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Response to the Data Challenges of the Affordable Care Act: Surveys of Providers to Assess Access to Care for People with Disabilities and the Presence of Accessible Exam Equipment

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Response to the Data Challenges of the Affordable Care Act


Surveys of Providers to Assess Access to Care for People with Disabilities and the Presence of Accessible Exam Equipment

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How The Affordable Care Act Addresses Access to Medical Care Facilities

- The ACA contains no language requiring architectural, programmatic, or equipment accessibility in medical office sites.
- BUT, contains requirements to
 - 1) collect information regarding where patients with disabilities receive care
 - 2) collect information about the physical and programmatic access of medical providers
 - 3) set standards for accessible exam and medical diagnostic equipment



Section 4302 of ACA requires the U.S. Department of Health and Human Services to:

[S]urvey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

- (i) locations where individuals with disabilities access primary, acute (including intensive), and long- term care;
- (ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria;
- (iii) the number of employees of health care providers trained in disability and patient care of individuals with disabilities.



Section 4203 of ACA requires standards for accessible medical diagnostic equipment

- a) criteria for medical diagnostic equipment used in physician's offices, clinics, emergency rooms, hospitals, and other medical settings.
- b) equipment to be accessible and allow independent entry to, use of, and exit from the equipment
- c) includes examination tables and chairs, weight scales, mammography equipment, x-ray machines, and other radiological equipment



What is required to implement these provisions?

1. Consistent means for identifying patients with disabilities
2. Measurement tools to gather information on:
 - a) accessibility characteristics of provider facilities
 - b) Presence of provider staff trained in disability and patient care
3. Accessible equipment standards
4. Procedures for gathering data on providers' facilities and training



Measuring Provider Office Accessibility

Studies of provider office accessibility have found numerous barriers

Three methodologies for data collection:

- Surveys and interviews with patients
- Provider self-administered surveys
- Independent on-site reviewers



Why Access Data are Important: Findings from Prior Studies

Medical building exterior and public interior spaces are largely accessible.

BUT

Barriers remain *inside* physicians' suites.

On-site review of 2389 California providers:

91.6% do not have a height adjustable exam table

96.4% do not have an accessible scale

83.4% have inadequate space in bathrooms

69.9% have restroom door hardware that does not meet ADAAG standards



Measurement of Provider Office Accessibility: State of the Art

- Several tools have been used to examine medical office access; each has a different number of items

- Most tools use selected items from the architectural elements of the ADAAG

- Only one or two instruments have been evaluated for reliability and/or validity

- Use across the U.S. has been uneven, with small sample sizes, often voluntary sites



Tools Used to Measure Outpatient Health Provider Office Accessibility

- **California Health Plans ADA Facility Site Review 2002-2010 (used by Mudrick, et al.)**
 - 55 items, 53 architectural, 2 equipment
 - 41 correspond to 1991 ADAAG
- **Health Care Accessibility Survey for People with Disabilities 2007 (Respect-*ABILITY* Coalition & Disability Rights Advocates)**
 - 61 items, partially from ADAAG
 - Includes communication & equipment items
- **Health Care Provider Disability Awareness and Capability Interview 2006 (San Francisco Health Plan)**
 - 33 items
 - Communication and programmatic items

Tools Used to Measure Outpatient Health Provider Office Accessibility

- **Outpatient Health Care Usability Profile 2008 (Drum, et. al.)**
 - 158 items, architectural, based on ADAAG
 - Items tested for validity with people with disabilities and ADA experts
- **ADA Assessment Checklist 2008 (Graham & Mann)**
 - 93 items, architectural
 - Based on amended 2002 ADAAG
- **Adaptive Environment Center's Checklist for Existing Facilities 1995 (elements essential for health facilities, used by Sanchez et. al.)**
 - Based upon 1991 ADAAG



Tools Used to Measure Outpatient Health Provider Office Accessibility

- **State of California ADA Facility Site Review 2011 (put into use 2/1/2011)**
 - 86 items: 82 architectural, 4 equipment
 - 1991 ADAAG and 2012 ADAAG
 - Expanded version of 55-item tool in use 2002-2010

California's 2010 1115 Medicaid Waiver requires an on-site accessibility audit for all primary care providers working with the 22 health plans participating in the waiver



Measurement of Provider Office Accessibility: State of the Art

Elements of access missing from the existing measurement tools:

- 1) Communication access indicators
- 2) Programmatic access indicators
- 3) Diagnostic equipment access beyond exam table and weight scale
- 4) Training of provider staff to provide care to patients with disabilities



Lessons Learned from Provider Accessibility Studies

- 1) Measurement of provider accessibility results from pressure and input from disability advocates and federal and state health agencies.
- 2) Accessibility tools need to be standardized for use across the U.S.
- 3) The ADAAG can provide the basis for some elements, but provides no guidance for other crucial elements.



