The Lewin Group
Improving Accessibility in Provider Settings
February 21, 2018
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Jessie Micholuk: Good afternoon, everyone. Welcome to the Disability-Competent Care webinar, ***Improving Accessibility in Provider Settings***. My name is Jessie Micholuk, and I will be getting us started today.

Should you have any questions now or 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 at the end of this webinar.

The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office (MMCO), has partnered with Chris Duff and other disability practice experts to develop the 2018 Disability-Competent Care (DCC) Webinar Series. This webinar series builds on our 2017 DCC webinar series that introduced the model of care and its seven foundational pillars. You can view this series and related resources at the Resources for Integrated Care website, https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2017_DCC_Webinar_Series/Series_Overview.

As I mentioned, this webinar will be interactive. We will have 45 minutes of presenter-led discussion followed by a 15-minute presenter and participant question-and-answer session. We'll also have a video replay, and slide presentations will be available after the session at the same website.

We are pleased to be able to offer credits for Continuing Education Units and Continuing Medical Education for this webinar, and the accreditation information is on your screen now. To receive credits, the post-test must be completed through the CMS Learning Management System with a score of 80 percent or higher by midnight on March 12, 2018. Further information is available at the Resources for Integrated Care website, https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2018_DCC_Webinar_Series/Accessibility_of_Provider_Settings.

This webinar is supported through MMCO to help 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, MMCO is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar. To learn more about current efforts and resources, visit https://www.resourcesforintegratedcare.com/.

I'll now hand the presentation over to your moderator, Chris Duff.

Christopher Duff: Thank you, Jessie, and I would also like to welcome everyone to this first webinar in the 2018 series. I am a Disability Practice and Policy Consultant who has been

working with The Lewin Group to develop the disability-competent care model and related webinars and materials. I will be joined today by several speakers that I will introduce in the order of their presentation.

We'll start off today with Sonya Bowen, a Healthcare Analyst at the Centers for Medicare and Medicaid, Office of Minority Health. Ms. Bowen works to promote accessible high-quality healthcare and to ensure that the perspectives of individuals with disabilities are reflected in CMS programs, policy development, and implementation.

Following her will be Patrick Going. Pat is a past director of the Rocky Mountain ADA Center and Chair of the ADA Committee for the Governor's Advisory Council. He specializes in ADA site surveys for medical practices and the Colorado Department of Transportation and Improvement Services.

Next will be Van Wilson, who is the Project Manager for Colorado's Medicare and Medicaid demonstration and facilitated the creation of Colorado's Disability Competent Care Assessment Tool and related training materials. Van has experience as a clinical social worker helping older Coloradans remain safe in their home and community.

Finally, we have Gabriel Uribe, who is the Independent Living and Diversity Services Manager at Inland Empire Health Plan. Gabriel has been with us before and always has very interesting presentations. He specializes in developing strategies to provide accessible and culturally competent healthcare services for populations that have different social, educational, economic and health disparities.

So, the focus today is on enhancing the accessibility of provider settings of care. There you're talking primarily about physical accessibility. If you'd like to learn about other components of accessibility, we have entered a link to previous webinars where we have addressed that issue on many occasions.

So at this point I will hand it over to Sonya for her portion of the presentation.

Sonya Bowen: Good afternoon. Thanks for inviting me to speak today.

Despite established laws and regulations requiring that all individuals have equal opportunity to access programs and services, many healthcare offices are still not fully accessible to people with disabilities. In disability-competent care, it is important to understand that access is a multi-faceted concept for people with disability.

Individuals with disabilities experience distinct barriers to healthcare in addition to what we typically think of when we talk about access to care. Accessibility barriers can be frustrating and exhausting to repeatedly encounter and often result in unmet care needs, sometimes with deadly consequences.

This slide shows some examples of contributors to unmet care needs for individuals with disability. It's notable that these barriers are further compounded in healthcare provider shortage areas.

Individuals with disabilities experience significant disparities in healthcare access and experience worse outcomes across clinical indicators. They're less likely to obtain preventive services such as mammography or Pap testing, and they're more likely to delay getting needed diagnostic or medical care because services and equipment may not be adapted to meet their needs.

