

May 29, 2019

Nathan Nau, Division Chief
DHCS
Policy and Medical Monitoring Branch

Re: Draft Update for the Facility Site Review (FSR) & Medical Record Review (MRR) Survey Tools and Guidelines

Dear Mr. Nau,

The Disability Rights Education and Defense Fund (DREDF) and Disability Rights California (DRC) appreciate the opportunity to comment on the Draft Update for the Facility Site Review (FSR) and Medical Record Review (MRR) Survey Tools and Guidelines prepared by The Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division (MCQMD). In addition to the comments and recommendations that we provide below, we also support comments submitted on behalf of the National Health Law Program, Justice in Aging, and Western Center on Law and Poverty on the MRR Tool and Guideline, and request your equal consideration of those additional recommendations.

DREDF is a national law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives. DRC is the protection and advocacy agency for California. We advocate, educate, investigate, and litigate to advance the rights, dignity, equal opportunities, and choices for all people with disabilities, including in the arena of healthcare.

The FSR and MRR survey tools and their associated guidelines set forth important measures that directly relate to barriers that affect the health and wellbeing of disabled individuals in California who receive health care through managed care organizations (MCOs). However, the ability of MCO's to collect needed information, and synthesize and report it accurately depends both on the clarity of the survey instruments and the categories of information being collected. Accordingly, we present several substantive additions to the FSR and MMR tools and guidelines that we ask you to consider. Our comments also respond to the 2019 drafts as compared with the survey tools and guidelines found in Policy Letter 14 – 004.

Background/Health Disparities Among People with Disabilities

Health and healthcare disparities among people with disabilities can be attributed in part to complex barriers that contribute to difficulties or delays in getting needed healthcare

and increase the likelihood of poor health outcomes. People with disabilities are more likely than the general population to experience difficulties or delays in getting the health care they need, not have had an annual dental visit, have high blood pressure, use tobacco, or be overweight. Women with disabilities are more likely not to have had a mammogram in the past two years or to have been screened for cervical cancer in the past three years.¹ They also have higher death rates from breast cancer than women without disabilities. Studies show that people with disabilities die from lung cancer at higher rates than the general population.² Identified barriers include lack of provider awareness and training, lack of accessible medical offices and facilities, and a dearth of accommodations such as accessible medical and diagnostic equipment, lifting assistance, or Sign Language interpreters. Certain inflexible policies also create barriers to care such as the inability of a provider to extend a patient visit to ensure time for lifting assistance on to an exam table or effective communication for someone with a speech or cognitive limitation.³

A 2015 study found that, "Population-level differences in health outcomes...are related to a history of wide-ranging disadvantages, which are avoidable and not primarily caused by the underlying disability."⁴ Another study illustrates certain of these avoidable disadvantages. In 2014, 256 specialty providers were asked if they would accept a referral of a large patient who used a wheelchair and required transfer assistance. The study revealed that 22 percent of the specialty provider offices could not accommodate this patient, 4 percent were architecturally inaccessible and 18 percent couldn't assist the patient to transfer onto an exam table. Gynecology was the subspecialty with the highest rate of inaccessible practices (44 percent).⁵ Such lack of accessibility and impairment-related accommodation is commonplace not only among specialty providers, but also among primary care practices, diagnostic centers and facilities, clinics, and hospitals. These barriers frequently prevent patients from obtaining needed care and treatment.⁶

Physical Accessibility Review Survey (PARS)

Since 2011, DHCS has required MCOs to conduct physical accessibility reviews of primary care practitioner (PCP) offices that newly contract with MCOs and every three years thereafter. MCOs must complete the Physical Accessibility Review Survey

¹ Sze Y. Liu, Melissa A. Clark, "Breast and Cervical Cancer Screening Practices among Disabled Women

² Ellen P. McCarthy, Long H. Ngo, Richard G. Roetzheim, Thomas N. Chirikos, Donglin Li, Reed E. Drews, Lisa I. Iezzoni, "Disparities in Breast Cancer Treatment and Survival for Women with Disabilities," *Annals of Internal Medicine* 145.9 (2006):637-45; Lisa I. Iezzoni, Long H. Ngo, Donglin Li, Richard G. Roetzheim, Reed E. Drews, Ellen P. McCarthy, "Treatment Disparities for Disabled Medicare Beneficiaries with Stage I Nonsmall Cell Lung Cancer," *Arch Phys Med Rehabil*, 89.4(2008):595-601.

³ National Council on Disability, "The Current State of Health Care for People with Disabilities," September 30, 2009.

