Pacific ADA Center
Healthcare and the ADA Webinar
Thursday, October 24, 2019
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The serious topics include physical accessibility, effective communication and reasonable modification of policy issues under the Americans with Disabilities Act of 1990 or ADA. Upcoming sessions are available at www.ADAPresentations.org.

These are monthly webinars and occur on the fourth Thursday of the month at 2:30 p.m. Eastern time, 1:30 p.m. Central time, 12:30 p.m. Mountain time and 11:30 a.m. Pacific time. By being here you are on the list to receive future notices for webinars in the series. Notices go out two weeks before the webinar and open that webinar to registration. You can follow along on the webinar platform 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 www.ADAPresentations.org. At the conclusion of today's presentation there will be an opportunity for everyone to ask questions. You may submit these questions using the chat area in the webinar platform. The speakers and I will address them at the end of the session. Feel free to submit them as they come to your mind during the presentation.

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Today's ADA National Network listening session is titled the Provider Accessibility Initiative or PAI. According to the 2017 CMS analysis, Medicaid and Medicare beneficiaries with disabilities received less preventive care than beneficiaries with no disability, because healthcare providers lack accessible exam rooms and/or diagnostic equipment.

The purpose of the Centene Provider Accessibility Initiative or PAI is to increase Centene providers who meet minimum federal and state disability access standards. During this webinar representatives from Centene and the National Council on Independent Living or NCIL will provide an overview of the PAI results to date. And commence practices to create a health system that promotes universal access for all.

Today's speakers are Sarah Triano, Kelly Buckland and Kait Campbell. Sarah Triano is the Director of Complex Care Policy and Innovation for Centene corporation. Prior she served in governor Jerry brown's administration as policy adviser to the California and labor workforce development agency and health and human services agency.

Participating in the first annual California Youth Leadership Forum for high school students with disabilities in 1992 and became nationally known disability justice advocate as the program director and access living of metropolitan Chicago and the executive director of Silicon Valley ADA Independent Living Center. Kelly Buckland is executive director for the National Council on Independent Living, the longest running national cross-disability grassroots organization run by and for people with disabilities. Kelly started his career at Idaho's protection and advocacy system. He served for over 20 years as the executive

director of the Boise cell Living Independence Network and the Idaho state Independent Living Council. He worked on issues affecting people with disabilities, including passage of the Personal Assistance Services Act and the Fathers and Mothers Independently Living with their Youth or FAMILY Child Custody Laws. In recent years Kelly has been honored with numerous state and national awards, including University of Idaho's president's medallion, the united vision for Idaho lifetime achievement award, Hewlett Packard distinguished achievement in Human Rights Award and induction into the national spinal cord injury Hall of Fame.

Kait Campbell is a Complex Care Product Performance and Innovation Analyst. She has been involved in initiatives focused on improving health outcomes of complex care population primarily made up of persons with disabilities. Kait earned her bachelor degree from St. Louis University majoring in healthcare management.

Now I'll turn it over to you. Sarah, Kelly and Kait.

>> KAIT CAMPBELL: Good morning or good afternoon. My name is Kait Campbell. Thank you for those introductions. I just like to preface that Sarah Triano will be about 30 minutes late to this presentation, but we will go ahead and she will join us here in about 30 minutes.

All right, so today Kelly and I are going to talk with you about how Centene Corporation and the National Council on Independent Living have addressed gaps in disability access and award-winning idea. In January of this year Centene in partnership with NCIL won the 2019 CMS Health Equity Award from the Office of Minority Health for our work in this initiative, and in August of this year we were ranked number 7 in Fortune's Change the World List and we're excited to share with you today some of the outcomes we've seen as part of this project.

Today we're going to go over the overview of both Centene and the National Council on Independent Living. We're going to go over some of our project activities and outcomes to date. And then at the end we'll have some time for questions and our closing.

So, again, my name is Kait Campbell and I'm an analyst at Centene Corporation. Centene is a St. Louis-based company founded in Milwaukee in 1984. We have roughly 45,000 employees and serve over 14 million members in two international markets. We're currently in 31 states and we provide government-sponsored healthcare programs such as Medicaid, Medicare, marketplace and correctional.

But the product that Sarah Triano and I focus on are specifically managed long-term services and supports in 11 of our states. We also provide Medicare and Medicaid insurance in six of our states as well as service a large number of people with intellectual and developmental disabilities.

And this is roughly over 345,000 members across the entire country.

>> KELLY BUCKLAND: This is Kelly Buckland. I'm the executive director of the National Council on Independent Living. We go by NCIL. NCIL is the longest running, as stated before, the national cross-disability grassroots organization run by and for people with disabilities. We

were founded in 1982 and NCIL represents thousands of organizations and individuals, including individuals with disabilities, Centers for Independent Living, statewide Independent Living Councils, and other organizations that advocate for the human and civil rights of people with disabilities throughout the United States.

>> KAIT CAMPBELL: So before we go into an overview of the Provider Accessibility Initiative, Sarah Triano, as described in her bio, was an executive director of a center of independent living in Silicon Valley in California. And one of her colleagues names was Cynthia. And Cynthia had asked Sarah to go with her on -- to an MRI appointment. And so Sarah accompanied Cynthia to her MRI appointment, and you should have seen the look on the technician's faces when they realized that Cynthia was deaf. So how was she going to get her MRI with her disability?