So, what does lack of accessible care look like for a person with healthcare needs? As an example, in the following video Larry Voss and his wife talk about his experience obtaining an MRI, showing some healthcare barriers commonly experienced by individuals with a physical disability due to both lack of accessible equipment and limited knowledge of disability-competent care and experience by medical professionals.

Note that the audio for this video will play through your computer speakers. There is also closed captioning available on the video itself if you would prefer to follow along that way.

[Video begins]

Larry Voss: And after, I guess, even a few more weeks, she said, well, I did find a place where we can schedule your MRI, and she gave me an address, and it was an outpatient facility connected with the hospital, but when I went there we found out that there was no way that physically they could get me as a wheelchair user and a vent user onto the exam table that they use for the MRI, and they didn't have a Hoyer lift or any kind of other ways of giving me access to that equipment. So after going down there we were essentially -- said, sorry, we can't help you, go back home. And we did and continued to, you know, try and follow up with the doctor -- my internist -- about scheduling the MRI.

So finally we did get a call from the nurse that she had found an accessible facility. This took about nine months in total. And when the scan was done, the MRI was done, they found that what had originally been a much smaller growth that they detected had become almost double the size during the course of the time it took to scan -- to set up the imaging.

Well, I think, you know, what we found out after many other scans that were done in my treatment, many other MRIs and CT scans, was that really this shouldn't have been a problem at all, that they had done other people using ventilators, and that there actually was a protocol for doing it, but the doctor that I had and his nurse evidently were completely unaware of that.

[Video ends]

So, effective disability-competent care considers access comprehensively, both in terms of what social factors may be impacting access to care and larger contributing factors in a care environment that go beyond the clinical encounter. Unfortunately, lack of awareness and our own implicit biases can play a part in perpetuating unintentional but very real barriers.

I want to mention social determinants of health, also referred to as social risk factors, because of their relationship with access to care. For example, poverty and disability are important social risk factors that impact each other, as well as other social determinants of health. So within the framework of continuous quality improvement there are opportunities to improve access to and within the care environment to help mediate the cyclical impact of disability and poverty on health outcomes.

It's also important to emphasize that access to the care environment for people with disability goes beyond accessible facilities and equipment, to include communication, the care processes themselves, available programs and services, and respect for each person and their lived experiences.

In looking at these particular examples of facility and service access, note that they are not meant to be exhaustive, and they're not a checklist for meeting federal accessibility rules. I'm not going to read through them, but I want to in particular highlight the importance of staff training. For example, the availability of accessible scales and exam tables may meet the letter of the law. However, lack of staff training to use this equipment correctly and safely assist participants ultimately does not make care more accessible to an individual who may need accommodations, and it also may put staff at risk of injury.

Before I get into considerations of the law, I want to acknowledge that there are a number of payment factors that can affect the care provided to people with disability. This is no doubt of importance to providers, as payment for care has not traditionally accounted for the additional time and resources often needed to provide adequate care to individuals with disability. In addition, the increasing focus on value-based payment paired with documented disparities in quality measures for people with disability reinforces the need for practical payment and measurement solutions that will meet both participant and provider needs.

As a quick disclaimer, this section on federal disability rights laws is intended as a high-level overview and does not constitute legal or technical guidance for meeting applicable statutory requirements.

It's important to understand how federal disability laws apply to the provision of healthcare. Becoming familiar with the basic intent of the law can help alleviate initial fears about potential liability and provide a framework for beginning the process of what I like to call continuous accessibility improvement.

To start with, a disability is defined under federal disability rights laws in part as a physical or mental impairment that substantially limits one or more major life activities. This is similar to what we think of clinically in terms of functional impairment or limitations in instrumental activities of daily living, for example. The main point here is that the statutory definition is broad, and as such covers many people with chronic illnesses.

So, Section 504 and the Americans with Disabilities Act, which I'll refer to as the ADA, are not the only federal disability laws, but they're most applicable within the context of healthcare

delivery. These two laws are similar in that they both protect qualified individuals from discrimination on the basis of disability.

