without stalls, are the grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?		☐Yes ☐No
	3.5.5.5	Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7” and 9” in front of the toilet and at least 15” high?		☐Yes ☐No

	Topic		Criteria for Assessment	Responses
3.5.5 Toilet Rooms	3.5.5.6	Is the space surrounding the sink at least 30” wide and 48” deep to allow wheelchair users to park in front of the sink?		☐Yes ☐No
	3.5.5.7	Is there >17” and <25” of clear floor space under the sink so that a person using a wheelchair can get close enough to reach the faucet?		☐Yes ☐No
	3.5.5.8	Are faucet handles operable with one hand and without grasping, pinching or twisting?	A knob handle is not considered accessible. 	☐Yes ☐No
	3.5.5.9	Are all dispensers mounted no higher than 40” from the floor?		☐Yes ☐No
	3.5.5.10	Are all dispensers operable with one hand and without grasping, pinching or twisting?	Dispensers include soap, paper towel, etc.	☐Yes ☐No

	Topic	Criteria for Assessment	Responses
3.5.5 Toilet Rooms	3.5.5.11 For toilet rooms without stalls, is there a minimum clear opening of 32” with the door open at 90 degrees, measured between the face of the door and the opposite stop?		☐Yes ☐No ☐N/A

	Topic	Criteria for Assessment	Responses
3.5.5 Toilet Rooms	3.5.5.12 For toilet rooms with stalls, is there a 60” diameter-turning circle or a 60” x 60” T-shaped space inside the stalls to allow a turnaround for wheelchair and scooter users?		☐Yes ☐No ☐N/A

	Topic	Criteria for Assessment	Responses
3.5.6 Exam, Treatment Rooms, and Medical Equipment*	*The questions in 3.5.6 only refer to exam rooms that the provider designates as accessible.		
	3.5.6.1 Do doorways to exam rooms that are designated as accessible have a minimum clear opening of 32" with the door open at 90-degrees, measured between the face of the door and the opposite stop?		☐Yes ☐No
	3.5.6.2 Is there a height adjustable exam table that lowers to between 17" and 19" from the floor to the top of the cushion?		☐Yes ☐No
	3.5.6.3 Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?		☐Yes ☐No ☐N/A
	3.5.6.4 Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table?	This includes armrests, side rails, padded straps, cushions, wedges, etc.	☐Yes ☐No

	Topic	Criteria for Assessment	Responses
	3.5.6.5 Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?		☐Yes ☐No
3.5.6 Exam, Treatment Rooms, and Medical Equipment	3.5.6.6 Is there a 60” diameter-turning circle or a 60” X 60” T-shaped space so that a wheelchair or scooter user can make a 180-defree turn?	 	☐Yes ☐No

	Topic	Criteria for Assessment	Responses
	3.5.6.7 Is a weight scale available within the medical office with a platform to accommodate a power wheelchair or scooter and the person?	Accessible scales are usable by all people including wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps, and/or who use mobility devices.	☐Yes ☐No
	3.5.6.8 If the facility provides specialized diagnostic service equipment, is the device(s) accessible?	This may include X-ray, ultrasound, and mammography equipment and gynecological exam tables.	☐Yes ☐No ☐N/A

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Assessment Summary Sheet

Strengths

Opportunities - In consult with practice, determine priority areas to address			
Item Number	Priority	Notes	Resources for improvement

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Disability-Competent Care Training and Informational Resources

Pillar 1: Communication Access

	Name	Section	Media format	Summary and relevant information
	Etiquette Quick Tips, Center for Disability and Health Policy	1.1	PDF	This tip sheet provides general etiquette tips, language issues, and examples of acceptable and unacceptable terms to use when referring to individuals with disabilities. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/EtiqBK_11_16_general.pdf
	Etiquette Quick Tips: Cognitive	1.1	PDF	These quick tips focus specifically on interacting with people with cognitive, intellectual, and psychiatric disabilities and provide suggestions for proper communication. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/Etiq_BK_11_16_Tips_cognitive.pdf
	Language Tips, "Language is More Than a Trivial Concern"	1.1	PDF	This one-page resource summarizes the list of acceptable and unacceptable terms in the etiquette quick tips sheet. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/Language-Tips.pdf
	Harris Family Center for Disability and Health Policy (CDHP) Provider Education	1.1	Webpage	This webpage provides a number of communication resources, including quick tips, checklists, and reports. http://hfcdhp.org/health-care-disable/provider-education/
	Augmentative and Alternative Communication Etiquette	1.2	PDF	This two-page resource provides guidance for augmentative and alternative communication, a form of communication that assists those with severe speech and language problems. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/AAC-Etiquette.pdf

