Pacific ADA Center
Emergency Management and Preparedness-Inclusion of Persons with Disabilities
ADA National Network Learning Session: The Geographic Distribution of Accessible Medicaid Participating Primary Care Offices in LA County
Thursday, June 25, 2020
2:10-4:00 p.m. ET

>> LEWIS KRAUS: Welcome to the Healthcare and the ADA Inclusion of Persons with Disabilities Webinar Series. I'm Lewis Kraus from the Pacific ADA Center, the moderator for this series. This series of webinars is brought to you by the Pacific ADA Center on behalf of the ADA National Network. The ADA National Network is made up of 10 regional centers federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act. You can reach your regional ADA Center by dialing 1-800-949-4232. Realtime captioning is provided for this webinar. The caption screen can be accessed by choosing the CC icon in the meeting control toolbar at the bottom of your screen. To toggle that meeting control toolbar permanently on, press the alt key once and then press it a second time. As always in our session, only the speakers will have audio.

The audio for today's webinar is being broadcast through your computer. Make sure your speakers are turned on and your headphones plugged in. You can adjust the sound by navigating to the audio settings on the bottom panel. You can adjust the sound by sliding the sound bar left or right in the audio tab. If you do not have sound capabilities on your phone -- sorry, on your computer, or prefer to listen by phone, you can dial 1-669-900-9128 or 1-646-558-8656. And you can use that webinar ID that is on the screen, 760-897-977.

And I want to note for everybody that the webinar is being recorded and can be accessed on the ADAPresentations.org website in the archives section of the healthcare section next week. This Webinar Series is intended to share issues in promising practices in healthcare, accessibility for people with disabilities. The series topics cover physical accessibility, effective communication and reasonable modification of policy issues under the Americans with Disabilities Act of 1990, the ADA. Upcoming sessions are available at ADApresentations.org under the schedule tab. Then follow to healthcare. These monthly webinars occur on the fourth Thursday of the month at 2:30 eastern, 1:30 central, 12:30 mountain and 11:30 a.m. Pacific time. By being here you are on the list to receive notices for future webinars in the series. Those notices go out two weeks before the next webinar and open that webinar to registration. You can follow along on the webinar platform with the slides. If you are not using the webinar platform you can download a copy of today's PowerPoint presentation at the healthcare schedule web page at ADApresentations.org. At the conclusion of today's presentation, there will be an opportunity for everyone to ask questions. You may submit questions using the chat area within the webinar platform and the speakers and I will address them at the end of the session. So feel free to submit them as they come to your mind during the presentation. To submit those questions, you type them into the chat text box area. Or if you are using keystrokes, press alt-H and enter your text in the chat area. If you are listening by phone and not logged into the webinar you may ask questions by emailing them to adatech@adapacific.org. If you have any technical difficulties during the webinar you can send a private chat message to Pacific ADA Center, the host, by typing that in the chat window

and type your comment in the box and press enter. Using the keyboard, you can do that by using alt-H to access the chat box. You can email technical issues to adatech@adapacific.org or you can call us at 510-285-5600. Today's ADA National Network learning session is titled "The Geographic Distribution of Accessible Medicaid Participating Primary Care Offices in LA County" this webinar will present finding from a study that examines the geographic distribution of these accessible Medicaid primary care offices in LA County and will describe methodology for collecting and utilizing data on office accessibility that has been implemented for thousands of primary care offices in California. This analysis makes it possible to illustrate equipment and geographic barriers that affect equitable access to healthcare for people with disabilities. Today's speakers are Mary Lou Breslin, a senior analyst with the Disability Rights Education and Defense Fund, DREDF. A leading civil rights law and policy center. Her current work focuses on the organization's healthcare, long-term services and supports and Home and Community-Based Services research initiatives. Nancy Mudrick is a professor of school of social work in Syracuse. Her recent research and partnership with Mary Lou and with DREDF addresses issues affecting the delivery of accessible and equitable healthcare to people with disabilities. Kyrian Nielsen is a research assistant at Syracuse University and working alongside Nancy and Mary Lou. Kyrian has been involved in research projects on the issues that people with disabilities face in accessing healthcare. So I am now going to turn it over to you, Mary Lou, Nancy, Kyrian. There you go...

>> Thank you, Lewis. This is Mary Lou. Can we see the next slide? Before we begin we would very much like to extend a special thank you to the organizations that have thought -- just the work we've been doing looking at accessible facilities in California is as important as we do and who have supported it, and that includes the Pacific ADA Center, the WITH Foundation, and the True North Foundation. And we specifically want to acknowledge and send out a big thank you to June Kailes and Brenda Premo, whose work began with California Medicaid Managed Care over a decade ago and that work continues today. And it was really instrumental in the development of the data collection process and the data that we present in this webinar today. So thank you very much both to June and to Brenda. June, if you're listening today, we are very grateful for all the work you have done. Next slide, please. So the webinar we'll be presenting today will be in three parts. In part 1 we plan to discuss why accessibility and geographic location matters for people with disabilities, who need healthcare from primary care providers. We'll also review research and data documenting access barriers and describe briefly legal requirements for healthcare setting access. In Part 2 we will be describing what we think is a feasible method for measuring primary care office accessibility across geographic region and present a survey tool based on the ADA architectural standards to assess accessibility. We also are excited to introduce our geographic and census data that can be used to evaluate the match of accessible provider offices to number of potential users. And finally in Part 2 we'll be presenting an example of data analysis that combines access characteristics and geographic location. In Part 3 we're going to be talking about House and federal agencies are recognizing the importance of need for measuring provider accessibility and some potential policy and advocacy opportunities. Next slide, please. So, learning objectives today include an understanding of the potential impact of the geographic distribution of accessible doctor's offices on healthcare for people with disabilities and knowledge of viable method for measuring primary care office accessibility. So with that I would like to just turn the presentation over to Dr. Mudrick.