The key difference between Section 504 and the ADA, and this includes different title provisions within the ADA, is in the applicable covered entities. However, it is possible for healthcare programs and services to be subject to both. But this slide provides the general framework for which provisions apply to different types of healthcare entities.

I also wanted to mention, in addition to federal law, the Medicaid Managed Care Rule, and it's not Medicare as shown on the previous slide. It includes requirements for states and health plans to provide needed communication supports to enrollees and potential enrollees who have a disability.

In regard to data collection and reporting guidelines, although there is no national level database reporting information on the accessibility of healthcare facilities and services, the Medicaid Managed Care guidelines do include a requirement that plan provider directories include information on the accessibility of network provider offices and facilities. Medicare or Medicaid plans have been reporting on accessibility elements in provider directories as a requirement of the financial alignment initiative.

So, there are different strategies to consider when developing and implementing an accessibility plan and budgeting for making improvements over time. Training for providers and office staff is a critical strategy for increasing accessibility in the care environment. For example, incorporating a standard process and then training staff for collecting information on accessibility needs at the time of scheduling an appointment and again at the point of care is similar conceptually to collecting address and insurance information with every appointment. Accessibility needs can change over time, so they should be routinely assessed and documented.

Other examples of low-cost changes to improve accessibility include rearranging furniture to ensure a consistently clear pathway and waiting area for individuals who use a wheelchair or other mobility device and also another example is designating additional accessible parking spots.

To help with financial barriers that health plans and providers may face in ongoing efforts to improve accessibility, there are two federal tax incentives that I wanted to mention that are available to eligible businesses, including in healthcare. The first is the disabled access credit. It's available to small businesses to offset costs for removing access barriers to facilities, obtaining or modifying equipment, and providing accessibility services and materials in alternate communication formats.

Secondly, the barrier removal tax deduction is available to businesses of any size, and it's a business expense deduction for costs associated with removing barriers to facilities or vehicles. I wanted to note that small businesses can sometimes use both tax incentives in combination if the expenses qualify under both tax code provisions. More information on both is available at IRS.gov and also ADA.gov.

A final note of importance is that there are new practitioner billing codes that are available under the Medicare Physician Fee Schedule for prolonged preventive services. This is significant in that the provision of reasonable accommodations and preventive care for individuals with disability may include extra time and resources. It's important to stress that the prolonged preventive codes can only be built with Medicare-covered preventive services where the beneficiary, coinsurance and deductibles are not applicable.

And at this point I will turn it over to Pat.

Patrick Going: Thank you very much, Sonya. We are now going to talk about some specific things we did in Colorado.

Three years ago it was decided to create a comprehensive survey tool to help medical providers in Colorado identify and make needed improvements so that their patients with disabilities were better served. The charge was to address the full range of disabilities, from people who use wheelchairs and walkers to people who are visually impaired and blind, hard of hearing, and those with other disabilities who have difficulty in receiving compassionate and thorough medical care.

The intent of this tool was to become a nonthreatening ally to assist in identifying areas of improvement, share readily achievable barrier removal and free resources and suggest best practices. The focus to determine the level of accessibility at individual practices consisted of three areas, or pillars.

One pillar looks at the built environment, or physical access. This area is the easiest to determine, and the tool borrowed from other checklists. The physical elements can be measured in a definitive way. The doors are 32" clear width or not, the parking lot has accessible parking or not, and so forth.

A second pillar looks at communication. This would be the availability of large-print materials, Braille, sign language interpreters, and communicating with people with intellectual disabilities; that is, how and where to acquire products and services to facilitate the information patients need.

A third pillar is programmatic. This is policy and procedures to ensure people with disabilities receive the same quality care. This includes disability etiquette.

With input from a good cross-section of stakeholders and gleaning sections from other checklists, like PARS and DOJ resources, the tool was developed. We then utilized this tool, with support from our regional Medicaid Accountable Care Collaborative at our local level and surveyed a dozen practices. The challenge was to convince practices of the benefits of this survey. We needed to overcome the significant reluctance to have an outside group come into their practice and to overcome their perception they could be in trouble or fined if they had a noncompliant ADA facility. We often heard, quote, do we have to?