So after many weeks of trying to find her an accessible MRI machine, by the time she was able to get her -- by time she was able to get her MRI, the tumor in her brain had grown inoperable and she had passed away.

So there is multiple stories that we have heard across the country from our members and we realized as we went around to our different states that are servicing members with disabilities, we were gathering feedback from them and realized this is a very, very big problem that we are so proud to partner with NCIL with and address.

So what is the goal of the Provider Accessibility Initiative? We want to provide equal access to quality healthcare that are programmatically and physically accessible to our members with disabilities, as well as their companions with disabilities. What I mean by physically and programmatically accessible, physically accessible is are you able to get into the provider's office? Are you able to use the restroom? Are you able to know your own weight, for example? And programmatic is are their policies and procedures in place to accommodate the member's disability needs, and do they allow service dogs, for example, just a couple examples of programmatic accessibility? But our overall goal here is we're trying to increase the percentage of our doctors' offices that meet minimum and federal and state disability access standards.

So why are we focusing on provider disability access? It's the right thing to do. Centene's National Disability Advisory Council, back in 2016 or 2017 had advised us that we needed to focus on this population and this severe need for universal access for all. So not only that, but there is a study by CMS that shows Medicaid and Medicare members with disabilities receive less preventive care than those with no disability.

And also it is a federal requirement. So in the 2016 Medicaid and CHIP managed care final rule, there is language in there that says that all of the provider directories must -- all the provider directories must show that providers detail disability access information out there.

So when our members go out to visit our providers' offices, the members need to know before going to the office, will I be able to get in the front door, for example.

This was a recommendation, as I said, from Centene's National Disability Advisory Council. Also Sarah and myself had done a road show with seven of our long-term services and supports and Medicaid -- Medicare/Medicaid plans across the country to get feedback from our members. What does disability access mean to them? What is their pain points? And when they're going to a doctor that meets their needs, what are they looking for specifically?

So how are we accomplishing our goal with the Provider Accessibility Initiative? Well, one, we want to make sure that all the information about accessibility and a doctor's office is correct. So the member can pick a provider that meets their needs. So we want to make sure that the providers are self-reporting on standard disability access survey in, you know, whether that's provider credentialing or contracting, so that we have a standard way of reporting the provider's disability access across the country. But it's not enough just to have providers self-report whether or not they're ADA accessible but we are conducting onsite Accessibility Site Reviews to verify this provider has self-reported disability access information. One, we are making sure the information in our provider directories is accurate and robust. Two, we are allowing doctors to apply for a national grant, which is the Centene Barrier Removal Fund. And, one, it provides funding to remediate priority disability access barriers, and, two, it allows technical assistance from the National Council on Independent Living, as well as local centers on independent living and education with our local health plans.

>> KELLY BUCKLAND: As Kait mentioned, this is a partnership between Centene and NCIL, and NCIL is proud and thrilled to be part of this. This whole project has been very worthwhile, which you'll see some of the outcomes and I think you'll agree with me. There's been a lot going on for us and had a good time doing it. Funding was made available in pilot states in three main areas. So the pilot states were Illinois, Texas and Ohio. Kansas, Florida and New Mexico were brought in this year. And we've done such things as bidding modifications, modified diagnostic equipment and programmatic access.

>> KAIT CAMPBELL: So now Kelly and I are going to take you through the process of how we award providers with access to this Barrier Removal Fund. So first and foremost at Centene we need to make sure we're getting stockholder input. As I mentioned earlier, not only did we consult Centene's National Disability Advisory Council but we went around and did a road show with the members at our local health asking them what does disability access mean to you and what are your pain points? So we got stakeholder input and providers as well. And also the next step was we got leadership buy-in. So as we were about to go into the three states in 2018 as well as 2019, we made sure that we met with each state's CEO of their health plan to make sure we get buy-in from the top down, to make sure this is a priority and will be a priority moving forward at their health plan.

After that we meet with the health plans and ask them to conduct an ADA analysis. And what that is is we ask them, hey, what is in your directory around disability access? Performance want you to pull that data and see, you know, of the providers that responded, yes, I have ADA accessibility. Or the providers that responded no, or a lot of providers have left the field blank because it's not a required field. What we had done is we took this analysis and looked across the entire state and said, you know, here is where you have your disability access network gaps, and this is where you really need to focus on these specific provider populations.

So the health plan then conducts marketing outreach strategies. So NCIL is the fund manager for the grant program, but it is up to the health plan to get the word out about this Barrier Removal Fund application.

The health plan does outreach, whether that's on the ground or in provider newsletters or some social media outreach as well. To N the word out about this grant program, and I would say it's been very successful over the last year.

>> KELLY BUCKLAND: So after the marketing has been done and the plans let providers know about the program, NCIL, during that same time, also is letting the Centers for Independent living know about the program and contact them about their availability to do the accessibility reviews. But after that marketing has been done, then we make the Barrier Removal Fund application go live. That means we publish it on our website and the people or the providers can then submit their applications.

It also has an application deadline. So they have to have applications into us before the deadline.