>> NANCY MUDRICK: hello. The next slide, please. All right. So this is Part 1. In this portion of the webinar we want to set the frame by briefly explaining why learning about the state of provider facility access is necessary. The reasons follow these three bullets, why accessibility and geographic location matter, what the research to date on access barriers tells us and does not tell us, and the legal and regulatory reasons for conducting analyses of facility accessibility. Next slide, please. So why does accessibility and geographic location matter? For accessibility health disparities are connected to access barriers. The number of studies document disparities in healthcare treatment and utilization rates comparing people with and without disabilities. For example, adults with disabilities are 2.5 times more likely to report skipping or delaying healthcare due to cost, and they are significantly less likely to receive some preventive care testing, such as mammography and PAP tests. People with disabilities report how physical access barriers delay their treatment or result in less than optimal treatment. Geography matters because access is not equal if there are few choices. How far should a patient expect to have to travel for primary care? Most people choose a primary care provider thinking about that provider's proximity to residence or work. They select physicians whose style is a good fit for them maybe in philosophy or use of medication or interpersonal style or reputation. So geography is connected to having equal opportunity to receive care from one's preferred provider. Geography also offers a metric for seeing where equal access does not really exist whereas statistics aggregated over a state or a region can mislead. Next slide please. The next slide... oh, thank you. Facility access is important because patients report experiences of inferior care or refusals to be accepted as a patient due to inaccessible primary care offices. The 2013 publication reports that 44% of specialty physician offices called to take a referral of a patient with a mobility impairment refused the referral due to lack of access of their building, their offices or equipment. Access barriers are well-documented in surveys and focus groups with people with disabilities. This fragmented video we're going to show right now contains excerpts from a large set of interviews conducted by DREDF in which people speak about their healthcare access and healthcare treatment experiences. Can you start the video now? Thank you.

>> DREDF. Healthcare stories. Part One. Tables and Scales.

>> Thank you. The next slide, please.

So these testimonies I think are very eloquent. And really set up the case for why we also need to look at this in a more formal way. So another reason we should monitor healthcare setting access is Titles II and III of the ADA apply to medical care providers, something this audience is well aware of. It means providers have obligation to enable full and equal access to healthcare services and make modifications to practice and procedures when never to make healthcare services fully available to individuals with disabilities unless those modifications would fundamentally alter the nature of the services. Next slide, please.

This slide expands upon why physical access matters for Medicaid Managed Care by linking the ADA to ADA Medicaid Managed Care federal requirements and sets the stage for data and methodology and analysis involving managed care plan providers that we present in part 2.

Title II covers a public entity that provides benefit or service directly through contracting or other arrangements. Medicaid Managed Care have obligations on how they deliver healthcare services as contractors under state Medicaid programs. Title III applies to private doctors' offices as public accommodations. Even a practice not on a Medicaid Managed Care panel must remove architectural and communication barriers to equal access when removal is readily achievable. And finally, in regulations for Medicaid Managed Care, the centers for Medicare and Medicaid services set out access requirements. States receiving Medicaid funding and distributing it to their managed care plans must assure CMS that the plan's network provider offices and facilities an adequate to serve the target population and that they are accessible. This requirement has existed in a general form for a number of years. Later in this webinar Mary Lou Breslin will talk about access requirements in the most recent version of the regulation. So the next slide, please. Documenting primary care office accessibility is important but it does not happen routinely due to a number of challenges. Here are five challenges to collecting access data. First, there is no national database. No single surveys conducted in every state and centrally collated. Thus we do not know the state of access nationally. In smaller regions we don't know if every person with a disability sees the same one or two doctors or whether there's a wide choice of accessible providers. Second, to date, where there have been surveys of provider office access, the sample sizes have been small, generally in the hundreds and maybe even less. Some surveys have used self-reports. The problem, because observed access is generally lower when compared to what was self-reported. Solicited respondents may have response bias since those confident about their accessibility may be more likely to respond. A third challenge involves who will conduct the access audit. In addition to provider self-audit, audit forms have been offered to patients to conduct the assessment when they visit their doctor's office. This puts a burden on people with disabilities and may create awkwardness between the patient and provider. This fourth challenge involves a provision in the Affordable Care Act that was promising but never implemented. Section 4302 of the Affordable Care Act required the Department of Health and Human Services to survey healthcare providers and establish other procedures in order to assess access to care and treatment in individuals with disabilities. And included in that, they were supposed to be able to identify locations where individuals with disabilities accessed their primary and acute care and long-term care. The number of providers with accessible facilities and equipment, and the number of employees of healthcare providers trained in disability and patient care of individuals with disabilities. No work was done to develop the mechanisms to do this in this section of the Affordable Care Act has now sunset. A final challenge involves the implementation of the 2016 Medicaid Managed Care regulations, which were issued but have not been implemented, and Mary Lou will say more about this. So now we move on to Part 2. Next slide, please.

So with the prior frame, in this part of the webinar we will describe a method for assessing primary care office accessibility used in California and then describe our work that combines the office accessibility information with geographic consensus data and we will show you the product of these three different datasets as an example for Los Angeles County. Next slide, please. In California, Medicaid Managed Care plans have been conducting on-site walkthrough audits of primary care office accessibility since 2006. The accessibility audits began as a voluntary add-on to an on-site audit mandated by the California Department of

Health Care Services. Today this add-on is part of the site audit. The basic audit asks for things like access and safety, personnel, qualifications, office management, clinical services, preventative services and infection control procedures. Starting in 2000, a small number of the California Medicaid Managed Care plans worked with June Kailes and Brenda Premo to design an accessibility assessment tool to be used at the same time as this mandated audit. The procedure for the audit requires that a trained reviewer walk through the primary care office to complete the full audit. The audits are conducted when primary care practice joins a plan and every three years after that. Each managed care plan holds on to the data they collect, but the plans share the data so that a single practice that is associated with more than one plan is reviewed only once in the cycle. What is important about this process is that it's mandated. Practices don't have the option to volunteer or to opt out. Next slide, please.