It was critical to arrange the onsite visits by working through the care coordinators for the respective practices. Once we were onsite and they realized we and the tool were supportive it went well. Here are some simple fixes and ideas.

I'd add offset hinges to widen doors; inexpensive threshold mats; service dog posters, which, as we know, is such a misunderstood issue; and the importance of accessible websites. Also, it is important to let for-profit entities know about the generous tax write-offs when costs are incurred and how to interact with a landlord to fix noncompliant elements. Sonya addressed that also.

The medical practices appreciated that the tool prompted them to think about patient transportation; the importance of accessible exam tables and scales, or at least where such tables and scales are located; how to interact with people with disabilities; the fact that exams may necessitate additional time; where to find sign language interpreters; and other doable solutions. The onsite visits also brought up issues like where to find local disability etiquette resources, help with 508-compliant websites, and general ADA questions.

This table is an example provided to the practices after the onsite surveys. The intent was to simplify and help the practices begin the process of addressing all three parts of the tool by starting with the built environment. The full tool is 48 pages. We found it was too overwhelming to address the full checklist on the initial visit. It is possible to discuss the communication and programmatic pillars over the phone later. In some instances we left behind a quick-look, two-page checklist that highlighted the most important first steps. You'll see some simple fixes on the table.

One last thought, whenever possible, enlist risk managers in the survey. They appreciate how an accessible building is a safer building. It helps to lessen worker comp claims and injuries to patients.

Over to you, Van.

Van Wilson: Thanks, Pat. First a big thank you to CMS and Lewin for the opportunity to highlight some of the work that we've done in Colorado that was made possible through Colorado's Medicare-Medicaid Demonstration. So I'm going to speak to some of the challenges that we encountered and overcame, to some degree, really engaging in this work from the Medicaid perspective. I hope this is helpful for those of you coming from the health plan perspective, as well.

When we began this work we had to be really realistic about the challenges of improving accessibility in the healthcare field and in working in this landscape. So it was important to assume that most providers wanted to do the right thing. All providers wanted to do the right thing. It was also important to realize that the ADA can require providers to implement real and significant initiatives that carry very real cost and resource implications, and we had to take these concerns seriously from the providers.

We also had to be realistic about Medicaid's limitations. We realized pretty early on that we had some limited jurisdiction to really enforce ADA requirements, and that really this was a function

of the Office of Civil Rights. We found that we needed to implement strategies that avoided scaring providers away. Pat mentioned that partnership approach, and it was really key. Finding a provider champion or a facility manager champion was really critical in making real changes to the provider office.

It was important to focus on engagement and participation of providers, and, as Pat mentioned, finding the right office staff. Facility managers, risk managers really found the comprehensive of our tool to be very valuable when they did their jobs. Ultimately we found success with those actionable concrete items that providers could take to implement and address to improve accessibility.

Some of the challenges that we encountered with the states really had to do with our role as a payer, as a Medicaid state agency. So first and foremost we had to maintain network adequacy. We worked and are working in a fee-for-service environment. We needed to maintain enough providers that contracted with Medicaid to serve all of our members. For that reason and for our limited jurisdiction we ultimately landed on a voluntary approach for providers due to our concerns about the scope of our authority.

What we found through these assessments is that, unfortunately, in some cases the provider capacity to address these opportunities identified by the tool were fairly limited, and we'll speak to that here in just a moment. A few things that kept providers at arm's reach and from engaging in proactive strategies, as Pat mentioned, the fears of litigation and potential ADA violations; the fear of having the, quote, ADA police inside their office; and then, finally, providers really resented the time and effort, to some degree, that was spent on an unfunded mandate, which is the ADA, for capital improvement costs. And this is an unfortunate reality of the ADA and a limitation in the landscape that we're working in.

We did learn a number of lessons. It wasn't all challenges. We did learn a lot of lessons while implementing this tool. As I mentioned before, using that collaborative, nonthreatening approach with providers is critical. Our partnership with the Independence Center in Colorado Springs was critical, and, truthfully, Pat's role and his personality in the provider office really put the providers and the office staff at ease and helped them to see that we were there to really help them and not to get them in trouble, frankly.