Lessons Learned from Provider Accessibility Studies

- 4) Medical office accessibility **MUST** be assessed by on-site reviewers.
- 5) Accessibility tools need to be developed with the care of research instruments, field-tested, assessed for reliability and validity.
- 6) Plans for collecting provider accessibility audits must include procedures for aggregation, analysis, and utilization of findings.



Lessons Learned from Provider Accessibility Studies

- 7) An effective access instrument meets the needs of multiple audiences.

Its development requires collaboration involving disability advocates, providers, state or federal agencies, and researchers.



Training for Disability Awareness and Patient Care of Individuals with Disabilities

- Medical students and practicing physicians report in surveys they have inadequate training for patient care of individuals with disabilities
- Training in disability is not required as part of accredited medical curricula, professional licensing, or facility licensing or accreditation



Training is Available

- A number of guides, videos, and training modules are available for physicians and other health providers.
- Some training is occurring in medical schools. A 2009 poll of 70 medical schools found that 26 had some sessions on disability (AAHD fact sheet).



Training for Disability Awareness and Patient Care of Individuals with Disabilities

- The content of training offered varies; no current consensus regarding necessary elements, or who requires training
- Much of the training is not competency-based, but focused on disability awareness



Content Issues for Measurement of Provider Training

- Scope
 - Clinical
 - Accommodations
 - Policies and procedures
- Standardized
- Measure competencies for different groups—physicians, dentists, nurses, physicians assistants
- Add to continuing education



Questions and Decisions

- What should be the content of qualifying training?
- Should mastery be indicated by certification or other means in order to consider an employee trained?
- Through what data collection vehicles will the extent of employee training be reported?



Training Data Collection: Methodological Concerns and Challenges

- Complex data collection challenges
- Requires a high level federal/academic/disability policy work group to determine the way forward
- Should build on existing work with training modules and research on training receipt and outcome

Items from California Department of Health Services Site Review Survey

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt	Site Score
F. Site personnel receive safety training/information. 8 CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030					
There is evidence that site staff has received training and/or information on the following:					
1 Infection control/universal precautions	1	1	1	1	
2 Blood Borne Pathogens Exposure Prevention	2	2	2	1	
3 Biohazardous Waste handling	3	3	3	1	
4 Child/Elder/Domestic Violence Abuse	4	4	4	1	

SAMPLE

Comments: Write comments for all "No" (0 points) and "N/A" scores.

D. There is 24-hour access to interpreter services for limited-English proficient members. 22 CCR §53855; CA H&S Code §1259; 42 USC §2000d					
1 Interpreter services are made available in identified threshold languages specified for location of site.	1	1	1	1	
2 Persons providing language interpreter services on site are trained in medical interpretation.	2	2	2	1	

Health Education Survey Criteria	Yes	No	N/A	Wt	Site Score
Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67					
Health education materials and Plan-specific resource information are:					
1 readily accessible on site, or are made available upon request,	1	1	1	1	
2 applicable to the practice and population served on site,	2	2	2	1	
3 available in threshold languages identified for county and/or area of site location.	3	3	3	1	

SAMPLE

ACA Mandate for Standards for Medical Equipment

- ADAAG standards for:
 - examination tables, examination chairs (includes eye and dental), weight scales, x-ray machines, and mammography & other radiological equipment commonly used
 - within 24 month period (March 2012)
 - Dept. of Justice plans ADA Titles II & III regulations: standards for numbers and types of medical equipment
-

Standards can be used in provider access instruments and surveys



Potential Strategies and Final Thoughts

Real change: Leadership Levels

- **Federal Roles (HHS, CMS, DOJ, NIH)**
 - Vision
 - Funding
 - Coordination
 - Research
- **State Mandates and Actions**
 - 1115 Waiver requirements—CA as example
 - MMCO/Benefits exchanges/health plans
- **Accreditation and Licensing**
 - Medical education requirement
 - Joint Commission physical & programmatic access measures