The audit tool is titled "Provider Facility Site Review Accessibility Tool for Seniors and Persons with Disabilities." The 2012 version, which is what we use, has 86 questions in total. Of these 80 questions involve physical accessibility and the items are derived from the 2010 ADAAG guidelines, accessibility guidelines. Six questions ask about equipment. The auditor walks through the site and observes characteristics like door handles and lighting and takes measurements, such as door width and weight, turning radius, ramp angles and so forth. Because California now requires the assessment for everybody, more than just the original floor plans are conducting these assessments. Next slide, please. This slide shows -- it summarizes the elements in the audit tool in major categories. And on the right-hand column we have the numbered elements looked at for each category. So the first category is parking with 13 elements, and they include things such as accessible space and signage. The second category is exterior route from parking, transport or sidewalk to the front door with 10 elements, and they are things like surface quality, ramps and curbs. Building entrance includes door width and swing and signage, and there are 8 elements in total there. Four, interior route and office interior, and that's 20 elements that look at the path of travel and floor surfaces, lighting, stairs if there are any, and characteristics. There are a section devoted to elevators if there is an elevator and there are 10 elements there, including looking at call buttons, signage and turning radius. 18 elements around toilet rooms with and without stalls are examined, turning radius and such thing as the location of grab bars and the faucets and doorway. Finally, there are seven items that address examination rooms and examination equipment. Six are the equipment questions about height adjustable exam tables, scales, patient lifts, and one question about the exam room itself. Next slide, please.

This is a screenshot of one page of the audit tool and it is a page in which the space around the sink is being assessed, and you can see that the graphic puts out what the measurements are that the auditor needs to measure and check there's sufficient size around the sink. This page also asks about the faucet handles and the protective covering on the pipes. Next slide, please. And this is another screenshot of the audit tool. And this is the page that asks about the presence of a height-adjustable exam table and also marks out the space needed next to a table for someone in a scooter or wheelchair to have enough space to park and transfer. So the auditor would be measuring for these dimensions. Next slide, please. So, now that I have explained the data source, we would like to show examples so you can see what is possible to learn from this. In 2017, Mary Lou Breslin and I contacted the people in the Medicaid Managed Care plans who were responsible or the accessibility review and asked if they would

send data for 2015 to 2016. We received data from five Medicaid Managed Care plans for emerged data set of 3993 primary care practices. Only accessed data and city and county and zip codes of the practice. We don't have addresses or other identifying information for the practice. We believe this data set could be the largest or maybe the second -- you know, one of two large datasets across the nation that have on-site review of doctor office accessibility. However, not every California Medicaid Managed Care plan sent data. So the statewide average of 3,900 offices is uneven across the state. However, the two plans in the county did send data, and for that reason we focus this analysis on the 2,096 practices in LA County. The next slide shows summary data on interior office elements and equipment from the data set. Next slide, please. The top half of the table lists across the county the presence of equipment and accessible toilet rooms for those 2,096 practices. 14.9% have height adjustable exam tables. 8.6 have accessible scales and 3.7% have patient lifts. 49% of bathrooms have between 70 and 100% of different access elements rated for their rooms. The numbers are not large, but for context, the exam table and scale numbers are about twice as large what we found in a 2006-2009 analysis of similar statewide data for California. At that time it was 8.4% for tables and 3.6% for scales in terms of being present in provider offices. The lower half of this slide uses the zip code information for geographic book, and from this we can see that 47% of the LA zip codes contain at least one practice with at least one height-adjustable exam table. 31% of zip codes have at least one practice with an accessible scale. And just shy of 16% have a practice with a patient lift. 26.6% have bathrooms with many of the accessibility features. Even with these numbers, though, we do not know whether the 47% of zip codes with an accessible exam table are all bunched together or whether they are evenly spread out through the county. For that, we need to be able to map them. And so I'll now turn this discussion to Kyrian Nielsen who will show you maps and explain how we -- actually how she did it.

>> KYRIAN NIELSEN: thank you, Dr. Mudrick. Could you move to the next slide, please? All right, so this slide is just laying out the methods that we used in creating the maps of accessible Medicaid participating primary care offices in LA County. As Dr. Mudrick mentioned, we were curious to see the geographic distribution of accessible exam equipment and wanted to know whether there was a goodness of fit between the presence of practices with accessible equipment and the people who might actually need this equipment. In doing so we used ArcGIS mapping software to create a geographic representation of this distribution. We used an ArcGIS map of Los Angeles County and overlaid the information from the audit tool that Dr. Mudrick talked about earlier to display the number of medical practices within that zip code that contain accessible medical equipment. We created three separate maps, each displaying a different type of accessible equipment, either accessible exam tables, accessible scales or patient lifts. In order to determine if there was a relationship between the presence of disability accessible equipment and the presence of people with mobility impairments, we downloaded data from the American community survey reporting the number of people with mobility impairment by zip code. We downloaded the 2016 data to match the data we had from the audit tool and did this by zip code because we had the audit tool data by zip code. We then grouped the number of people reporting mobility impairment into three separate categories from 0 to 2,000, 2001 to 4,000 people and 4,000 and above. In order to put this on the map, we color coded the three categories with yellow indicating that a zip code contains between 0 and 2,000 people with mobility impairment or indicating that between 2001 and