Providers were much more willing to make improvements if they saw the business case, and that was kind of a key place to start our work. As I mentioned, it was really important for Medicaid, the payer, to partner with a community organization. In particular we found that the centers for independent living were very well set up within their community to do this type of work. And in Colorado Springs we worked very closely with the Independence Center.

Engaging providers with low-cost, practical improvements we found really kind of piqued their interest and perhaps opened the doors to larger assessment or improvement efforts. And then, finally, we had to understand that proper engagement with providers really required internal champions within their office and required their time and their money. And that limitation's very real, and it's often very limited, and I would argue this is where outside funding and perhaps foundation funding can assist with the effort.

Some of our recent successes here in Colorado, due to our strong partnership with the Independence Center in Colorado Springs most of our initial assessment efforts were focused around that area. And so what we've found recently, those providers who had the initial assessment a number of years ago have kept this as a high priority within their practice.

And so we've heard recently that a number of those providers have committed to making tangible improvements within their clinics by purchasing accessible equipment. One of our PACE providers in that area, they've ordered 10 accessible exam tables, and two of our providers committed to buying accessible exam tables and Hoyer lifts, which we saw in the video are used for lifting people from a wheelchair to an exam table or to another procedural instrument.

So, some of our next steps here in Colorado, how do we expand this work? We did encounter some significant challenges with the assessment and technical approach. Pat mentioned the length of this. With ADA I think we all kind of understand to some degree that the devil's in the details. It does matter when it comes down to inches and the height of particular things within an office. So for that reason we continue to and in the past few years continued to work with stakeholders to determine more palatable strategies for providers, which, in our case, really took a tack towards provider education and training.

My last bullet here, I'm very proud to share with you all a series of training videos that we developed here in the state that were based upon the technical elements of our Disability-Competent Care Assessment Tool but really hoped to convey the experience of persons living with disabilities and the challenges that they encounter on a daily basis when trying to access those most basic of preventative services.

I would encourage you there to check out our link. You'll see all seven videos there, as well as a link to our Disability-Competent Care Assessment Tool, which will provide you kind of a comprehensive list of all three of those pillars that Pat mentioned. Thank you for the opportunity again to kind of present about some of the work we've done in Colorado. I'm now going to pass it to Gabriel Uribe, from Inland Empire. He's going to speak a little about their disability-competent care efforts.

Gabriel Uribe: All right. Thank you, Van.

So, yes, at Inland Empire Health Plan we are very excited to share some of the results of our Accessible Clinics Project that we led or have been leading for the last couple of years.

The project started kind of as a result of some of the things that Sonya, Pat, and Van identified in their presentations of some of the barriers that are existing for people with disabilities. In California we are grateful to have a couple of the health plans that are interested in doing some good work in this area and also having a strong Department of Healthcare Services at the state level that has allowed us to kind of lay the groundwork to identify our clinic sites' accessibility features through a statewide Physical Accessibility Review Survey campaign that is required of all the health plans in the state.

And basically what that does, the PARS accessibility review, it allows health plans to go in into different provider offices in a non-punitive fashion and look at some of the accessible features that are within the clinic, some of the improvements that can be done, and, similar to Pat and Van's strategy, share with the organizations the feedback and say, hey, if you want to look at certain things in the future to improve your accessibility these are some of the things that you could do.

Leveraging that data, we decided to look at our network and see what were some of the deficiencies or gaps for our communities that required access to care. We leveraged the different variables within the data and identified different clinics in the area that had adequate accessible features as far as entry, as far as some accessible equipment, existing equipment within the clinics, and we identified a large group of areas that we could go ahead and provide accessible equipment to. So we decided to provide two things that we thought would make a big difference, and that was an accessible exam table and also accessible weight scales and exam table/weight scale combos.

We set up in a way that we looked at the region. We have a pretty vast region. We serve about two counties. And we looked at the time and distance that it would take for our members to get to certain geographic areas. We looked at the existing equipment in the area, and we decided to provide grants to about 100 providers in the area who could utilize the accessible tables or the accessible scales. After identifying the different areas of opportunity, we went ahead and sent out a call to action or an application process to all of our provider network and said that we were making this program available to all of them.