>> KAIT CAMPBELL: And after the deadline, NCIL then sends all of these electronic applications to the health plans. And it has all of that provider's information in this application. And the health plan does an analysis on these providers to say, hey, these providers are eligible for the grant, or these providers are not eligible. Typically over the last two years, we have not awarded large hospital organizations, because they have the organizational budget and should already be ADA compliant. Same thing with nursing facilities as well. The primary population that they serve in the nursing facility are people with disabilities and they need to already be ADA compliant. But I will say we did award some smaller community hospitals as a part of this grant program that we'll talk about later.

Some other things we want to make sure as well is the providers that apply, they must be our health plan provider. And they must be in network. They must be an in-network provider.

>> KELLY BUCKLAND: And so after we do this first round of eligibility and we determine who the providers that are eligible are, then NCIL works with the local Centers for Independent Living because now we know where the providers are located and what centers area they're in. We contact those centers and contract with them to go out and do an accessibility site review on the provider. We then gather all of those accessibility site reviews and we have -- we convene a Barrier Removal Fund committee. Most of the members are chosen by the health plan, but we also do have the Center for Independent Living -- or a Center for Independent Living sit on the Barrier Removal Fund committee, and also a person with a disability who sits on the committee, and Tim Fuchs, the operations director at NCIL and myself also sit on the committee.

The entire committee does score each one of the applications, and those applications, along with the scores and the Accessibility Site Reviews, and whatever other information that we can

gather, we bring all of that to the Barrier Removal Fund committee meeting. And those meetings are held in the state where the Barrier Removal Fund is being awarded.

So after we have had the committee meeting and we decide which awards we're going to be giving, for those award decisions are made during the BRF committee, usually we run out of money, so we develop a waiting list for those who we're not able to fund. Because sometimes things happen, and the ones that we awarded were able to do the work, and so we end up being able to fund some of the ones on the waiting list.

So after those award decisions are made and the contracts are signed, then we go ahead and let the providers get underway with their scope of work.

And that's kind of where we are right now. Or that's what we just completed right now under 2019 states.

So the invoice -- a lot of those invoices have been submitted. And we actually weren't able to go back to those state's waiting lists. And I think we funded almost all of those that were on the waiting list. Because of cost savings and different things, we were able to fund all of the ones that were on the waiting list.

There is a couple that we had to extend the contracts because they weren't able to complete the scope of work during the time of their work, but most of those invoices have been submitted, and most of the checks have been sent. And at this point, the health plan is going out and verifying the completion of the work.

>> KAIT CAMPBELL: And the way this grant program works is that this is a reimbursement grant. So as we award these providers with accessible exam tables or scales or ramps or parking lot improvements, we ask them to work with contractors -- or that is where some of the technical assistance comes in as well, NCIL or the local CILs will put the providers in contact with the appropriate contractor, and the provider completes their scope of work and submits an invoice to NCIL and then NCIL pays that invoice. What we're finding is that what we have allocated towards that provider is that it's actually -- a lot of the invoices are coming in less than what we had granted them initially.

So we are seeing a cost savings there, and especially around accessible exam tables and scales. We have gotten a lot of those requests, as you'll see later on in the slide deck.

So the National Council on Independent Living has contracted with the couple of accessible exam table and scale companies to receive bulk purchasing discounts, so that we're able to grant more providers, multiple exam tables and scales at a discount price.

So where we're at, in 2019, as Kelly just said, a lot of the providers have been submitting their invoices and now as we're closing out the project in 2019, we're asking the health plan staff to go out and verify the completion. So they go out and make sure that all of the scopes of work are in place. They're taking pictures of these accessibility improvements.

Now, when NCIL contracted with the local center on independent living to conduct the accessibility site review, we asked the local CILs to take pictures of, you know, what needed improvements. Was it, you know, an inaccessible stairwell or was it inaccessible parking? So what they had done was take these pre-pictures, as we call it, and we're asking the health plans to take follow-up pictures. So we have these really great pictures to show you of pre and post-improvements. And we're also collecting member and provider success stories from this initiative as well that we're happy to share with you.

So some of our outcomes over the last two years. Since 2018 we have conducted over 2600 onsite Accessibility Site Reviews across seven states, which are California, Illinois, Texas, Ohio, Kansas, Florida and New Mexico. They were conducted by health plan staff as well as 31 different Centers On Independent Living. Now, we ask that health plan staff accompany the local center on independent living when they go out to conduct the onsite reviews. The CILs are really the disability experts in this area and we're trying to train -- we are training our health plan staff on what it means to be ADA compliant as well.

So over the last two years NCIL has received 255 Barrier Removal Fund applications across six states and has provided well over 225 hours of technical assistance to the applicants and the grantees.

And lastly, like Kelly mentioned earlier, we do meet locally with our six Barrier Removal Fund committees over the last two years and it's made up of local members with disabilities, local Centers On Independent Living, as well as our providers. So we're making sure we have all the stakeholders involved when making decisions. Of the 255 applications that we did receive over the last two years, we ended up scoring 176, and you might be wondering why. And that's because when the health plan receives these applications, some of these providers are excluded right away depending on their specialty, whether they're in or out of network and their current standing with the health plan, for example.

So to date we have awarded 108 healthcare providers at a total of 140 locations across the six states. And have awarded over $1 million in grant funds through the Centene Barrier Removal Fund.

And, of course, these grantees range in size as far as how many members they serve, and their location. So rural versus urban and their specialty as well. So we awarded primary care providers, dentists, OBGYN, mental health clinics, podiatry, urology, etc., etc. And we're not just awarding physical access improvements but programmatic access improvements.