4,000 people reported a mobility impairment and red indicating that 4,000 or more people reported having a mobility impairment within that zip code. And lastly we overlaid a 10 square mile grid to provide context to the map indicating the distance people might have to travel in order to find a practice that contains certain accessible equipment. You can go to the next slide, please. So on this slide is the first of the three maps. This is displaying the number of practices per zip code that contain a height-adjustable exam table. In looking at this map of Los Angeles county, the map is boundary by zip code and each zip code is colored according to -- using one of the three colors mentioned previously, yellow, orange or red, depending on the population density of people reporting a mobility impairment. And to add numbers to what you're seeing, 57% of the zip codes are yellow, again, indicating that a population density of people with mobility impairments ranges from 0 to 2000. 32% of zip codes are orange, 2001 to 4,000 range. And 6% of zip codes are colored red, which indicates there are more than 4,000 people in the zip code that report a mobility impairment. It can be seen a few zip codes on the map are colored gray. This reason being that we didn't have population data for those zip codes. In each zip code there's a black circle with a number in it. This number indicates the number of primary care practices within that zip code that contain a height-adjustable exam table. This is not the number of exam tables in that zip code. It's the number of practices that have an exam table. The numbers of practices with exam tables from this map ranges 1-10 with most circles containing either 0 or 1. A majority of zip codes there are no practices or one practice with a height-adjustable exam table. Of the 233 zip codes we have data for, 88 report having zero practices with exam tables. And only one zip code that has practices with exam tables, and this zip code is over on the southeastern portion of the map. It can be seen that there are few zip codes without a black circle and again this is because we were not given equipment data for that particular zip code. It can be noticed that the zip codes are much more spread out in the northern portion of the county and much smaller and squished together in the southern region. This is due to the population density of LA County because the majority of the population lives the southern portion, so the zip codes are much smaller and more packed together to reflect this. Whereas in the north, the zip codes are larger because there is less of a population in this area. For this reason, the black dots indicating the presence of practices with height-adjustable exam tables are in the southern portion of the map and spread out in the top half. The northern section of the map is predominantly yellow and orange, but if you notice there is one very large red zip code in the center of the map. It's notable this zip code has zero practices with exam tables in it. And if you look in the zip code of the surrounding area they also have low numbers of practices with exam tables. This is concerning for this particular zip code given a there is a high population of people with a mobility impairment and very little access to potentially needed equipment in that zip code and the surrounding zip codes. And this would suggest someone who needs that equipment would have to travel very far to get the care they would need. Southern portion of the map is mixed in color and there is a larger concentration of red zip codes in the bottom center of the map. You can see that there are more practices with exam tables in the southern region but again the majority of zip codes have either zero or one practices with exam tables. All right, and we can move to the next slide.

Moving to the second map, this one is displaying the number of practices per zip code that have accessible scales. So as you can see, this map is similar to the first. It's still a map of LA County and has the same coloring as the first map. We're using the yellow, orange and red

coloring scale. However, on this map the black dots are indicating number of practices that contain accessible scales instead of accessible exam tables. The number of practices per zip code still ranges from 0-10 but you can notice there are more zeros and lower numbers on this map. On this map there are 133 zip codes that have zero practices with accessible scales. Again, there's only one zip code that has 10 practices with accessible scales and it's an orange zip code located in the densely populated region of the county near the center. Though it's great the zip code has many practices with accessible scales, it's interesting in the northern region of the map, the majority of the zip codes have zero practices with scales despite still being a giant red zip code in the middle of the map. Again, this is concerning because an individual with a mobility impairment in that region would likely have to travel a great distance in order to find this equipment if they needed it or have to accept subpar healthcare. We can move to the next one.

So this is showing the last of the three maps. This is displaying number of practices with patient lifts. Again, this map is similar to the first two and contains the same zip code coloring. But you can notice that the range of practices per zip code containing lifts on this map is even lower. So this ranges from zero to six practices in the zip codes. It's clear there are many more zeros and ones on this map. There are actually 174 zip codes with zero practices with a patient lift and only one zip code has six practices, it's an orange zip code in the central portion of the county. Again, large red zip code in the center of the map has zero patient lifts and the northern zip codes, only two to three of the zip codes have a number other than zero, which again highlights the point that for people in this region that may need specialized equipment they likely would have to travel pretty far in order to get it.

All right, we can move to the next slide. So this is showing an additional map of LA County but you see the coloring is different from previous maps and no black dots indicating the presence of specialized equipment. Only four zip codes are colored on this map and these four are zip code highlights. So we're going to dive a little deeper in the each of the zip codes in the coming slides. The first highlighted zip code is 93550, which is Pomona, California. It is a large zip code in upper middle section of the map that we pointed out a couple times. The second is 91767, North Pomona, California, orange zip code on far right lower portion of the map. The third zip code 90007 is Los Angeles City California, also an orange zip code located in lower middle section of the map. And last, the 90201 Bell Gardens, California is a red zip code located in the middle lower portion of the map. So we selected these four zip codes for highlights based on having unique characteristics such as a presence or lack thereof of practices with accessible equipment of the high poverty rate or racial ethnic characteristics of that particular zip code. Beyond the geographic distribution of the practices with accessible equipment we were concerned that distance might not be the only issue of concern and that poverty or income, race or ethnicity might also be influencing factors for the disparities in equipment. All of the poverty, race and ethnicity information depicted in the next four slides is from the 2016 Census Bureau data. We can move to the next slide. So this slide is showing the information from the first of our four zip code highlights. This is zip code 93550, Palmdale, California. We selected the zip code because it has a high population density of people with mobility impairments and a lack of practices with accessible equipment. We also found it interesting because of the high poverty rate and ethnic makeup. This zip code has total population of roughly 75,000 people with 4,855 or 7.2% of people in this zip code reporting a