We developed an application that looked at a couple of things for each provider. We looked at their existing building accessibility. We looked at the current medical equipment that they had. We also addressed training and their training needs, and we also looked at the types of services that they provided. So, as a managed care provider we contract with specialists and also with primary care, and the needs of each site are different. So, as we reached out to the organization, our care provider network, they were able to provide details to further help us make a decision on an award.

The criteria that we utilized to prioritize the provider sites that we would award was, like I mentioned, the PARS data that we picked from the state, the geographical information as we laid out the locations of the different sites and facilities, and the specialty work.

After looking at the different areas of need, we decided on awarding about 100 of these devices, and we also realized that we needed to do as an organization or to have an investment in the educational component of the piece of the project that we were doing. So we were awarding equipment but we also need to provide the organizations with the how-to's on how to utilize the equipment properly, what some of the equipment features will allow them to do as far as preventative care, and also how to avoid injury to the individuals who are involved in providing the care utilizing the equipment. We also took the opportunity to discuss with the organization or the provider sites more on the different accessibility components that the health plan had built into its programs, issues related to cultural competency, also some of the senior and disability community resource linkages that the health plan had established, and so on and so forth.

Prior to the Accessible Clinics Project, we only had about 19 providers that had access to accessible exam tables in our area or accessible scales. After the Accessible Clinics Project the number went up to about 119, which represents about 5 percent of our provider network, and about 50 or more of those tables went into areas where we had concentrations of members who are seniors and persons with disabilities at over the population of 1,500 or more.

Some of the things that we learned from the Accessible Clinics Project is that providers are more likely to participate in projects or programs when they're incentivized to be a participant. By awarding a table or a weight scale, we realized as an organization that we were not just also supporting IEHP members, but we were supporting these entire practices' patient experience. And one of the things that after the project we realized that perhaps it might be a good idea to leverage different health plan relationships to see where some of these facilities are getting some of this equipment, perhaps work together in different communities where you have multiple health plans to coordinate the awards of equipment, if that is something that other health plans would be interested, and, in turn, provide a greater coverage of accessible devices across the network.

So our next steps after looking at the Accessible Clinics Project as a health plan is, of course, to continue looking at some of the resources that we may leverage in the future to provide further accessible equipment to different clinics, but also to look internally and look at our health plan services, starting with our health education program, and ensuring that our health education programs are also led and held at physically accessible facilities or utilizing curriculum that is accessible, and also anything that's related to virtual programs that we may put on our website or do online, that those are accessible to individuals with disabilities.

Additionally, as we look at other health plan features like accessible mobile apps in the age now that a lot of our business has moved online, to ensure that individuals with disabilities can utilize those mobile apps, utilizing some of the different types of software that might allow people to have access to services. Also, as we look into virtual primary care visits, so things like Doctors on Demand and things of that nature, to ensure that individuals who are deaf or hard of hearing can access those services along with some of the multimedia content that the plan may push out.

So when we look at accessibility across the board, we started with Accessible Clinics, but we understand that the scope of services, or what clinics are doing in general, is not only now taking place in a traditional clinic setting. It's also moving on into the web. So we want to make sure that in the future we address that, as well.

Jessie Micholuk: Great. Thank you, Gabriel, and thank you, Pat, Van and Sonya for your presentations today. This was wonderful. We are now moving into the Q&A portion of our presentation. I just want to remind our audience that you can access the Q&A at the bottom part of your screen to bring up that platform, and you can insert questions there for any of our presenters from today and we'll be happy to answer them during this portion.

We've had a few questions come through during the presentation. We have our first question here. This is for Colorado. It looks like Colorado obviously doesn't have a concrete method for

enforcing disability-competence in practices, so how can you encourage the practices or providers to take up the disability-competent care methods that you presented today?

Patrick Going: This is Pat, if I can take this and then toss it over to you, Van. I think one angle is to really emphasize, and I believe Sonya brought this up, the good business practice of removing barriers and the fact that more people will access that practice, both Medicaid and Medicare patients. So I think there was a slogan we had at the ADA Center, which is Good Access is Good Business, and I think if we can emphasize that, that is a part of what might help.

