

## MEMORANDUM

To: Adela Flores-Brennan, Phoebe Hawley, Raine Henry, Colorado Department of Health Care Policy and Financing  
From: Paul Presken and Sara Schmitt, Colorado Health Institute  
Re: Barriers to Getting Disability Competent Care  
Date: April 25, 2024

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The Colorado Health Institute (CHI) is working with the Department of Health Care Policy and Financing (HCPF) to review patient access to disability competent care in primary care offices. This memo is the fourth of five that CHI will provide by June 30, 2024. These memos cover:

1. Best Practices in Disability Competent Care
2. Disability Competent Care in Federally Qualified Health Centers (FQHCs)
3. Federal and State Accessibility Requirements
4. Barriers to Getting Disability Competent Care
5. Final Recommendations

This memo covers Objective 4 and questions from the approved Data Collection Plan. The following numbers correspond with the memo numbers listed above.

Objective 4. Identify barriers to accessing disability competent care in primary care settings and FQHCs in Colorado.

- Question 4.a: What access barriers to disability competent care do people living with disabilities experience?
- Question 4.b: What barriers to providing access to disability competent care exist for primary care providers and FQHCs?
- Question 4.c: To what extent does access vary and why?

CHI combined key themes across all questions. Within each, CHI organized findings using [HCPF's 3 Pillars of Access to Disability Competent Care](#). The first, Communication Access, offers ways to communicate. Programmatic Access suggests policies or procedures to ensure people with disabilities receive the same quality of care as others. And Physical Access describes barriers that people with disabilities face when traveling to or moving within their provider's office.

CHI used the terms providers and provider offices to cover both primary care providers and FQHCs.

CHI spoke with more than 50 Colorado providers, people with disabilities, and disability advocates to reach the findings in this memo.

## Key Findings

The main barriers to giving and getting disability competent care fall into three areas — limited training, money, and preparation.

- **Limited Training.** Providers are not taught how to give disability competent care during their schooling. If they do receive training, it may be taught with other types of cultural sensitivity and inclusivity trainings. Or they may only get one class or unit during medical school or residency. Other staff, such as front desk staff and care coordinators, may have never had this kind of training.

Patients with disabilities and their families cite a lack of sensitivity to their lived experiences. One advocate said that "providers are not intentionally trying to be insensitive, but because of their lack of training, it comes across that way."

Providers referred to limited training on topics like how people with disabilities experience different health issues (such as reproductive care or chronic disease management); how to use accessible medical equipment and how to fit that equipment into office workflows; and what requirements are in the Americans with Disabilities Act (ADA). Providers also needed training in empathic care, whole-person health, social services for people living with disabilities, and dealing with their own biases.

One partner said that Regional Accountable Entities may offer training and encourage providers to attend, but do not require them.

- **Money.** Patients with disabilities need more services, but primary care providers are often not adequately paid for their care. They also do not have the staff available for the level of care these patients require. Needs may include more frequent visits, longer visits, communication or physical accommodation, support with referrals to specialists and/or social services, help with paperwork, and advocacy for their overall health and well-being. One person living with a disability said that "we come with more and we want to make sure our providers are compensated."

Some providers said they are frustrated when they cannot meet patients' needs. They said the systems they work in don't let them provide care the way they want to. Visits are shorter than they should be, and offices have limited non-clinical staff to provide social or wrap-around support. They lack the funds to offer the care they

would like to and that patients prefer, such as physical modifications, equipment, and interpreters.

Money shortfalls can affect the provider-patient relationship. A provider said frustration over lack of resources can lead to providers perceiving the patient as the problem. Patients said they often feel providers treat them indifferently or as an inconvenience — and this treatment becomes another barrier to care. This feeling was echoed by a different provider who said that sometimes funding is not enough. A clinic needs both an accessibility champion and the ability and capacity to make changes.

