COLORADO HEALTH INSTITUTE

MEMORANDUM

To: Adela Flores-Brennan and Phoebe Hawley, Colorado Department of Health Care Policy and Financing
From: Sara Schmitt, Colorado Health Institute
Re: Disability Competent Care in Primary Care Final Recommendations
Date: June 18, 2024

Introduction

From January to June 2024, the Colorado Health Institute (CHI) worked with the Colorado Department of Health Care Policy and Financing (HCPF) to conduct research on disability competent care. Our research looked both locally and nationally. We identified and summarized baseline requirements in state law for competent, accessible, quality care in primary care and Federally Qualified Health Centers (FQHCs).

CHI worked closely with people living with disabilities, in collaboration with the Colorado Cross-Disability Coalition (CCDC) and the Chanda Center for Health, as well as with HCPF, providers, provider associations, advocates, and researchers to complete this work.

CHI worked with partners to assess accessibility for all disability types with a priority on physical, visual, and/or hearing limitations. Research activities included a literature review, interviews, focus groups, and a facilitated discussion session. CHI summarized its findings into four memos. This memo summarizes key findings from these memos and provides recommendations based on CHI's research.

Recommendations reflect a key finding: Meeting legal requirements is just one part of disability competent care. Recommendations are categorized into three areas: ensuring accessible care, increasing capacity for disability competent care among providers, and increasing availability of disability competent care across Colorado.

When appropriate, these recommendations build on developments underway, including requirements in the request for proposals for new Regional Accountable Entities (RAEs) in the Accountable Care Collaborative beginning in 2025.

Recommendations assume a culture of collaboration and leadership as well as a shared commitment to advancing equity and ensuring accessibility among all partners. These partners include Health First Colorado members, state agencies, RAEs, provider associations, advocacy groups, and primary care providers including FQHCs. Recommendations address opportunities within HCPF's authority but need partner involvement and participation. Intentional, ongoing partner engagement is highlighted

throughout these recommendations to ensure continued collaboration and monitoring as well as alignment with ongoing partner activities.

Staff and resources may not currently be available within HCPF to fully implement these recommendations. This list is not exhaustive but reflects the project's research and findings. Recommendations are opportunities to act now to advance access to and availability of disability competent care.

Recommendations

To ensure all Medicaid members have accessible care, HCPF should:

- Develop or circulate existing state and federal information that clearly and explicitly describes statutory requirements for accessibility (including but not limited to those documented in CHI's memos as appropriate) including recent updates to Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, and State of Colorado technology standards. This communication should be sent directly to all contracted providers and clinics (including primary care and FQHCs) as well as circulated through provider associations, RAEs, and disability consumer advocate agencies.

- Engage with the Colorado Department of Public Health and Environment (CDPHE) to learn how existing health facility licensing inspections, certifications, and audits can monitor for accessibility requirements. Verify CDPHE's timeline and process for following up on deficiencies and confirming that needed corrections are made.

- Promote funding mechanisms, including grants and no-interest loans, for providers that meet certain criteria to purchase or upgrade equipment or make clinic renovations to increase accessibility. Criteria should be created in collaboration with people living with disabilities and provider associations.

- Convene a working group in collaboration with people living with disabilities to update the Disability Competent Care Assessment Tool. This group should evaluate the existing Tool, identify areas that need to be updated and strengthened, and determine how to use the Tool moving forward. This group should recommend how provider directories can spotlight providers who demonstrate competency based on the Tool.

- Require RAEs to document and report to HCPF and their Member Experience Advisory Council and Regional Program Improvement Advisory Committee (PIAC) about how they are: ensuring availability of accessible accommodations,

communicating with members about how to request accommodation, and conducting ongoing monitoring for compliance through their Network Directories.

- Create or confirm the availability of an easy-to-access process for members to file accessibility grievances in collaboration with people living with disabilities and provider associations.

- Engage with local directors at the U.S. Department of Health and Human Services, Administration for Community Living, and the Office of Civil Rights to identify opportunities to ensure recommendations and strategies are not missing critical items and seek support on enforcement mechanisms beyond what is already available.

To increase capacity among providers for disability competent care, HCPF should:

- Update and circulate existing information about best practices, policies, and procedures for disability competent care in primary care settings (including but not limited to those documented in CHI's memos as appropriate) among providers and through provider associations and RAEs. This information should be developed in collaboration with people living with disabilities and also be incorporated into an updated Disability Competent Care Assessment Tool.