There is no funding available that I know of, and money oftentimes is the bottom line for decisions. But hopefully there will be some options coming up. Van, would you be able to expand on any of that?

Van Wilson: Yes, thanks, Pat. I think as I mentioned in my presentation really outlining the business case, how this could ultimately save them money and potentially avoid any litigation that may happen through the ADA, as we know that that is the primary way in which accessibility improvements are enacted is through litigation. I think taking that proactive approach is definitely hard to convince providers at the outset, but making the business case to them that this is a good risk management strategy is one way.

I'm also really encouraged by the new codes that Sonya mentioned on I believe it was Slide 26, that there is some additional cash flow, for lack of a better word, that's available to providers who serve a high volume of members with disabilities. The excuse that they don't have enough money to make these capital improvements will no longer be quite as strong if they are, in fact, able to bill for these additional services provided.

Jessie Micholuk: Great. Thank you both. Sonya, I know we were referencing your slides, but did you have anything to add that you wanted to add on that topic, as well?

Sonya Bowen: Sure. First of all, if anybody in the audience has questions around the new payment code I'm not the lead on that, but I can certainly link folks to the policy lead for this code. It is new, and there have been a lot of questions coming in, so folks are becoming aware of it and are interested in it, which is encouraging.

In addition to the business case, I think it is helpful, as well, to frame accessible healthcare as a quality issue and to think about in targeting any population for quality improvement there are changes and interventions that are targeted, and so I think sometimes it's helpful to think of it in that way, as well. You want to improve the quality of care and the outcomes for your patients.

Then also the video that was shared, that's actually one of a series of videos put out by the Disability Rights Education and Defense Fund (DREDF), and that particular couple, if you go to the DREDF website, I think there's a seven-part video, and I've found it really useful. In going through the whole thing it really drives home the issue of quality and how if we don't address accessibility it really can and does lead to unnecessary poor outcomes.

Jessie Micholuk: Great. Thank you, Sonya. Yes, the mention about the DREDF videos is great. We've used them in a lot in our webinars, and there's a lot of great information on their website, too. It really gives you that participant perspective.

Okay, so we've had a couple more questions come in here. One question is for Gabriel. We have a person from our audience asking how specifically you evaluate usage, so sort of figuring out if the practice is actually using the equipment and how exactly you would check that.

Gabriel Uribe: Yes, so most of our evaluation was based on previous utilization. We looked at the practices that had a high amount of membership that identified as seniors or persons with disability and also that had, through our Encounter data that the health plans receive, that they had a high utilization for some of the specialist practices, as well. So we have not yet done this. We ran the project last year. We're still collecting data for the year after.

What I can tell you, though, is that we also worked with our other resources within the health plan, with our care managers, with our member service representatives, and provided them a list of these facilities so that they have access to route or reroute members who may have some access needs to the appropriate provider. Similar to what we saw in the video, we saw that a person was looking to go into a provider's office for an MRI with accessible equipment, we've had already multiple cases where women, for example, have tried to access gynecological services, something like a Pap smear, and have not been able to access it with their primary care doctor, and in turn called the health plan and we have been able to redirect them to a site that has that. So, again, we base it on the historical data, the Encounter data, but we also do some redirection as part of our process once we completed the project.

Jessie Micholuk: Thank you, Gabriel. I have another question here. This is one that I haven't ever seen come up before. Pat or Van, maybe you could take a go at it. Is there any way to incorporate disability-competent care policies in a pharmacy benefit manager? Has that ever come up for you?

Patrick Going: That's a tough one. We actually just implemented a new pharmacy benefit management system here in Colorado. I'm thinking of polypharmacy and those sort of complications that often occur with members with disabilities. We haven't thought of that or thought about addressing that as part of our strategy, but it's an interesting question. I think that oftentimes because of our fee-for-service system there is duplication of services and perhaps providers are not communicating as well as we would hope. So the existence or the prevalence of polypharmacy does happen here in Colorado. So that'll be something we look into. It's a good question. Sorry I don't have more information for you right now.

Sonya Bowen: This is Sonya. I wanted to piggyback on that. Another big issue around pharmacies and accessibility is having prescription readers for people who are blind or have low vision. This is something that I'm not sure what the level of awareness is, but it's definitely something that can be considered and looked into as far as another strategy for creating accessible pharmaceutical solutions.