mobility impairment. This zip code has median household income of 38,000 and poverty rate of 32.3%. On this slide there's a basic chart with the first row showing the number of practices with equipment within this zip code. Showing that there aren't any practices in this zip code to have an exam table, lift or a scale. For this zip code, the second row of the chart isn't applicable since there are no practices with equipment in the zip code. Given there aren't any practices accessible equipment in the zip code, the 4,855 people reporting mobility impairment went to seek care outside the zip code if they needed accessible equipment so we recognize mobility impairment is a broad term and that's simply because someone indicated the presence of a mobility impairment doesn't mean they would necessarily need this equipment. There's also a pie chart on this slide indicating the racial and ethnic makeup of the zip code. The pie chart shows that the racial makeup of the zip code is predominantly Hispanic, roughly 65% followed by white at 16% and Black or African American roughly 13% . And remaining of racial and ethnic group make up less than 10% of the population. As you can see, this zip code is highly concerning given numerous vulnerability factors of the population including the fact the population is predominantly made up of minorities and high population of density of people with mobility impairments, high poverty rater poverty rate and no practices in the zip code with accessible equipment. The location of the zip code is also concern given it's in the northern more spread-out region of the county, which means people have to travel pretty far in order to find equipment. All right, we can move to the next slide. So this slide is showing the second of the highlighted zip codes. 90201, Bell Gardens, California, the other red zip code located in southern center portion of the county. We selected this zip code because we found it interesting despite similarities between this zip code and the previous zip code we talked about, Palmdale, it's very similar in terms of population density and impairment and racial and income factors but this zip code is a lot more accessible. This has the same layout of previous slide with table indicating the presence of practices with equipment in the zip code and pie chart indicating racial and ethnic breakdown. This zip code has total population of 101,000 and 4,228, 4.5% of people report mobility impairment. Median household income is 37,000 with poverty rate of 28.2%. The equipment table shows that there are six providers with exam tables, one provider with a lift and five providers with scales. The second row of the table is going off of the assumption that each of the 4,228 people with a mobility impairment in this zip code need specialized equipment. We recognize this is likely not the case however we wanted to show the disparity between the need and the presence of equipment. The second row shows that each of the six practices with an exam table would have to see 704 people with a mobility impairment. It also shows that of the 4,228 people with the mobility impairment in this zip code, all of them would need -- all of them that need a lift would have to go to the same practice and five practices with scales would each have to see 845 people. The racial and ethnic breakdown shows 95% of people are Hispanic and all the remaining ethnic groups make up less than 10% of the population. Previously mentioned, this zip code is similar in some characteristics to Palmdale, California however located in the more densely populated area of LA County and poverty rate is slightly lower. There's a potential that these two factors might play a part in the increased presence is important. We can move to the next slide. So this is showing the third of the highlighted zip codes. It's 91767, North Pomona, California. This is the orange zip code located in Far East and southern portion of the county. We found this zip code interesting because it is lower needs in terms of the number of people with a mobility impairment and yet it has more practices with accessible equipment. This zip code has a population of roughly 48,000 and 2,924 or 6.4% of people indicate having a mobility

impairment. The median household income of the zip code is 49,000, roughly 50,000, with a poverty rate of 20.5%. The equipment table on this slide shows there are ten providers with exam tables, four providers with lifts and four providers with scales. Again, the second row is based on assumption that all the people who reported impairment would need the equipment, again recognizing this is likely not the actual case, however, this would indicate that the 10 providers with exam tables would each have to see 292 people, and the four providers with lifts and scales would each have to see 731 patients. Again, the racial and ethnic makeup of the zip code is predominantly Hispanic at 66% with 16% being white and roughly 9% being Black or African American, and remaining ethnic groups make up less than 10% of the population.

As you can see the zip code is still very racially diverse but the median income is much higher than the previous zip codes and the poverty rate is lower. This is interesting because despite there being a lower population density of people with a mobility impairment or less of a need, there are more practices with accessible equipment, potentially pointing to a relationship between income and accessibility. We can go to the next slide.

So this is showing the last of the four highlighted zip codes, 90007 and this is Los Angeles, California. As a reminder, this is the other orange zip code located in the southwestern portion of the county. We selected this zip code because of its extremely high poverty rate, which we will get to. The zip code has a total population of 40,920 with 2,028 people or 5% indicating a mobility impairment. The median income of the zip code is 22,420 with poverty rate of 48.5%. The equipment chart here shows two providers with exam tables in this zip code. No providers with lifts and one provider with a scale. Again, assuming that all 2,000 people would need this equipment, this would mean that 1,014 people would have to be seen by each of the two providers with exam tables and all 2,028 people with a mobility impairment would need to go to the same provider if they need a scale. It also shows those who might need a lift in the zip code has to go outside their zip code to find a provider that might have that equipment. The racial breakdown of this zip code shows that 52% of the population is Hispanic. 18% is Asian. And 17% is white, 10% is black or African American and the remaining ethnic groups make up less than 10% of the population. This zip code is particularly interesting given the extremely high poverty rate and increased racial diversity, though it is still predominantly Hispanic. This zip code is still more accessible than some of the others like Palmdale, the first zip code we talked about, in terms of providers with equipment but still disparity of the need and level of equipment available. It should be noted this zip code is home of USC, University of Southern California, which may play a part in high poverty rate though surrounding areas of the university are still very impoverished. We're not sure if university presence in this zip code influences presence of accessible equipment within the zip code. With that I will turn the time back over to Dr. Mudrick.

>> NANCY MUDRICK: thank you. Next slide, please. So before talking about what is on the slide about key insights from mapping the accessible offices, I want to point out some have caveats with the data analysis. First, the audit instrument that the accessibility data is based on was not designed with research explicitly in mind and so there are -- there is some unclear wording for some of the questions, and that can affect the data quality. Second, the data collection process is done separately by each of the managed care plans, so because it's not overseen by a single entity, there are some questions about the consistency in the data

collection process. Third, the data are from primary care physician practices associated with the two managed care plans, but they do not represent all primary care practices in California in LA County, I should say. They only represent the LA County practices associated with the two managed care plans. Finally, we have only limited information on the characteristics of the practice. We have the zip code and county and character sticks and so with this limited information, we're sort of limited in what we conclude about the patients that are seen in these practices and the characteristics of their practices themselves, like group practices, are they single doctor practices and so forth. So those are a few caveats with the data, but let me talk next about some of the key insights from this analysis, especially with the maps, although I think Kyrian has done a wonderful job teasing out the meaning of these. The northern part of LA County offers very few choices of accessible offices, even though the zip codes contain a number of people with mobility impairment. The distances are large. And for someone urgently in need of an accessible setting, this is a real challenge to get to care. And the zip code detail indicates and strongly suggests that incomes are low and that can also affect the ease of travel. Even where travel may be easier in the denser southern part of the county, many zip codes have no practices with accessible equipment. Choices of accessible providers are therefore limited. And the number of people with mobility impairments per practice with accessible equipment also pose some limits on a nearby choice. Even if the accessible medical practice is down the block from a patient, a patient may not be able to use that provider if that provider is not on the plan with which that particular patient has subscribed. So there's a little more than just where it is. Does it match with your plan? The zip code detail suggests that it's important to ask whether accessible offices are also more likely to be present in higher income zip codes or in zip codes with a smaller presence of people of color. So I think the detail we have seen really continues to raise questions about disparities that cross disability and race and ethnicity. Mary Lou Breslin will discuss how this analysis and methodology fit into the larger health policy context. I'll turn it to you, Mary Lou.