- Collaborate with people living with disabilities, provider associations, and RAEs to define an ongoing, required disability competent care training, including the modules being developed through the Office of Community Living and offered on the Behavioral Health Administration's learning management system. Pursue options for offering training to non-clinicians within practices and clinics, including office staff.

- Develop a payment model with input from the Alternative Payment Model 2 Design Review Team for enhanced per member per month or incentive payments for long-term services and supports for Medicaid members living with disabilities to promote disability competent care and specific activities such as, but not limited to, extended appointment times, preventive screenings, executing ongoing documentation (such as medications, durable medical equipment, Medicaid eligibility or redetermination, certification periods, etc.), and dedicated team members to coordinate care for people living with disabilities. Providers should evaluate their current abilities using the updated Disability Competent Care Assessment Tool and develop an action plan with milestones and measurable, reportable outcomes, which should be created in collaboration with people living with disabilities and provider associations.

- Continue promoting and encouraging the use of telehealth and virtual visits as an approved, reimbursable care modality.

To increase availability of disability competent care across Colorado, HCPF should:

- Develop or support an ongoing, cross-department workgroup among staff from the Office of Community Living, Health Equity Task Force, Colorado Civil Rights Division, Governor's Office, the Colorado Disability Opportunity Office, CDPHE, the Colorado Department of Human Services, and the Behavioral Health Administration to convene quarterly to discuss shared priorities.

- Integrate disability competent care within an existing workgroup of the state's PIAC and/or pursue forming an additional disability competent care advisory group comprised of people living with disabilities (with a focus on intersectional identities emphasizing representation from marginalized and underrepresented communities such as African American, American Indian/Alaska Native, Asian American, Native Hawaiian and Pacific Islander, Hispanic/Latino/e/a/x, rural and non-English speakers). Additional participants should include advocates, provider groups, and RAEs. This group should ensure ongoing, public monitoring and evaluation of efforts to advance disability competent care. This group will review progress toward these recommendations and other efforts to expand access to and availability of disability competent care.

- Request that RAEs provide HCPF with data disaggregated by disability status within their Health Equity Plans and Performance Improvement projects on an annual basis at minimum, to be reviewed by the state's PIAC and/or a disability competent care advisory group.

- Convene RAE Equity, Diversity, Inclusion, and Accessibility Officers (required by the ACC Phase III Request for Proposals) and other related initiatives on a quarterly basis — or include these topics in existing meetings — to discuss activities, challenges, and opportunities. Potential topics of discussion and collaboration include:

    - Shared cultural and disability competency training for staff and Network Providers to ensure consistency and quality.

    - Confidential review of Health Equity and Performance Improvement disaggregated data by disability status to assess for continuous quality improvement.

- Best practice and resource sharing for model policies, materials, and accommodations.

Key Research Findings

CHI's research identified several themes from within the literature and through discussions with partners and people living with disabilities. These themes are summarized below. The previous four memos provide additional context, data, and information.

- Accessible care that meets the legal and regulatory requirements for physical and communication access so that people with disabilities have full and equal access to services and buildings is just one aspect of disability competent care.
- Providers don't always understand what they are legally required to provide for accommodations such as modifications in policies, practices, or procedures. In addition, not all providers know how to integrate needed accommodations into their practices and workflows.
- Offices do not offer have consistent access to highly qualified American Sign Language (ASL) interpreters. In-person ASL interpreters were frequently perceived to be identified as the hardest accessibility service to offer, based on cost and a limited workforce.
- 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 or do not know how to offer these options. Access to movable exam tables with lifts is very limited across the state.
- The main barriers to giving and getting disability competent care fall into three areas — limited training, money, and preparation.
- Providers typically have limited data about their patients with disabilities. Not all electronic medical record (EMR) systems let providers document a patient's disabilities, needs, or preferences for accommodation in a standard way nor do providers often know how to use their systems to gather this information.
- Best practices in disability competent care include:
    - Training and education programs for providers and any staff who interact with patients that are well-defined and test for disability know-how afterward.

- Workflow and communication practices that make the best use of EMR software and ensure that communications and systems are accessible.
- Physical equipment and spaces that are easy to access and have lighting suitable for people with disabilities.
- Care models that consistently coordinate care, set up needed accommodations, and provide a variety of related clinical and non-clinical services.
- Virtual care practices that include flexible ways to connect with providers online for patients who prefer virtual options.
- Extended appointment times.

Next Steps

Partners involved in this research expressed interest in supporting these and other efforts. Next steps include sharing the final recommendations memo with partners as well as identifying people within HCPF who can incorporate these recommendations into their work plans and activities.