>> KELLY BUCKLAND: So here are some of the things we provided through the grants. So as Kait mentioned, one of the most popular things that people requested were accessible exam tables. So we have awarded -- we have awarded 63 accessible exam tables. This included one accessible OB/GYN table, two accessible podiatry exam chairs, and one accessible dentist chair.

We also awarded 19 accessible scales, 79 automatic door openers. This was a surprise to me, how many applications we got for automatic door openers.

We did ten renovations to parking lots, meaning the parking lot was either re-striped or the surface was smoothed out so that it made it accessible to people. We did 33 restroom improvements. Eight entrance improvements. Fifteen interior building improvements, which includes stuff like vinyl flooring, widening of doorways, waiting room chairs, portable air filters, portable blood pressure machines, Hoyer lift and sound proofing walls, which we have a picture we'll show you.

We did 12 ramps, 113 units or 45 projects for programmatic access improvements, and we have details in a slide later as well. And we also awarded nine wheelchairs.

>> KAIT CAMPBELL: And through all of these improvements that we have made across our six states, this has affected 103,000 of Centene's members with disabilities. And this does not include their companions, as well as other patients that are being seen at these doctors' offices.

>> KELLY BUCKLAND: And I just want to mention also that all of these providers also got the Accessibility Site Reviews that we talked about, and that allows them to see other areas that needed improvement beyond what is...

Some of these we'll be doing other improvements later.

>> KAIT CAMPBELL: As the health plan goes out and verifies accessibility improvement with that provider, not only are they taking pictures and success stories, they're also sharing the Accessibility Site Review with the provider and says, hey, here is your survey that we have conducted prior to your accessibility improvement. Now you are more accessible based on these improvements that you have made, but here are some other ways that you could improve accessibility at your office. And that could be something as little as, you know, moving around equipment, for example, like whether that is trash cans or chairs in the waiting room to make it more accessible to people with disabilities, as one example, for a low cost improvement.

So the first outcome that we would like to talk with you all about is Rock Island County Council On Addictions. In Illinois.

So Illinicare Health is one of the healthcare plans we granted the Barrier Removal Fund to, and here at the addictions clinic, in the top left-hand corner is a picture of an inaccessible women's wing. It's inaccessible because the stairs are severely inaccessible, and so the state actually shut down the women's ward of this addictions clinic because of its inaccessibility. So the women were housed with the men. And through Centene's National Barrier Removal Fund, on the slide there are pictures of the current -- sorry -- the renovations, taking out the inaccessible stairs and putting in the accessible ramp and handrails.

So through the Centene Barrier Removal Fund, now women are able to live separately in their own ward at this addictions clinic.

Another improvement that we made in Illinois was automatic door openers, as Kelly was mentioning earlier, this is one of our more popular items requested from the providers. On the slide is a quote from Dr. Sarah Patrick who is the administrator of Jackson County Health Department. She said "Since the installation of our automatic door openers, I have been pleased to announce more adults, wheelchair patients in our facility receiving much needed services. I see this being a positive addition and a great way to meet all members of our community. We would not have been able to make these upgrades to our facility at this time without the funds from this grant. Thank you again! "

Now, on this slide we have italicized wheelchair patients, because that is not the appropriate way to address any member or any person with a disability. So we would like to think that we are making baby steps and small improvements but you know, there is education that needs to be given to these providers as well.

>> KELLY BUCKLAND: And as you know, the automatic door openers are not required under the ADA, but a medical facility like this, they're almost a requirement, and in a lot of cases they are a requirement. So I think that's why they were so popular and why so many people asked for these. But it's because they really are needed, especially in the medical settings. But like I said, they're not required under the ADA, but they certainly have increased access to a lot of medical facilities.

>> KAIT CAMPBELL: On the next slide is an example from our health plan in Texas named Superior Health Plan. On the slide on the left-hand side is a picture of a roll-on scale. For a member using a wheelchair to access the scale and be able to take their weight. There is a video on the right-hand side of the accessible UpScale, which is the combined accessible exam table and scale. It allows members to independently transfer on the table and for the table to take that person's weight as well.

And Gabriel, if you're on the line, I know we tried testing this video. Are you able to pull up the video for us?

>> This is our UpScale table here that was provided for us by Superior, and we're thankful for that. It is automatic. It goes up and down, which is great. We can sit a patient up, transfer a patient very easily by removing one of these side arms. It has a built in scale, built-in measuring table as well. It's fairly lightweight, so flexible to use in the clinic. We'll be able to perform ultrasounds if we need to. We have leg pieces that are attachments so we can do GYN exams with this table as well for anyone who doesn't have use of their legs.

>> KAIT CAMPBELL: Thank you. We had a provider in Illinois that had reached out to us and thanked us for these grant funds because prior to receiving this accessible UpScale, they were giving PAP smears to women directly in their wheelchairs prior to receiving this.

So, you know, what we're trying to promote here is universal access for all. And I'm sorry, it's not just pap smears, but it's also...

>> KELLY BUCKLAND: There was a lot of reasons why the accessible exam tables are needed for both men and women. But we also learned that you really should have both the roll-on scale -- even though the table will weigh you, the roll-on scale, once you know the weight of your wheelchair, you do not have to continue to transfer every time. So the wheelchair scale is also still needed so that you don't have to transfer every time you go in to be weighed. But both of them are very helpful and very needed.