>> MARY LOU BRESLIN: thank you both Nancy and Kyrian. So let's go to the next slide, please. So in Part 3, I would like to talk briefly about how measuring access in medical offices is starting to be reflected in broader healthcare initiatives and policy and what some of the opportunities for using the data we have so far to advance policies that could improve healthcare for people with disabilities. The next slide, please. So what is happening across the U.S.? We have been seeing some really important changes in the way federal agencies are viewing their role with measuring accessibility of healthcare facilities. In particular we have been seeing very significant work coming out of CMS, and that is only appropriate in that both HHS and CMS are responsible for an enormous amount of healthcare services provided to everyone in the country. While these changes haven't really been promoted yet, a ground shift in data collection, such as we have been describing so far today, they still signal a trend in the right direction and they present some very important advocacy opportunities for the future. We also have been seeing the evolution of partnerships between Medicaid Managed Care organizations and disability organizations that are aimed at improving accessibility of provider facilities and services. Obviously, too, as many of you know, academic institutions are researching and publishing more studies on the effective barriers to care and health outcomes and the role that accessibility or lack of it play in promoting or preventing good health outcomes and equitable care. Of course, legal advocacy continues using ADA and Section 504 of the 1973 Rehab Act. Next slide, please.

So let's take a quick look chronologically of some of the progress we've been seeing. As most of you know, hospital system access litigation has been going on for 20 years or more beginning with one of the larger cases, which was the case involving Kaiser Permanente in the early 2000s. Private firms and attorneys have brought many more cases as well, and the Department of Justice's barrier-free healthcare initiative has resulted in many settlements, particularly involving auxiliary agent and services within larger healthcare provider systems and networks. Thanks to community advocacy, this, again, is a nod to both June Kailes and Brenda Premo. In 2012, the California Department of Health Care Services extended the physical access audit that we've been talking about today to specialty and ancillary service providers with emphasis on high volume providers. The audit that is being used for specialty and ancillary services, service providers includes some additional questions on certain kind of equipment, including mammography machines, for example. As Nancy and Kyrian mentioned, the results of the study we've been talking about earlier applied only to primary care offices. At the federal agency level in 2015, the Office of Minority Health within HHSCMS released an important equity plan for including quality of Medicare that included a statement calling for an increase in physical accessibility of healthcare facilities. The plan focused on six priority areas aimed to reduce health disparities among vulnerable populations, including racial and ethnic groups, the LGBT community, and really for the first time people with disabilities. It was a little interesting in that -- the fact that this happened so far into the current century, even though the ADA and 504 occurred decades earlier. While it might seem obvious that departments within HHS would recognize that healthcare facilities are not fully accessible, especially in lights of the agency's regulatory authority under Section 504 and the ADA, perhaps more importantly the equity plan actually, in our view, signaled for the first time that HHS, and specifically the Office of Minority Health within CMS recognized disability as a bona fide population health disparity demographic and that people with disabilities experienced significant barriers to health and healthcare that are deserving of attention. And also for the first time accessibility was included at the same level of importance with the other five priority areas, including -- this is with respect, again, to Medicare, including expanding the collection reporting and analysis of standardized data and developing and disseminating promising approaches to health disparities. 2016 was a big year. In 2016, again, the CMS Office of Minority Health commissioned a study examining the intersection of race, ethnicity and disability, further signaling that it had fully embraced disability as a disparities population. Again, in 2016, HHS/CMS released sweeping new Medicaid Managed Care final rules and they included a final rule that provided a framework for scaling up data collection efforts currently underway in the small number of states, some of which we have been discussing today. This is in regard to accessibility of healthcare providers for people with disabilities. The rule requires that Medicaid Managed Care plans provide directories include information on the accessibility of network provider offices and facilities. The rule also directs states to develop and enforce network adequacy standards that consider the ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications and accessible equipment for Medicaid enrollees with physical or mental disabilities. The rule requires that states ensure managed care organizations prepaid inpatient health plans and prepaid ambulatory health plans comply with contract requirements to ensure network providers provide physical access accommodations and accessible equipment.

The caveat is that with the change of administration, this rule was, for all practical purposes, shelved, even though it wasn't fully withdrawn, and HHS signaled to the governors in every state that they would be willing to work with them to find ways to not implement the parts of the rules that the governors thought might be administrative burdens while the administration worked on revising these regulations. The reason we mention these Medicaid Managed Care rules is because this was an attempt by the agencies to put forward very, very strong and important and really new language that would have applied to all the Medicaid Managed Care organizations and held out a lot of open and opportunity to be able to sort of move a needle on accessibility. We hope that at some point in the future the content of this rule can be revisited in a serious substantive way and can be used effectively for advocacy to increase accessibility. Next slide, please.

So, again, within CMS, the Medicare Medicaid disorder nation office, sometimes called the duals office, created under the Affordable Care Act created a self-assessment tool released in 2017. The tool was posted to a website called "Resources for Integrated Care" that offers technical assistance products and webinars to help both providers and health plans in coordinating care for dually eligible beneficiaries, that's people who have both Medicare and Medicaid. The pillar three of the self-assessment tool focuses on access and relates to understanding and addressing barriers to care including physical barriers. The duals office has been really entrepreneurial in its work to try to advance the issue of accessibility and healthcare. So this is one of the manifestations of that advocacy. Also, in 2017 CMS released an issue brief and that provides detailed steps providers can take to remove barriers to care. I think one of the more interesting efforts by CMS was the agency's attempt to spur managed care health plans into collecting accessibility data on provider networks using the three-way contracts between CMS, the state and the health plans it served dually eligible beneficiaries. This is sort of corollary to the intent of the 2016 managed care rule. These contracts were held to a very high standard, requiring a detailed explanation of the accessibility of plans provider network. And CMS required that the contracts explain its mechanisms for conducting onsite accessibility reviews and in some cases use of specific survey tools and designation of a responsible person to carry out the surveys. Policy modifications, auxiliary agent services and more. All these are required, of course, by the ADA. They're seldom set out in detail in contract language. Generally these contracts include a provision requiring that the parties attest to complying with the ADA with little or no guidance about how to do so. While it's unclear how serious the plans took the contract requirements, we know that that's, of course, -- the devil is in the implementation details. I think what is important is that CMS understood and attempted to move forward on the issue of accessibility by being clear that the extent to which barriers to care needed to be evaluated and removed and presented quite detailed guidance about how to evaluate the network participants. At some point in the future, we hope that this model can be revisited, along with development of some implementation tools that would assist states and plans to really conduct meaningful work on the issue. Next slide, please.

