The Geographic Distribution of Accessible Medicaid Participating Primary Care Offices in LA County

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Acknowledgements

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Pacific ADA Center
WITH Foundation
True North Foundation

We also wish to acknowledge June Kailes and Brenda Premo, whose work with California Medicaid Managed Care plans more than a decade ago was instrumental in the development of the data collection process and the data we present.
Presentation Overview

I
Why does accessibility and geographic location matter?
Review research and data documenting access barriers
Describe legal requirements for health care setting access

Part II
• Describe a feasible method for measuring primary care office accessibility across a region
• Present a tool based upon ADA architectural standards to assess accessibility
• Show use of geographic and census data to evaluate the match of accessible offices to number of potential users
• Provide an example of data analysis combining access characteristics and geographic location

Part III
• Policy applications for these methods and analyses
Learning Objectives

We would like you to take away from this presentation—

An understanding of the potential impact of the geographic distribution of accessible doctors’ offices on health care for people with disabilities

Knowledge of a method for measuring primary care office accessibility
Part I

♦ Why does accessibility and geographic location matter?
♦ The research and data documenting access barriers
♦ The bases of legal requirements for health care setting access
Why does accessibility and its geographic location matter?

Health disparities are connected to access barriers

- Physical barriers and inaccessible examination equipment contribute to health disparities because they result in inferior care, delayed care, or refused care.

Access is not equal if there are few choices

- If a patient is required to travel a great distance to an accessible health care setting, the patient may delay care or “settle” for a proximate but inferior care experience.
Patients report inferior care or refusal to accept as a patient due to an inaccessible primary care office.

My name is Alice Wong and I live in San Francisco.
Titles II and III of the ADA apply to medical care providers

Both titles require—

Full and equal access to their health care services and facilities

Reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e. alter the essential nature of the services).
ADA Title II: Non-discrimination in health care applies to

“a public entity, in providing aid, benefit, or service,... directly or through contractual, licensing, or other arrangements” (28 CFR § 35.130(b)(1))

ADA Title III: Private health care providers are defined as public accommodations (28 CFR 36.104 (1))

A public accommodation is required to remove architectural and communication barriers to equal access and treatment in health care when removal is readily achievable

Medicaid regulations 2016 (42 CFR 438) require states ensure that Medicaid managed care plans offer

 accessibility of network provider offices/facilities and network adequacy standards that consider physical access and accessible equipment
Challenges to Monitoring Health Care Office Accessibility

There is no national database. We do not know whether all, most, or few primary offices are prepared to provide care to people with disabilities.

Most prior research on primary care access is based upon small sample sizes in a single geographic area, or asked practices to voluntarily self-administer the audit tool. Some efforts involve having the patient bring the tool and conduct the audit, which may burden the patient or create awkwardness between patient and provider.

The ACA had a provision, never implemented (now sunsetted), to require data collection about the preparation of health care settings to provide care to people with disabilities.

The 2016 Medicaid Managed Care regulations were issued, but have not been fully implemented.
Part II

- Methods for conducting an access audit
- Combining audit data with geographically located census data
- Examples of data analysis with LA County as a case study
**California Access Audit: Overview**

Accessibility audits began as voluntary add-ons to state-mandated on-site reviews of Medicaid Managed Care primary care offices in California. Managed Care Plans worked with June Kailes and Brenda Premo to develop the tool and train auditors on its use. Then it was appended to the state-required review.

| Data are collected for a walk-through of primary care physician offices | Trained managed care plan staff conduct the audits using a structured form | California now mandates the audit when a primary care office joins a Medicaid managed care plan, and every 3 years thereafter | Each plan holds the data it collects; plans share data so that a single site is not subjected to multiple reviews |
“Provider Facility Site Review Accessibility Tool for Seniors and Persons with Disabilities,” 2011

Part of the California Department of Health Care Services facility site review form and process

The 86-item 2011 audit instrument is comprised of 80 physical access elements derived from the ADAAG (ADA Accessibility Guidelines) 2010 revision

It asks questions about equipment presence and characteristics

The tool requires measurement of door widths, ramp angles, and turning radii, as well as observation of interior and exterior elements
# Summary of the Accessibility Elements

