COLORADO HEALTH INSTITUTE
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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: Disability Competent Care in Federally Qualified Health Centers (FQHCs)
Date: March 28, 2024

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 second 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 the following objective and questions from the approved Data Collection Plan. Objective and question numbers correspond with the memo numbers listed above.

Objective 2. Summarize current state and national efforts among FQHCs for ensuring accessibility.

- Question 2.a: What have FQHCs done, what are they doing, and what's planned in the next year in Colorado and across the country to ensure accessibility?
- Question 2.b: How are these efforts being measured?
- Question 2.c: What factors help or detract from these efforts?

CHI reviewed findings from the literature and spoke with more than 45 national partners, Colorado providers, individuals with disabilities, and disability advocates to reach the findings in this memo.

Key Findings

- FQHCs do not have much data on how they care for disabled patients nationally or in Colorado. Information about people with disabilities who seek care at FQHCs is also limited.
- FQHCs have no additional federal requirements for accessibility beyond what is required for other health care providers participating in Medicaid.

- FQHCs most often adapt for physical disabilities, although this may be limited to building access and navigation.
- Factors that improve care for patients with disabilities include team-based care, care coordination, and inclusion.
- Barriers to improving care for patients with disabilities include resources, the way FQHCs are paid, lack of standards, and access to services.

About Federally Qualified Health Centers

FQHCs are important safety net providers. According to the Bureau of Primary Health Care, FQHCs are charged with providing primary and preventive care that is affordable, accessible, and high-quality. They offer these services in outpatient settings regardless of a patient's ability to pay.

This bureau oversees all FQHCs that receive federal funds. The Health Center Program Compliance Manual outlines requirements for health center programs. Each FQHC must have a board that assures compliance with all laws and regulations. At least 51% of FQHC board members must be patients.

Colorado's 20 FQHCs have clinics across the state. Just over half of FQHC patients in 2022 were enrolled in Medicaid (51.7%). A handful were eligible for both Medicaid and Medicare (4.4%), according to the Health Center Program Uniform Data System. FQHCs do not report the percentage of patients with a disability.

HCPF pays FQHCs a cost-based per-visit rate for medical, dental, and specialty behavioral health visits. Visits include in-person, audio, video, or data interactions (for example email or online messaging) between patients and qualified providers.

Question 2.a: What have FQHCs done, what are they doing, and what's planned in the next year in Colorado and across the country to ensure accessibility?

National Examples

CHI was not able to find data on national efforts among FQHCs. A local researcher at the Colorado School of Medicine is beginning a nationwide research project exploring the intersectionality of race, ethnicity, and disability in the context of health care access and is conducting her research among FQHCs, including some in Colorado.

One key informant said they believed that FQHCs are more easily able to increase access for non-English speakers and people without documentation than for people with disabilities. The Health Center Program Compliance Manual does not mention people living with disabilities, except for seasonal workers who are no longer employed due to disability.

Other State Examples

The Health Resources and Services Administration (HRSA) funded an initiative to increase language and disability access to patients of primary care clinics and FQHCs. The University of North Carolina School of Medicine received a five-year grant in 2023 to educate and train residents in family medicine. CHI spoke with the grant's project manager, who explained that residents and faculty will partner with experts to increase their disability competence. The training program started in early 2024. It will include annual surveys to measure its impact on patient care and attitudes toward people with disabilities.

Colorado Examples

CHI's research identified several efforts by FQHCs in Colorado to increase competent care for people with disabilities.

A few years ago, an FQHC in southern Colorado worked with its local disability coalition when opening a new facility. Partners identified specific physical access needs for the new building. Curb-free entries, wide doors, and low counters were the most requested. The FQHC invited coalition members to tour the building before it opened to ensure the changes were adequate. This FQHC also trained staff on how to communicate with people who read lips and safe transfer practices.

Most stakeholders CHI talked to said FQHC buildings are compliant with the physical requirements of the ADA, especially newer construction. "You can typically get into buildings," one stakeholder said.

Several FQHCs use the clinics' electronic medical record alert functions to flag patients' communications needs or mobility concerns. Staff can select communications needs (deaf; hard of hearing, including which ear; interpreter required; legally blind; visually impaired; etc.) from a menu. They also can list physical access needs (motorized wheelchair, service dog, need to limit time in waiting room, etc.) in text fields.