Jessie Micholuk: Yes, that's very interesting. Thank you, Sonya, for jumping in there.

Okay, a couple more questions that have come in here. I think we might have time for two more. I think, Gabriel, this is back to your specific program. Is there a site or is it even available on the state website where people can see which providers have the equipment that they may need, or is that something that might be developed in the future?

Gabriel Uribe: So, in California, most health plans already provide that website in their directories, so you can look at the provider directories and the provider directory will have legends that will let you know what type of equipment or access features are involved. On our website, we've included those in our provider directory through what we call the PARS data that we collect for the state. So you can access that there.

Now, it's important to know, also, that these reviews usually happen every other year or sometimes every three years for the different facilities. So it is possible that providers update their equipment and then provide that information either to the health plan or to members through their physician association. So there's multiple ways to find that information. My suggestion is if you have consumers that are trying to find accessible features in specific clinics is to call the health plan and have the health plan assist in locating if they can't see something on the provider directory online.

Jessie Micholuk: Great. Thanks. Good advice. The last one here, we can start with maybe California and then get some input on it from Colorado on their practices, but can you talk a little bit about the training modules to help train providers on equipment usage, where are those from, and how can you access those?

Gabriel Uribe: Yes, so we worked very closely with Western University Health Systems to develop training that was responsive to the population, to people with disabilities. Actually they were very involved with the actual design of the table. So we approached a vendor that was an integral part of the design of the features for the actual accessible tables that are out in the market now, and we also collaborated with them by bringing some of the experiences that our own care managers were having when interacting with members and some of the limitations and barriers that they were having.

Working together with this group, bringing in seniors and persons with disabilities into the discussion, we were able to address the medical need of accessibility and accessible equipment. We were also able to follow-up with social determinants of health that result as part of somebody who is dually eligible and who has all these other barriers at home in the community. We were able to provide accessibility resources not just in the clinic but also once they step outside of the clinic, whether that's transportation, pharmacy, access, and education to providers letting them know if they have individuals who are blind who are their patients they can actually request accessible labels at the pharmacy through our vendor.

So that's what we trained on. We trained on not just the accessibility there at their site, but also the other component, too, that I wasn't able to share a while ago, was that when we did these reviews we also shared some of the little improvements that they could do to their own clinics, as well. A lot of the providers ended up doing some of those modifications even though we didn't

award them any funding for it as a result of our encounter there. So that training component really goes far, because they could begin to see the value in that.

Our next plan and our next step is to go there after a three-year mark and start looking at what are some of the things that the providers learned, some of the things, the benefits that they saw clinically, and also we track the community resource connections that the health plan does at our level to see what are some of the impacts that that has had in the community in general.

Patrick Going: This is Pat in Colorado. I wanted to reference a resource at ADA.gov that sometimes is difficult to find. If you go to ADA.gov and click on Technical Assistance Material, scroll down to Publications of General Interest, and the fourth one down is Access to Medical Care for Individuals with Mobility Disabilities. It is about 12 pages, as I recollect, very comprehensive, and with pictures and text; I think it is a resource that staff would find real helpful and would be good for staff trainings. Certainly refer folks back to the videos that HCPF through Van's office produced.

Jessie Micholuk: Great. Thanks for the additional information, Pat. We will be sure to include those resources on our resources list that we post online, too.

I want to thank Gabriel, Pat, Van and Sonya for your time today. We really appreciate all your work in putting together this webinar, and to the audience, thank you for participating and for your questions.

We have another webinar next week. The topic is ***Serving Adults with Disabilities on the Autism Spectrum***.

Please feel free to send any additional questions via the chat on the platform or our email address that's at the end of this presentation, and we will be sure to follow up with you.

For more information on obtaining those CEUs or CMEs and also for any additional resources, please visit our website, https://www.resourcesforintegratedcare.com/.

As always, your input is essential in developing new trainings and resources, so we ask you to please answer our brief survey that will appear automatically on your screen when this webinar ends. And you can send any additional comments, as I mentioned, to our email. That's RIC@lewin.com.

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