In addition to federal agency actions we're seeing partnerships between managed care health plans and disability advocates. For example, 17 health plan has established a partnership with the National Council on Independent Living. Requiring providers in some markets to self-report accessibility using the California audit tool we have been talking about today. While this model relies on the providers what they report is being verified by local Independent Living

Centers and providers who wish to remove an identify barrier can a play for a grant from Centene's fund and as of 2018, 52 healthcare providers across Illinois, Texas and Ohio received a total of $470,000 grants to remove both physical and programmatic barriers. Sen teen received an award for the work which is an indicator that it remains a problem and work is being done to remove the barriers and needs to be acknowledged.

The same program was rolled out in Florida, Kansas and New Mexico.

Continuing this leadership role with CMS Office of Minority Health launched initiatives aimed at improving access to care for people with disabilities in 2020. This involves videos, a patient guide and resources inventory. Next slide, please.

So the work that California has done to initiate and systematize collection existence of accessibility data for primary physician could be potentially replicated in other states and even nationally as long as certain types of healthcare continues to be delivered in the offices of physicians. We need to know more about accessibility of those physician facilities and we need to find effective ways of incentivizing removal of barriers and purchase of examination equipment. A step would be to create national audit instrument perhaps based on California tool or another tool, which is tested and validated that plans are required to use. CMS took important steps in suggesting that plans be required to use a tool and didn't go so far as to specify a particular tool in most cases. The Medicaid Managed Care plans themselves are really quite well positioned to assume a proactive role in determining provider network accessibility and availability of accessible equipment. In California some incentivized access modifications and even provided accessible equipment for high volume providers. This model has shown not only to be effective but needs to be replicated. Teaming with local advocacy organizations has proven effective as well in terms of identifying barriers, recommending solutions and providing staff training. While several federal initiatives have required managed care plans to publish access information and provider directors as mentioned earlier, this information is often inconsistent and more often missing altogether. So increasing availability of this information in directories would be an important step in helping people with disabilities determine the level of accessibility of the providers in their networks. Next slide, please. So I just would like to end with a very quick summary of the main points we have touched on in the webinar today. Number one, it is possible to audit a large number of primary care offices. The California method has worked and it's replicable. Number two, audits produce information that we know are useful both to providers and to patients and they're useful from a research standpoint as we have shown today. Number three, a geographic look can help target priorities for action. I think that the material that Kyrian presented shows that this is a valid way to understand the impact of the limited amount of accessible equipment that is available and it serves as an advocacy tool. Knowing the density of accessible care sites doesn't relieve every provider of ADA obligations. Patients also have to be able to choose their provider when that is feasible within the limitations of their health plan, and number five, CMS and other federal agencies have a role in monitoring, facilitating and enforcing physical access to healthcare facilities. When seeing that they have begun to take up the mantle of that role, we need to work with them going forward and increase their oversight roles because they were willing to take on some important new initiatives. We hope that that -- those initiatives can be renewed and revisited soon in the future. And finally, attention to physical and programmatic

accessibility of healthcare facilities is increasing with public and private efforts, but nevertheless monitoring for progress is still necessary as I think the work that we have been doing over the last --itis almost 15 years, the monitoring that California has been doing shows. So that wraps it up for me. I'm going to turn it back over to Lewis to see if we have any questions.

>> LEWIS KRAUS: all right. Thank you, Nancy, Mary Lou, Kyrian. That was a great presentation. For everyone listening, this is the time to submit questions in the chat window and we'll get to those in a moment. I do want to mention that somebody did ask where they can find that video that Mary Lou sent or showed, and so she put that in the chat room. So if you have a question about that. Or if you have a question about where to find that, you can get that in the chat window. So let me ask one question before we get to the questions that are coming in. Are you -- in terms of the research, do you have plans to expand this to do other related work to this or how does your-what does the future look like on this?
>> NANCY MUDRICK: Mary Lou, you want to answer this or do you want me to --

>> MARY LOU BRESLIN: I would defer to you and I may have one comment, but please go ahead.

>> NANCY MUDRICK: all right. Well, so certainly one thing we want to do is we want to publish this data -- publish these findings and that's the next thing that we're going to work on. Another possibility that I -- we haven't had a chance to explore. I mentioned briefly that we actually got a hold of the California plan's data for the period 2006 to 2009. The format of the tool was a little different in that time period than they revised it for use in the -- starting in 2012. But we still have some data from the 2006 to 2009 period and there are some practices that are represented both in the 2006 to 2009 period as well as the more recent period. So one additional analysis that is possible is to look at how -- if there was change, how much change there was for these particular providers for whom we have data at two points in time. What we know is the aggregate difference in how many, you know, percentage of exam tables, at least at this point in time, but for any particular provider we don't really know. And the two datasets have over -- have an overlap in particular practices, but they're not identical. We didn't get the -- the five plans who sent data most recently were not the same plans that sent us data earlier. Three of them were the same, but then two of them were different. So that is another analysis that we're interested in doing. And I think that the third thing that we have talked about is to really spend more time talking about these policy issues that Mary Lou has highlighted most recently and connect this work more concretely to what its policy implications are.

>> MARY LOU BRESLIN: I was going to say I think one of the challenges that we faced is collecting the data through the managed care health plans, the ones that have worked with us have been very gracious about their willingness to share the data with us. Their willingness to do so I think will affect our ability to continue either collecting newer data as we're going forward and/or taking a look at the ancillary and specialty provider data, which I think is -- we haven't looked at yet, and I think that's something that we would like to do that the requirement to collect that data has been in effect for eight years. So there should be a fairly decent amount of information available now, if the plans would be willing to share it with us. If they

have it and can organize it and send it to us in a way that makes sense and they're willing to share it. So I would say we probably would be talking about whether that would be one of the next steps for us.