One FQHC conducts a basic assessment for patients' needs regarding language and learning levels. The findings of this assessment are included on the patient's electronic medical record as a 'front page' available to anyone accessing the chart. In addition, barriers and preferences are set up as alerts that pop up anytime the patient is scheduling an appointment and/or checks into a clinic.

Staff at one FQHC keep whiteboards in clinic rooms to use with patients with limited hearing. Another places wheelchairs around its clinic for patients with limited mobility.

A rural FQHC has contracted with ASLIS (American Sign Language Interpreting Services) to offer on-demand video interpretation. The clinic used grant funds to purchase large tablets for each clinic to support virtual interpretation. When a patient needing

interpretation services is scheduled for an appointment, the clinic confirms whether a patient is comfortable using video interpretation.

One FQHC participated in a research study to assess the impact of asking patients with communication limitations to complete a brief survey on a tablet to share their preferred communication methods. Patients reported increased respect as a result of this tool, with the biggest effects found among patients of color. The clinic is seeking grant funding to integrate this survey into its electronic medical record.

Only one FQHC dedicated clinic time for people living with disabilities. This Denver clinic was started for people with spinal cord injuries but is now available for patients with other physical disabilities. The clinic used grant funding to buy accessible tables, Hoyer lifts, and wheelchair scales, and to modify the existing clinic space to include door opener buttons. Staff were trained on safe transfer practices, wound care, and catheter changes. This clinic includes a physical therapist in each session and offers longer visits on select days.

Question 2.b: How are these efforts measured?

Only one person interviewed said their FQHC provider sent them surveys to ask for feedback on their care.

Question 2.c: What factors help or detract from these efforts?

Helps

Factors that improve access to competent care for people with disabilities fall into three categories: team-based care, care coordination, and inclusion.

- Team-based care: FQHCs often offer team-based care that brings together medical, dental, behavioral health, and pharmacy services. This model limits the patient's need to move between settings while addressing multiple care needs.
- Care coordination: FQHCs can help patients find social services and supports by hiring care managers and coordinators, but they may lack expertise for people living with disabilities.
- Inclusion: Leadership should, in theory, advance access to competent care. Although board requirements are limited to factors such as race, ethnicity, and gender, FQHCs could also include patients with disabilities.

Hurdles

Barriers to increase access to disability competent care in FQHCs fall into three categories: resources, standards for compliance, and access to services.

- Resources: Interviews showed a need for funds to pay for physical updates. For example, clinics may only have money to offer one accessible exam room in the whole clinic. One provider said that having the right equipment can improve their comfort levels and bring in more patients. Stakeholders also said the way FQHCs are paid in Colorado can be a problem. FQHCs that make upgrades, train staff, and make other efforts to increase their level of care for people with disabilities will not be paid to reflect the costs of these changes for one to two more years. Lastly, FQHCs are only paid for provider visits, which means time spent to connect people to social supports, coordinate their care, and provide other services is not covered.

- Lack of standards: Stakeholders said a lack of clear standards around providing competent care to people with disabilities leads to differences within FQHC systems and clinics. One stakeholder said "accessibility means different things to different people in a clinic." They felt that FQHCs should be held to high standards, given their mission to provide health care to all who need it. They already meet federal requirements to receive funding. They said that FQHCs are not intentionally breaking laws, but simply following the Americans with Disabilities Act requirements is not enough. And yet the Compliance Manual doesn't mention disability competent care or offer standards of care for people living with disabilities. One stakeholder felt that providing FQHCs with "resources that come with specific requirements will yield better outcomes."

- Access to services: Most stakeholders had trouble finding in-person American Sign Language interpreters. They said cost and getting interpreters were the biggest problems, especially in rural areas of the state, even for FQHCs that have contracts for these services. An additional hurdle for people living with disabilities is limited access to telemedicine. From April 2020 to January 2022, only 9% of telehealth services paid for by Medicaid were provided by FQHCs or rural health clinics, according to data from the Colorado All Payer Claims Database. Additional research may be needed to explore why this mode of care is limited among FQHCs.

Conclusion

FQHCs play a critical role in ensuring access to health care for all Coloradans, especially those enrolled in Medicaid or without insurance. FQHCs seem well able to offer competent care for people with disabilities. But financial barriers and a lack of guidance may limit their efforts.

All stakeholders expressed a desire to continue talking about how FQHCs can improve, often referring to their missions and philosophies as a guiding factor.