<table>
<thead>
<tr>
<th>Element category</th>
<th># of Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parking.</strong> Accessible spaces, width, signage, curbs, route to building, van spaces</td>
<td></td>
</tr>
<tr>
<td><strong>Interior route from parking, transport, and sidewalk.</strong> Curbs, path width, surface quality, ramps, ramp leg length</td>
<td></td>
</tr>
<tr>
<td><strong>Door width and swing, signage to accessible entrance, handles</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Interior route and office interior.</strong> Non-stair clear path, floor surfaces, lighting, stair characteristics, door weight, waiting area, sign-in, signage, patient controls, alarms</td>
<td></td>
</tr>
<tr>
<td><strong>Audible, visible controls, signage, turning radius, emergency call system</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Bath rooms with and without stalls.</strong> Turning radius, grab bars, faucet handles, sink characteristics, door weight</td>
<td></td>
</tr>
<tr>
<td><strong>Examination rooms and exam equipment.</strong> Interior spacing, height adjustable table, accessible scale, patient lift</td>
<td></td>
</tr>
</tbody>
</table>
Example of audit tool elements for bathroom sinks and faucets:

<table>
<thead>
<tr>
<th>Question # (CE)</th>
<th>Criteria (CE = Critical Elements)</th>
<th>Explanation/Guidelines</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>68 (CE)</td>
<td>Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?</td>
<td>This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Is the space in front of the sink free of trashcans and other movable items?</td>
<td>Self explanatory.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Are the pipes and water supply lines under the sink wrapped with a protective cover?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71 (CE)</td>
<td>Are faucet handles operable with one hand and without grasping, pinching, or twisting?</td>
<td>A knob handle would not be accessible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example of audit tool elements for height adjustable exam table:

<table>
<thead>
<tr>
<th>Question #</th>
<th>Criteria (CE = Critical Elements)</th>
<th>Explanation/Guidelines</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 (ME)</td>
<td>Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?</td>
<td>Self explanatory</td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82 (ME)</td>
<td>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?</td>
<td><img src="image" alt="Diagram" /></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)</td>
<td>Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.</td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Data Analysis of Site Review Audits

In 2017 we requested the site review data for 2013-2016 from the California Medicaid Managed Care plans.

Five plans sent data, including the two plans that serve Los Angeles County, comprising a total of 3993 primary care offices.

LA County audit data covered 2096 physician offices (practices).

The only identifying information provided was Zip code (no names or addresses).

The data were merged into a single dataset and any duplicates were removed.

The next slide summarizes findings for interior office elements that are most often problematic, toilet rooms and examination equipment.
<table>
<thead>
<tr>
<th>Accessible Physician Office Elements</th>
<th>LA County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of practices (n=2096)</td>
</tr>
<tr>
<td>Light-adjustable examination table</td>
<td>14.9%</td>
</tr>
<tr>
<td>Accessible weight scale</td>
<td>8.6%</td>
</tr>
<tr>
<td>Patient lift to assist with transfers</td>
<td>3.7%</td>
</tr>
<tr>
<td>% - 100% of toilet room features meeting accessibility standards</td>
<td>49.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Least One Office within the Zip Code Has the Element Present</th>
<th>Zip Codes (n=233)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Light-adjustable examination table</td>
<td>47.3%</td>
</tr>
<tr>
<td>Accessible weight scale</td>
<td>31.0%</td>
</tr>
<tr>
<td>Patient lift to assist with transfers</td>
<td>15.9%</td>
</tr>
<tr>
<td>% - 100% of toilet room features meeting accessibility standards</td>
<td>26.6%</td>
</tr>
</tbody>
</table>
With ArcGIS software we mapped the facility audit information by the zip code in which the medical practice is located.

We placed within each zip code the number of medical practices with at least one accessible exam table, with similar maps for scales and for lifts.

The number of people reporting a mobility impairment by zip code was downloaded from the 2016 American Community Survey and grouped into categories: 0-2000, 2001-4000, and 4001 and above.

Zip codes on the map were color coded by these categories; yellow, orange, red from lowest to highest population numbers.

A 10 square mile grid is laid over the map to provide an indication of the distances.
Practices with Height Adjustable Exam Tables

Color key: Number of primary care practices with mobility impairment
- Yellow: 0 - 2000
- Orange: 2001 - 4000
- Red: >4000
- Grey: No population data

Numbers within the black circles are the number of primary care practices within that zip code that have a height adjustable examination table.

Grid lines = 10 sq. miles

Breslin, Mudrick, Nielsen, 2020. Do not copy without permission
Practices with Accessible Scales

Color key: Number of practices with mobility impairment

- Yellow: 0 - 200
- Orange: 2001 - 4000
- Red: >4000
- Grey: No population data

Numbers within the black circles are the number of primary care practices within that area that have accessible scales.