>> KAIT CAMPBELL: The next project outcome we would like to talk to you all about is from our Barrier Removal Fund at Buckeye. The picture is a very inaccessible restroom from Momentum Counseling and Consultation. So there is a before and after picture. Kelly, would you like to describe what is inaccessible about the picture on the left-hand side?

>> KELLY BUCKLAND: Sure, I'm hoping it's pretty obvious to everyone, but -- so if you see the location of the sink and there's no grab bars, the sink is right in the way, so if you were going to try to do a transfer, you wouldn't be able to get up next to the toilet. And then the trash can is right there, too.

And there's rugs that cause issues with people who are using wheelchairs. A lot of times these things get wound up in your wheels and all kinds of stuff. So anyway, you can see all that. Plus if you haven't noticed, you see that the paper towel dispenser is way up high, so nobody -- and you couldn't get to it or reach it. And then if God forbid there was a fire you had to try to reach that fire extinguisher, it would be a problem.

But anyway, then I think you can see on the right all of the accessibility improvements that have been made. You can now access the toilet much easier. The grab bars are there to help people do transfers, and there's a much larger space for mobility.

>> KAIT CAMPBELL: And at this same counseling center, we also awarded them soundproofing walls. In the picture on the left-hand side, it's a picture of a hallway, and you can see the walls, but you can't really tell that they're soundproof walls. And prior to the soundproof walls at this mental health clinic, you could hear people in the other examination rooms. So it was very, very important that this provider had soundproof walls. They said it allows their clients to feel comfortable sharing their symptoms and challenges.

So the clients' outcomes are improved when they can accurately present their symptoms and needs.

So now we wanted to share some more programmatic access improvements that we have made over the last two years. We have a noise canceling headphones and assistive listening devices. We awarded a digital annunciator for an elevator. We have also soundproof walls. We provided TV and DVD sensory accommodations for the dentist office. So as a member is getting dental work done, they are able to listen to the TV or DVD while they are getting their dental work done.

We also have awarded quite a few weighted stuffed animals and weighted blankets this year, and provided -- we switched out a lot of fluorescent lighting for natural lighting and circadian lighting as well.

So some of our lessons learned from our first year of implementation was having a simultaneous roll-out. In 2018 we have implemented this in three states every year, but in 2018 we kind of spaced out the health plans, and what we have found is that in 2019 by simultaneously rolling out the health plans at the same time these providers -- sorry, these health plans had a little bit more competition amongst each other. When we would meet every week and ask them about the provider outreach, you know, how many providers have they done outreach to? And were they own the ground delivering these applications? Were they using social media outreach, for example? What was the most successful outreach for that health plan?

But not only did we implement this simultaneously with the three health plans, we did the exact same with fund disbursements. Each health plan got the exact same amount of funding per state, but we had an additional pot of funds left over for them to compete against each other based on the number and quality of the Barrier Removal Fund applications that were received.

And the provider average as well, I had mentioned earlier, with the simultaneous roll-out, the health plans were able to have a little bit of healthy competition trying different ways to do outreach to providers. And Kelly also contacted the local Centers on Independent living as well, letting them know the Barrier Removal Fund was available in their state.

>> KELLY BUCKLAND: So this is a bit of -- as I mentioned earlier, this has been a very fun project for us. I think a lot of times the work that we do at NCIL, you don't readily see your accomplishments, and this stuff you can readily see the improvements that are made. So it's very rewarding that way. And it's just been a lot of fun to do. But I'm not sure anything like this -- quite like this has been done in the past.

So we have learned a lot of lessons through not only 2018 but we continue to learn lessons even this year and will probably continue to do that as long as we're doing it.

>> KAIT CAMPBELL: We are continuing the Barrier Removal Fund at Centene and with NCIL for the next five years. So we plan to go into an additional 15 states through 2024.

And that's all that we had for you today. So I guess now it's time for questions. And we can briefly discuss some next steps.

So, of course, as we mentioned, the Accessibility Site Review earlier, we have a call for advocates who are on the line today or who listened to this webinar, we think it would be absolutely great to take these accessibility -- the ADA questions to your state Medicaid office and make this is a requirement for all providers to start reporting more detail disability access information about their service location or their provider's office.

>> KELLY BUCKLAND: And Sarah Triano has joined us, and Sarah, you may want to talk about what California has done.

>> SARAH TRIANO: Sure. So the state of California actually has requirements that all health plans in the state conduct onsite Accessibility Site Reviews, like we talked about, basically verifying the information that providers have given about their disability access. And those have been going on -- those site surveys have been going on since 2011. And you know, when we bring this to other states, this project to other states, it's a federal requirement, right? Most of the stuff that we're talking to you about is all federal requirements, but I got to tell you, if we had a state that was like California that said you know what, health plans, you have to do this, it would make our jobs a lot easier.

>> KELLY BUCKLAND: And this becomes really important, because when you go on to the website to find a provider and you look at ADA access or physical access because of disability, or disability access in general, that's really important that that information is accurate. Because I know from looking at hotel websites and other places, including doctors' offices, what it tells you on the website and the experience when you get there are two completely different things. A lot of times it says it's accessible and then it's not.

So having this information that is done on a standard major and done with a tool and done with somebody who knows what they're doing makes a big difference when that information goes on the web.