>> LEWIS KRAUS: great. I would say as a former resident of Los Angeles, having grown up in Los Angeles, I know exactly -- and I think you guys hit it really perfectly, the difference between those northern counties and the southern and eastern counties where basically Los Angeles County is kind of a microcosm of rural, suburban and urban areas. And so those northern ones are really rural. And so in LA, as everybody knows, you do a lot by traveling, by car, by public transportation, to move around. So moving to different places or going to different providers is not surprising and may not be something close by. It would be interesting to see if those providers -- I know they're already doing the yeoman's effort for you, but would be great if they can provide some kind of patient population, just zip code statistics so that you can sort of see when they're patient load is coming from.

You please tell more about what the reviewer's training entails? Do reviewers typically have a background in architecture facilities, healthcare or something else?

>> MARY LOU BRESLIN: I can take a shot at that. Let me just say that we were not involved in one of the key levels of training with the providers but more involved with sort of an overarching training, so I can give a little bit of a picture of what was done.

Again, this is a very significant way to both June Kailes and Brenda Premo, who were working with the plans to create an interest for accessibility and created the initial training modules that were used with the plans, but basically for the primary care office audit, the plan sent out somebody from their staff. Often it was a nurse. I think more often than not it was someone who had a nursing degree who was within the plan's employment purview. They received two levels of training, at least initially. One of them took place in the -- I don't know, like around 2011 or 2012. Probably 2011. Involving sort of an overview of what the issues are for people with disabilities and healthcare access. And my organization, DREDF, was involved with several other organizations, including Brenda and June and their affiliations to offer this training. So this was sort of an overview of what the major key issues are and why the facility site review included this additional audit requirement. Then their staff, some key staff within a couple of key health plans sort of took over the larger training and they put together a number of people from a number of plans and go through the audit instrument itself, the tool, and explained what was expected of the site review when people actually landed onsite in a physician's office. So, you know, this was really about sort of explaining how to use the tool, what it meant, you know, to take certain kinds of measurements. Certain things were explained that might have this kind of architectural aspect, so that they didn't feel they couldn't handle the assignment to fill out the audit correctly. So initially there was two levels of training. I can't speak to what they're doing right now. I'm sure there's been staff turnover and changes in the audit process, but at least for the data that we're reporting on in this webinar, folks who were an trained up to collect it did have a pretty good overview of what was expected.

>> LEWIS KRAUS: Nancy, were you going to add anything or...

>> NANCY MUDRICK: the only thing that I would add is that the training was, as Mary Lou said, a mix of making sure people understood what the issues were for people with disabilities as well as how to use the tool. And one thing that I thought, I went and observed one of them, was the fact that they were training people to together from different plans, so that they -- you know, they brought together folks from these different plans and did it in different settings, like in -- like I watched one in LA County one time. And I thought that was actually very interesting, because it gave folks a chance to make sure that they were, to some extent, going to do the same thing, because they were being trained together in the same session and they heard each other's questions and so forth.

You know, one of the issues that comes when we try to publish the data from this analysis is, well, what's the interrater reliability in using this tool. Because this process was not envisioned as a research process that... you know, we can't speak extremely strongly to that question, but the fact that they were across several plans training people together, I think, increased the ability for there to be some better interrater reliability as a consequence of the joint training.

>> LEWIS KRAUS: I also want to point out when Mary Lou at the end was talking about the CMS efforts and the Centene efforts, that Centene and NCIL actually did a webinar on our healthcare Webinar Series in October. So if you're interested in what they were doing, you may want to go back to our archive at ADApresentations.org to listen to their presentation. And then CMS and also minority health will be making a presentation on our Webinar Series in September. So you can hear from them about what they are -- what they have done, what they're doing now, and maybe what they're planning to do. I'm not sure. So that will be in September, September 24th. All right. Well, you all will -- I appreciate you all being here. If you have questions or if something comes up as you're thinking about this going forward, you can contact -- actually, can they contact you? Do you have your contact information there? Maybe you can put your contact information in the chat win dough.

>> MARY LOU BRESLIN: I'm sorry, Lewis, we should have said this earlier, the contact information is on the last slide. And the previous two slides before the contact information includes a series of resources, and these are references and links to the material that we presented at the webinar. So I think it's all available.

>> NANCY MUDRICK: and go back two slides to the first of the resources slide, so at the top is a paper we published last year out of these data that provide more frequency distributions on the accessibility data, and this is... I think this is only LA County as well. Anyway, this is an open access journal, so you can have access to that, which presents the data we just talked about. And then as Mary Lou said, these other links are to various documents that she has talked about in the course of the policy discussion.

>> LEWIS KRAUS: great. Thank you. All right. So you can pick up these slides at the ADApresentations.org today in the schedule section. By tomorrow it will be the archive section. Go ahead and go to their contact information so if people want to contact them, they can. Or if you have other questions that are specifically about the ADA in relation to what maybe you've heard today, you can contact your regional ADA Center at 1-800-949-4232.

You're going to receive a link to an online session evaluation. Please complete that evaluation for today's program, because we really value your input and want our funder to understand about the value of the presentations we've been putting on. We want to thank all of our speakers today for sharing the time and knowledge with us. And that was really a great presentation and a reminder to all of you listening that the session is recorded and it will be available for viewing next week at ADApresentations.org in the archive section of healthcare. Our next webinar will be on July 23rd and we'll be joined by Dan Garrett of the Pacific ADA Center and Emily Schuman of the Rocky Mountain ADA Center for presentation on specifics of physical access in healthcare and more detail of what was gone over here today. So we hope that you can join us. Watch your email two weeks ahead for the announcement of the opening of that registration. So thank you again, everyone, for attending. And thank you, again, Mary Lou, Nancy and Kyrian, for your time. Great presentation. It was really interesting.

Have a good rest of your afternoon, everyone!

Bye-bye!