Grid lines = 10 sq. m.

Practices with Patient Lifts

Color key: Number of practices with mobility impairment

- Yellow: 0 - 200
- Orange: 2001 - 4000
- Red: >4000
- Grey: No population data

Numbers within the black circles are the numbers of primary care practices within that area that have patient lifts.

Grid lines = 10 sq. m
Zip Code Highlights

93550
Palmdale

91767
North Pomona

90007
Los Angeles

90201
Bell Gardens
Selected zip code detail: 93550 Palmdale, CA

Total Population: 74,929  
4,855 people with a mobility impairment (7.2%)

<table>
<thead>
<tr>
<th></th>
<th>Exam Tables</th>
<th>Lifts</th>
<th>Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Providers with--</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of people per provider with--</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Median household income: $38,316, Poverty rate: 32.3%

Zip Code 93550 Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>12114</td>
</tr>
<tr>
<td>Black Or African American</td>
<td>9937</td>
</tr>
<tr>
<td>Hispanic</td>
<td>48171</td>
</tr>
<tr>
<td>American Indian Or Alaskan Native</td>
<td>301</td>
</tr>
<tr>
<td>Asian</td>
<td>2044</td>
</tr>
<tr>
<td>Native Hawaiian &amp; Other Pacific Islander</td>
<td>147</td>
</tr>
<tr>
<td>Other Race</td>
<td>171</td>
</tr>
<tr>
<td>Two Or More Races</td>
<td>1468</td>
</tr>
</tbody>
</table>
Selected zip code detail: 90201 Bell Gardens, CA

Total Population: 101,279  
4,228 people with a mobility impairment (4.5%)

<table>
<thead>
<tr>
<th>Number of Providers with--</th>
<th>Exam Tables</th>
<th>Lifts</th>
<th>Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

| Number of people per provider with-- | 704.7 | 4,228 | 845.6 |

Median household income: $37,267, Poverty rate: 28.2%

Zip Code 90201 Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2014</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>3092</td>
<td>3.02%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>698</td>
<td>0.68%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>97775</td>
<td>95.38%</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>108</td>
<td>0.11%</td>
</tr>
<tr>
<td>Asian</td>
<td>653</td>
<td>0.64%</td>
</tr>
<tr>
<td>Native Hawaiian &amp; Other Pacific Islander</td>
<td>52</td>
<td>0.05%</td>
</tr>
<tr>
<td>Other Race</td>
<td>166</td>
<td>0.04%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>255</td>
<td>0.09%</td>
</tr>
</tbody>
</table>
Selected zip code detail: 91767 North Pomona, CA

Total population: 48,068  2,924 People with a mobility impairment (6.4%)

<table>
<thead>
<tr>
<th></th>
<th>Exam Tables</th>
<th>Lifts</th>
<th>Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Providers with--</td>
<td>10</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Number of people per provider with--</td>
<td>292.4</td>
<td>731</td>
<td>731</td>
</tr>
</tbody>
</table>

Median household income: $49,881, Poverty rate: 20.5%

Zip Code 91767 Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>8103</td>
</tr>
<tr>
<td>Black Or African American</td>
<td>4408</td>
</tr>
<tr>
<td>Hispanic</td>
<td>32416</td>
</tr>
<tr>
<td>American Indian Or Alaskan Native</td>
<td>165</td>
</tr>
<tr>
<td>Asian</td>
<td>3417</td>
</tr>
<tr>
<td>Native Hawaiian &amp; Other Pacific Islander</td>
<td>25</td>
</tr>
<tr>
<td>Other Race</td>
<td>98</td>
</tr>
<tr>
<td>Two Or More Races</td>
<td>791</td>
</tr>
</tbody>
</table>
Selected zip code detail: 90007 Los Angeles, CA

Total population: 40,920  2,028 People with a mobility impairment (5%)

<table>
<thead>
<tr>
<th></th>
<th>Exam Tables</th>
<th>Lifts</th>
<th>Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Providers with---</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Number of people per provider with---</td>
<td>1,014</td>
<td>NA</td>
<td>2,028</td>
</tr>
</tbody>
</table>

Median Household Income: $22,420, Poverty rate: 48.5%

Zip Code 90007 Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7554</td>
</tr>
<tr>
<td>Black Or African American</td>
<td>4376</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22815</td>
</tr>
<tr>
<td>American Indian Or Alaskan Native</td>
<td>21</td>
</tr>
<tr>
<td>Asian</td>
<td>8082</td>
</tr>
<tr>
<td>Native Hawaiian &amp; Other Pacific Islander</td>
<td>143</td>
</tr>
<tr>
<td>Other Race</td>
<td>207</td>
</tr>
<tr>
<td>Two Or More Races</td>
<td>871</td>
</tr>
</tbody>
</table>
Key Insights from Mapping Accessible Offices

Medicaid participants with mobility impairments in the northern geographically large zip codes do not have medical practices with accessible equipment nearby.