So the call is for other states to follow California's lead here and make it a requirement.

>> DANA BARTON: Please remember to submit your questions in the chat window and we'll get to those in a moment. Are you all ready to answer some questions? We have a few for you.

>> KAIT CAMPBELL: Yes.

>> DANA BARTON: All right. So the first one that I have is -- are these outcomes or projects available by state?

>> KAIT CAMPBELL: They are. We have all of the specific project outcomes broken out by our six states.

>> DANA BARTON: And where can people find those if they wanted to look at them?

>> KAIT CAMPBELL: You can contact me. My name is on the very last slide here. I'm trying to click to the last slide. I apologize.

Feel free to reach out to my email or via phone and I can share the specific project outcomes by state.

>> DANA BARTON: Great. Thanks, Kait. Go ahead.

>> KAIT CAMPBELL: I was going to say again, those six states are Illinois, Texas, Ohio, Kansas, Florida and New Mexico.

>> DANA BARTON: All right. Another question we have that came this is the person writes "I'm curious what the time frame looks like for applying for the grant. Is it a lengthy application or quick, from the time the business is approved, how soon can they have improvements made to their building?"

>> KELLY BUCKLAND: Well, that's a... that's quite a lengthy question. So let me try to take it at a piece at a time. The application process is pretty quick. We give people about three weeks or a month to apply. So the application is really pretty short. The longer part is really the description about what the fund does and what kinds of things we can pay for and what physical access is versus programmatic access, because we want people to know the full range of things that they can apply for. So we take a lot of time to explain all of that in an FAQ kind of a manner. But the application itself is rather short, and it's fairly easy to fill out. This is another one of those lessons learned. We were having people submit written application and you have to remember these are medical facilities. Some of these people are doctors. And so their handwriting was really illegible, you couldn't read it, so we went to a web-based format where they fill out the application on the web, and that improved things a great deal. And, you know, quite frankly, some of them were good about filling out the application and some of them we had to go back to and ask questions of them. The application wasn't filled out that well. But it's a pretty quick turnaround. And then the approval time really is fairly quick as well. I mean, we give the Barrier Removal Fund committee a couple of weeks to score the applications. They're all volunteers, but we make them work pretty hard. There are a lot of applications to read and some of them are quite lengthy, and scoring each one of them takes time. And it does take time for that to occur. But we usually make those decisions within like the next month. And then it takes a little time to put the contracts in place and get the scope of work developed and that kind of a thing, but I would say that most projects are completed like within another month. So in each phase, is it about a month, right?

>> KAIT CAMPBELL: Yeah, roughly, in total, since -- roughly three months in total, since we award the provider and they sign the contract and get their scope of work completed, roughly. Depending on the type of improvement. Now, some providers have more detailed scopes of work such as restroom improvements or some rural areas, for example, we had a rural area in New Mexico having a hard time trying to find a contractor to build a ramp. So we allow on a case by case basis.

>> KELLY BUCKLAND: In the presentation, like I mentioned, some of them we have actually extended this year until the end of November. But like, for instance, if it's like an accessible exam table and just having it delivered, it doesn't take that long. So like Kait said, it depends on what the project is. If it's a building project where they're tearing down walls and rebuilding something, it takes longer, or building a ramp.

>> DANA BARTON: A couple more questions, this one is: Who is qualified to conduct an ASR? Is there a required form or model survey form?

>> SARAH TRIANO: I will tell you in the state of California they have very specific requirements for this kind of onsite review, but for our project, we have chosen to partner with the National Council on Independent Living and all the local Centers for Independent Living. We don't require them to have an architect degree or any special certification. We believe that the Centers for Independent Living have a lot of the knowledge that they need in order to complete the survey.

>> KELLY BUCKLAND: So there is a specific tool that each center is required to use. And it highlights on the main areas of access that we want to address at facilities. The parking lot entrance, the bathroom, those kinds of things.

And then we do conduct a training with all of the centers on how to go through the tool and how to use it prior to them actually doing it. We think, obviously, the Center staff have the basic skills to do that, but this specific tool we do a training on the specific tool itself. And Kait is one of those trainers and does a fabulous job at it.

>> KAIT CAMPBELL: Thank you. And Centene's Accessibility Site Review tool is modeled after the California PARS tool.

We're taking a step further and adding on programmatic access questions as well as we mentioned earlier in the webinar. We had taken the survey and circulated it around with Centene's National Disability Advisory Council, June Calles, Dave Hanson and many other stakeholders to make sure that we were incorporating a wide variety of questions.

>> SARAH TRIANO: And the programmatic questions in the tool, actually the disability rights defense fund created a document that outlined what healthcare access, programmatic access looks like in healthcare facilities for folks with disabilities, based a lot of the programmatic questions on that. I think kind of one interesting thing to note is that many of the projects, though, that we're funding here go beyond the requirements that are in these surveys, and even the Americans with Disabilities Act. Kelly, do you want to talk about --

>> KELLY BUCKLAND: I talked about that a little bit, the door openers, that they were required through the ADA, -- that they weren't required through the ADA, but one of the most requested items. The survey tool itself is really based on the ADA.

>> DANA BARTON: So a couple folks are wondering if you're able to share this tool.

>> KAIT CAMPBELL: Yes, we can share the tool. Feel free to reach out to me. Again, my contact information is on this slide. Again, it Kaitlin.m.Campbell@Centene.com.