- **Preparation.** Few patients felt their providers' offices were thinking ahead about their needs or accommodations nor were they prepared when the patient arrived. Providers said they didn't have a consistent process for documenting patients' needs or a way to implement these accommodations throughout a clinic.

## Question 4.a: What access barriers to disability competent care do people living with disabilities experience?

### Communication Access

- Offices do not have consistent access to highly qualified American Sign Language (ASL) interpreters. Communication Access Real-time Transcription (CART) is not always an adequate option.
- Provider offices assume rather than ask about a patient's preferred ways to communicate. For example, providers don't confirm whether a patient is comfortable using virtual interpretation.
- Some offices require patients to write their signatures. Similarly, offices do not always help patients complete paperwork.
- Patients with vision loss do not have consistent access (such as screen readers) to read the information they need — from medical chart notes to lab results.

### Program Access

- Patients with disabilities often rely on public transit (where available) or Medicaid non-emergency transportation. These services are not always reliable, consistent, or timely. This can cause patients to arrive late and be penalized, either by not being seen or having challenges with being able to reschedule again.
- Provider offices do not regularly offer virtual care options (audio or video), even for routine care, and require patients to come in for face-to-face visits.

- Patients with disabilities do not get enough time with providers or staff to work through their medical concerns. One advocate living with a disability said that “extended appointments are essential.”

### **Physical Access**

- Offices often lack safe options (whether it be a trained staff member or a lift) for patients to transfer from wheelchairs to an exam table. This can result in a limited medical exam.
- Patients with limited physical mobility, those who use walking aids, and those with wheelchairs can have trouble getting through narrow hallways. Office areas with chairs, scales, or other things in the way can also be a problem.
- Small exam rooms are difficult. Patients with disabilities may have a caregiver or attendant, an interpreter, and additional equipment with them during a visit.

### **Question 4.b: What barriers to providing access to disability competent care exist for primary care providers and FQHCs?**

#### **Communication Access**

- In-person ASL interpreters were frequently identified as the hardest accessibility service to offer, based on cost and a limited workforce.
- Providers don’t always understand what is required under the Americans with Disabilities Act (ADA) as well as how to apply the needed accommodations to their practices and workflows.

#### **Program Access**

- Providers know that care for patients with disabilities takes longer and is more complex. These patients need longer appointments or additional support from providers and staff. Yet providers do not receive additional funds for these patients. One advocate felt that offices did not know how to appropriately code visits for people with disabilities to reflect their complexity and need.
- Not all electronic medical record (EMR) systems let providers document a patient’s disabilities, needs, or preferences for accommodation in a standard way. Providers may not be able to update their EMR due to cost. Or they rely on a larger health system’s EMR, which would have to prioritize these changes.

## Physical Access

- Providers lack resources to modify their building or purchase, install, maintain, and train staff on the accessibility equipment they would like to offer. This includes movable tables, wheelchair scales, lifts, automatic door pushes, and lower counters.

## Question 4.c: To what extent does access vary and why?

### Communication Access

- Access to interpretation services, especially in-person ASL translation for patients with hearing limitations, was often cited as a major barrier in both rural and urban communities.

### Program Access

- Access to virtual care (phone or video) is not consistently available.
- Proactive outreach and assessment of patients' accommodation needs and preferences vary.
- Only a few providers offer extended visit times for patients with disabilities.

### Physical Access

- Access to movable exam tables with lifts is very limited across the state.
- Most offices are accessible from the outside through ramps and curb cuts but can be less accessible inside. Inside the office, barriers to access include narrow hallways and exam rooms, no automatic door pushes, or door buttons positioned at the wrong height for someone in a wheelchair.

## Conclusion

Primary care providers and patients experience barriers to providing — and receiving — disability competent care. Some barriers are tangible, such as adequate equipment or accommodations, workflows, and office layout or design. Other barriers such as attitudes or system-level gaps in education and payment models are intangible, but they present real consequences for people living with disabilities and providers seeking to provide high-quality, accessible care.