Many practices in the dense urban area lack accessible equipment, although travel to an accessible practice may be more feasible.

The number of people with mobility impairments per practice with accessible equipment implies that patients may have only one or two nearby choices; choice may be reduced if the nearby provider with equipment does not belong to the patient’s Medicaid plan.

The profiles of the highlighted zip codes raise questions regarding whether, among Medicaid participants, there are ethnic and racial disparities in the accessibility characteristics of the medical practices most likely to serve them—with greater implications for the quality of care received.
Part III

- The measurement of medical care access in the context of larger health policy
I. What is Happening Across US

Federal agencies increasing involvement and role with states and plans
- Medicare
- Medicaid/Medicaid dually eligible LTSS contracts
- Equity concerns

Community partnerships between Medicaid managed care organizations and disability services and advocacy groups

Academic centers turning attention to health care access barriers research

Legal actions
II. What is Happening Across US

ADA hospital system litigation increasing access (2001-present)

California physical access audit extended to specialty and ancillary service providers, that serve a high volume of seniors and persons with disabilities (2012)

HHS/CMS, Office of Minority Health: Equity Plan for Improving Quality of Medicare: Increase physical accessibility of health care facilities (Sept. 2015)
III. What is Happening Across US

CMS Medicare-Medicaid Coordination Office: Disability Competent Care Self-Assessment Tool (Physical Accessibility)—Resources for Plans and Providers for Medicare-Medicaid Integration (2017)


Managed LTSS contracts: Key accessibility requirements as of 2017
- On site accessibility reviews; use of specific surveys
- Designated responsible person
- Reasonable accommodation, policy modification, auxiliary aids and services
IV. What is Happening Across US

Centene Health Plan partners with National Council on Independent Living
- Providers nationwide self-report accessibility using CA audit tool; verified by IL Centers
- Barrier removal fund
- 52 health care providers receive $470,000 in grants (2018)
- Centene receives CMS Health Equity Award

CMS Office of Minority Health: Improving Access to Care for People with Disabilities – videos, patient guide, 'Resources Inventory' (2020)
In the Future

National standardized access audit

Enhanced Role for Medicaid Managed Care Plans

– Proactive Role in auditing accessibility of provider offices, including equipment

– Incentivizing access modifications if needed; pay for procurement of accessible equipment for high use providers

– Team with local advocacy organizations on training
Summary Points

It is possible to audit a large number of primary care offices; the California method is replicable.

Audits produce information that is useful to providers and patients.

A geographic look can help target priorities for action.

Knowing the density of accessible care sites does not relieve every provider of ADA obligations; patients must also be able to choose their provider.

CMS and other federal agencies have a role in monitoring, facilitating and enforcing physical access to health care facilities.

Attention to physical and programmatic accessibility of health care facilities is increasing with public and private efforts; however, monitoring for progress is required.
Resources for More Information


Improving Access to Care for People with Disabilities

Modernizing Health Care to Improve Physical Accessibility—Resources Inventory

Increasing the Physical Accessibility of Health Care Facilities

Consent Decree, Olson v. Sutter Health (2008)
Resources for More Information (continued)

Medicaid and CHIP Managed Care Final Rule

Medicaid and CHIP managed care final rule

Dual access to care: "Core Competencies on Disability for Health Care Education," Ohio State University, Nisonger Center.

Core competencies on disability for health care education OSU Nisonger
Core competencies on disability for health care post-consensus OSU Nisonger

CMS Medicare-Medicaid Coordination Office. Disability Competent Care Self-Assessment Tool

Disability competent care self-assessment tool

Medicare-Medicaid Coordination Office. Disability Competent Care Self-Assessment Tool

EDF Promoting Physical and Programmatic Accessibility in Managed Long-Term Services and Supports Programs.

Promoting physical and programmatic accessibility in LTSS

Increasing Visibility, Transparency, and Access through the Provider Accessibility Initiative

Increasing access through provider accessibility initiative
Contact Information

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