>> DANA BARTON: Okay. We have time for a couple more questions, so I'm going to ask one more. And that is what specific company measure each site, do they include things like clinical care cost effectiveness, patient satisfaction, etc.?

>> KAIT CAMPBELL: So currently we are going to be implementing a member survey. So I talked earlier about the health plan verification, we're getting all these great quotes from members and providers and great before and after pictures, so we have a lot of qualitative data, but we're looking to get more quantitative data. And we want more feedback from our members, because this is directly impacting them. I have developed seven questions to -- that would be emailed to our members that are being seen and impacted by these I improvements at these awarded providers locations. They have not gone out quite yet because we want to make sure -- like, for example, around this last year we were wrapping up the improvements in Illinois, Texas and Ohio. We want to make sure that the member has enough time to go back to their provider, maybe for their annual visit, and be able to experience that accessibility improvement, for example. So that is coming down the pipeline with at least our 2018 states here shortly.

>> SARAH TRIANO: I would just say that, you know, we had an OB/GYN in Illinois who reached out to us after they received their accessible exam table. Did you share this story already? So we can say, yay! Now they have a successful exam table. I don't know, though, that we can say for sure that now women with disabilities have less cases of cervical cancer or something because of that. I think intuitively we think of that as probably absolutely the case, but we really need, you know, major research institutions or somebody to help us do that kind of research, because it's really hard to isolate that particular thing with that particular outcome.

>> KELLY BUCKLAND: I really do think these are fundamental next steps. We really do want to measure what is the cost effectiveness? Like Sarah just said, we believe that if you go in and -- like one of the examples I have given, like myself, I go to get a physical exam, and I don't get a pro state exam like everyone else or weighed like anyone else does, because my doctor doesn't have any of that. So I think we believe that the more complete exam you get, the better care you get, and therefore your health outcomes are better, and the cost effectiveness is better as a result of that. It's a very good question.

>> KAIT CAMPBELL: We would love to see an increase in preventive care visits, for example.

>> DANA BARTON: Another question is: You mentioned expanding to 15 states by 2024. Any idea which of the states would be included?

>> KAIT CAMPBELL: Our 2020 states are going to be Indiana, California and Pennsylvania. But we don't know after 2020 at this point.

>> DANA BARTON: Okay, so you haven't picked out those states yet. Okay.

So can you tell us, in your list, what kind of barrier removals have you provided in 2018 and 2019. Person who asked this question says I don't see anything for sensory impairments such as vision loss or hearing loss. Are those things you also provide for such as Braille literature or signage or sign language interpreters?

>> KAIT CAMPBELL: My apologies. I did skip over that. If I go back a few slides... on our programmatic access outcomes slide, we do provide Braille signage and materials for provider materials. Now, as a managed care organization, our health plans should be providing Braille signage and materials for health plan brochures and materials. But for the provider specifically, we have awarded lots of Braille signage for restrooms and for hallways and exam rooms and for elevators as well. We do award Braille signage and reading materials. Lastly, the one thing I apologize, I did not mention, we did award a video remote interpreting -- I believe we awarded some -- a couple of iPads with the Proloquo2 app, which allows for -- it's a subscription service for ASL interpreters. And we did award this in a rural location, specifically there was only one ASL interpreter for many, many counties. So this was definitely a need in that area.

>> SARAH TRIANO: I will say, though, in general, we don't award these kind of things because we make it really clear to the health plans and to providers that folks who are deaf and who use sign language, other folks with disabilities who use sign language, they prefer an in-person interpreter who is qualified in interpreting in health situations. So we don't typically do this. But also the health plans themselves are required to create for interpretation, sign language interpretation and other language interpretation for our members. And so we didn't want to use the money from this, from our grants for that because it's already funded through the health plans.

>> DANA BARTON: Okay.

>> KELLY BUCKLAND: They were made aware of that as part of this process too. So if they didn't know that the ASL was available, they did for the end part of the project.

>> DANA BARTON: Okay. Another question I have is if you guys would talk about accessible exam table recommendations and requirements as per the ADA.

>> KELLY BUCKLAND: I'm not sure I understand the question.

>> DANA BARTON: Is there a specific table orb specific recommendation for equipment per the ADA?

>> KELLY BUCKLAND: Well, the ADA... the requirements for exam tables under the ADA are still -- the rules around that are still -- haven't been completed is the only thing -- that's the -- that's not the right term, but they haven't been finalized.

But we do know what is in there. So we know what the requirements are that have been proposed. They just haven't been finalized. And the exam table that we showed you in the slides, the UpScale, that exam table does meet the requirements that are in the proposed regulations.

>> SARAH TRIANO: From the United States Access Board.

>> KELLY BUCKLAND: Right.

>> DANA BARTON: Great. Another question that just came in: Has there been a need to alter the footprint of exam rooms, such as access along one side of the accessible exam table?

>> KELLY BUCKLAND: We haven't seen that, but I'm not sure we've been looking for it either. That's probably something we should build into the ASR that we're doing.

>> SARAH TRIANO: We do look at clearance space from exam table and entrance.

>> KELLY BUCKLAND: And we look at the room itself.

>> SARAH TRIANO: Yep.

>> KELLY BUCKLAND: I'm not sure we looked at where they put it.