Name	Section	Media format	Summary and relevant information
Identifying Communication and Accommodation Needs, Center for Disability and Health Policy	1.2	PDF	This checklist provides questions to ask for identifying communication and accommodation needs, as well as identifying preferred modes of communication. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/Questions_Identifying_Communication-Accommodation_Needs.pdf
Accommodation Checklist for Seniors and People with Disabilities	1.2.1 - 1.2.3	PDF	This short, two-page checklist can be used by providers to assess their clients' communication, medical equipment, and physical access needs. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/Accommodation_Checksheet.pdf
Accommodating Seniors and People with Disabilities: Model Policies and Procedures for Primary Care Practices	1.2.1 - 1.2.5	PDF	This document provides model policies for providers on how to accommodate individuals with disabilities by removing both physical and communication barriers. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/SFHP_MODEL_PandPs_for_Providers.pdf
Etiquette Quick Tips: Hearing	1.2.1.6	PDF	This one-page resource contains quick tips for interacting with people who have hearing disabilities. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/Etiq_BK_11_16_Tips_hearing.pdf
Etiquette Quick Tips: Speech	1.2.1.7	PDF	This two-page resource contains quick tips for interacting with people who have speech disabilities. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/Etiquette_BK_11_14_speech.pdf
Etiquette Quick Tips: Visual	1.2.1.10	PDF	This two-page resource contains quick tips for interacting with people who have visual disabilities. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/EtiquetteBK_11_14_Visual.pdf

Pillar 2: Programmatic Access

	Name	Section	Media format	Summary and relevant information
	Resources for Integrated Care Webinar: Integrating Behavioral Health Competency Within Disability-Competent Teams	2.1.3, 2.2.3, 2.2.4, 2.2.12	Webinar	The webinar presenters: helped participants understand the prevalence and importance of addressing participant behavioral health needs; and discussed strategies to facilitate timely communication and collaboration between behavioral health providers and disability-competent care teams. https://www.resourcesforintegratedcare.com/concepts/behavioral-health/integration
	Resources for Integrated Care Webinar: The Care Coordination Relationship	2.2	Webinar	The objective of this webinar was to introduce the care management relationship aspect of the Disability-Competent Care model, including: the importance of establishing the relationship between each participant and the Interdisciplinary Team (IDT); lessons from care management studies; the difference between case management and person-centered care management; overview of self-directed care; and introduction to the IDT component of the DCC model. https://www.resourcesforintegratedcare.com/concepts/disability-competent-care/pillar5/care_coordination https://www.resourcesforintegratedcare.com/physical_disabilities/disability_competent_care/webinar/webinar8/care_management
	Resources for Integrated Care Webinar: The Individualized Plan of Care	2.2	Webinar	The objective of this webinar was to explore the individualized plan of care by: introducing the interdisciplinary care team and the care planning process; applying the care planning process to adults with disabilities; and aligning care coordination resources with the unique needs of each participant. https://www.resourcesforintegratedcare.com/physical_disability/dcc/webinars/care_delivery5
	Accommodating Seniors and People with Disabilities: Model Policies and Procedures for Primary Care Practices	2.2.8	PDF	This document provides model policies for providers on how to accommodate individuals with disabilities by removing both physical and communication barriers. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/SFHP_MODEL_PandPs_for_Providers.pdf

	Name	Section	Media format	Summary and relevant information
	Resources for Integrated Care Webinar: Building a Disability-Competent Provider Network	2.3	Webinar	The objective of this webinar was to explore a disability-competent provider network through: building on existing capacity' understanding the importance of supporting the participants' existing, productive specialty relationships; identifying and promoting accessibility within a large provider network; identifying and developing disability-competency in a broad provider network; and identifying unmet participant needs and engaging providers to meet those needs. https://www.resourcesforintegratedcare.com/physical_disability/dcc/webinars/delivering_dcc/webinar8

Pillar 3: Physical Access

	Name	Section	Media format	Summary and relevant information
	Tax Incentives For Improving Accessibility	General	Webpage	This webpage contains links to federal and state tax deductions and credits to help reduce the overall costs of making facilities accessible to individuals with disabilities. http://www.ada.gov/archive/taxpack.htm http://www.hfcdhp.org/briefs/brief6-tax-incentives/
	Improving Accessibility with Limited Resources	General	PDF	This document provides suggestions and examples (with pictures) on how to remove physical barriers to access with low-cost solutions. http://webhost.westernu.edu/hfcdhp/wp-content/uploads/3-Brief-Access-Limited.pdf
	North Carolina Office on Disability and Health: Removing Barriers to Health Care: A Guide for Health Professionals	General	PDF	This resource outlines specific ADA requirements, tips for modifying environments to become physically accessible, and illustrations to accompany the guidance. http://fpg.unc.edu/node/6264
	U.S. Department of Justice: Access to Medical Care for Individuals with Mobility Disabilities	3.5.6	PDF	This report addresses ADA requirements and provides additional text and illustrations to ensure physical accessibility in exam rooms and with medical equipment. http://www.ada.gov/medcare_mobility_ta/medcare_ta.pdf