>> KAIT CAMPBELL: Through the grant program we have expanded the walls and restrooms, for example, not just stalls but actual restroom walls. We have expanded as well entrances to buildings. We've expanded those entrances as well.

>> KELLY BUCKLAND: We made some of the exam rooms bigger too. We have expanded some exam rooms because the exam rooms were so small. But I don't know that we actually have, like, gone back and looked after the exam table has been delivered, where they put it, if there was enough room to get... you know what I'm saying? Maybe the site follow-up we'll start to look at that?

>> KAIT CAMPBELL: Absolutely.

>> DANA BARTON: Go ahead.

>> KELLY BUCKLAND: That is a really good question.

>> DANA BARTON: So another question that came in, what we have up on the screen currently, but one of the participants is wondering, what are the benefits of the weighted stuffed animals and weighted blankets from a healthcare standpoint?

>> KAIT CAMPBELL: So this is access improvement, especially for, you know, any -- a person of any age that needs -- who might be sitting in a waiting room and uses this weighted stuffed animal or weighted blanket as a way to calm your nervous system or to help reduce anxiety.

>> SARAH TRIANO: For folks with intellectual and developmental disabilities, this is a standard accommodation that they use in other instances. And we worked really closely with Autistic Self-Advocacy Network to examine potentials of external programmatic accommodations that could help with the needs of folks with some developmental intellectual disabilities and this is one of the ones but also requested by some providers.

Do you want to talk about the sensory rooms too?

>> KELLY BUCKLAND: Before we go there, maybe quickly, from a healthcare standpoint, the reason it's important from a healthcare standpoint, if there's too much sensory overload in a waiting room, which there can be a lot of times, especially if you have kids and stuff in a waiting room, overloading the sensory can cause people to leave. They don't keep their appointment. They don't get the exam or treatment they were there for. And so their healthcare obviously is affected by that.

>> KAIT CAMPBELL: In Kansas there was a mental health clinic and in the Barrier Removal Fund application, specifically requested funding for two different waiting areas. One is a sensory -- one was a sensory avoider room and one was sensory seeker room. In sensory seeker room there was padding on the walls. There was bubble gum. There was bubble wrap. And, like, different types of music that the person could listen to in this room. Now, in a sensory avoider room, they had noise canceling headphones. They had bean bag chairs. They had hammocks to accommodate, you know, the different types of reasoning for that person visiting that mental health clinic, and their application was amazing. They said that the reason they wanted to implement these two sensory rooms was so that these members, who are going to this clinic -- this was, you know, an alternate way for them so they wouldn't have to go directly to the hospital or have an in-patient claim. They were trying to create another atmosphere for these patients to get the care that they needed without having to pay an in-patient expense.

>> DANA BARTON: Those are great examples. I think we have covered all of the questions that have been submitted. If you're still listening in and you have a question that is Burke that you want to ask, go ahead and get that submitted. Otherwise, Kait, can we get your contact back up just so the participants can write that down in case they have a question that maybe they don't want to ask publicly.

And I'll give it another minute for questions to come in.

Is there anything for our panelists that you were hoping someone would ask and they haven't and you wanted to touch upon or anything you remembered that you would like to share?

>> SARAH TRIANO: I don't know if you guys have already raised this, I apologize for the repeat, but when we first started this project, I know one of the big questions that we had was... wait a minute, these doctors' offices, they're already required to do this, you know? The ADA has been in place for a really long time, you know, why are we giving them money to actually do something that is already required?

And I think, you know, when we looked back and looked at it, though, we said, yeah, it has been a requirement for this long, but it still hasn't fundamentally changed. ADA has fundamentally altered many spaces, transportation, access to other kind of accommodations in the community, but this is an area that is still really inaccessible for folks with disabilities, and you know, how well has it worked for us? (chuckling)

You know, what we've been doing so far, it hasn't. And we really wanted to actually transform the healthcare space and start to just make sure that folks with disabilities could get in and get an equal doctor visit like everybody else right away. And, you know, some of these providers are Medicaid mom-and-pop doctors' offices. They have chosen specifically to serve folks who are lower income, and they really don't have a budget to purchase an $8,000 accessible exam table. And so we figured there's get this started, let's get this work stimulated and get it going, because it's a start. It's something.

So I just wanted to mention that, because I know a lot of folks may be wondering that. It's already required, why are you doing this?

>> DANA BARTON: That's great.

So you've got Kait's information up here. I know the panelists are open to having folks contact them. To our participants today, you can contact your regional ADA Center at 1-800-949-4232.

You'll receive an email link with a link to an online session evaluation, and we ask that you complete the evaluation for today's program. We value your input. It helps us get better.

Also, I just want to say a special thanks for our speakers today for sharing their time and their knowledge with us. So thank you, Sarah, Kelly, and Kait.

A reminder that today's session was recorded. It will be available for viewing next week at the archives section in the healthcare section at www.ADAPresentations.org.

And as we kind of enter into holiday season, we'll not have another webinar in this series until January of 2020.

And you can mark your calendars for our next webinar on January 23rd and we're going to be joined by the Northwest ADA Center and they will present on Effective Communication in Healthcare. We hope you will join us. Just watch for your email about two weeks ahead of time for the announcement of the webinar and the opening of the registration.

And we thank everyone for attending today's really valuable session. Thanks so much!