⁴ Gloria L. Krahn, Deborah K. Walker, Rosaly Correa-De-Araujo, "Persons with Disabilities as an Unrecognized Health Disparity Population," *American Journal of Public Health* 105 S2 (2015):

⁵ T. Lagu, N.S. Hannon, M.B. Rothberg, A.S. Wells, K.L. Green, M.O. Windom, K.R. Dempsey, P.S. Pekow, J.S. Avrunin, A. Chen, and P.K. Lindenauer, "Access to Subspecialty Care for Patients With Mobility Impairment: A Survey," *Annals of Internal Medicine* 158 (2013):441-446.

⁶ National Council on Disability, "The Current State of Health Care for People with Disabilities," September 30, 2009.

(PARS) Tool (See PL 12-006 Attachment C), an 86-item survey instrument based on the 2010 Americans with Disabilities Act Standards for Accessible Design.⁷ The PARS tool enables MCOs to collect information uniformly about both physical accessibility and the presence of accessible examination tables and weight scales for these PCP practices. MCO reviewers then incorporate some basic elements from the accessibility survey into the Full Scope Site Review Survey with the help of Full Scope Site Review Guidelines. However, neither the draft revised survey nor the guideline include height adjustable exam tables or accessible weight scales as essential elements required for a PCP practice to meet MCO standards for participation.

Recommended New Additions to FSR Survey and Guidelines

Height Adjustable Exam Tables and Accessible Weight Scales

Recommendation: In light of extensive research showing that such equipment is needed to ensure people with mobility limitations can be weighed and fully examined, as required by best clinical practices standards, these two items should be added to section I. Access/Safety for both the survey and guidelines.

Recommendation: Section V. Preventive Services Reviewer Guidelines also offers an opportunity to insert references to both height adjustable exam tables and accessible weight scales. This section discusses protective barriers required for exam tables, but does not indicate that an exam table must be height adjustable. The section also includes a detailed discussion about acceptable types of weight scales, but makes no mention of accessible weight scales. Such references should be added to both the guidelines and the survey.

Effective Methods of Communication

The 1990 Americans with Disabilities Act requires that covered entities such as physician offices ensure that a person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity. Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. For example, a blind person who requests information about methods to lower cholesterol might require that the information be provided in an accessible format such as digital, audio or Braille. Communication disabilities can also include learning and reading disabilities. Section V. Preventive Services Reviewer Guidelines spells out that health education services and materials must be provided in threshold languages and in various forms including audio or visual presentation aids. The guidelines do not however mention that the materials must also be made available for people with disabilities generally, and within these populations, that are in formats that achieve effective communication.

Recommendation: Add a reference to Section V. Preventive Services for both the guidelines and survey that indicates the PCP practice makes available educational

⁷ U.S. Department of Justice; http://www.ada.gov/2010ADAstandards_index.htm.

materials in accessible formats when required to ensure effective communication with people with disabilities.

COMMENTS: 2019 Proposed Full Scope Site Review Guidelines

Site Accessibility

DHCS issued a Policy Letter on May 22, 2014 informing Medi-Cal MCOs of updates to the site review policy and setting forth criteria for summarizing PARS data for physical accessibility of MCO PCP network providers. The draft 2019 Site Review Survey and Guidelines propose changes to both these documents as they affect identification and reporting of accessible elements.

The 2014 Full Scope Site Review Guidelines include Criteria A, "Site is accessible and useable by individuals with physical disabilities." Accompanying reviewer guidelines include a statement summarizing the ADA as well as city, county and state accessibility requirements for physical access. The guidelines also call out six elements that must be present, if applicable: accessible parking, ramps, exit doors, elevators, clear floor space that accommodates a wheelchair user and companion in waiting and exam areas, and sanitary facilities. Reference to elevators is eliminated in the 2019 draft guidelines although the elevator reference is retained in the draft site survey. DREDF hopes that the elimination of the elevator references in the draft guideline are an unintended omission. The 2019 draft also makes substantive changes to parking, ramps, exit doors, and sanitary facilities.

We support the proposed changes in the guideline for parking, ramps, and exit doors and we do not recommend any changes to guidelines for clear floor space. Our major concerns have to do with the guideline for elevators and sanitary facilities.

Elevators

We question why a reference to elevators is absent in the 2019 draft guidelines when it remains in the 2019 survey draft and the information surveyed is still logically necessary. The rationale for providing guidelines for evaluating the presence of an elevator is based on the fact that people with functional limitations who cannot climb stairs need to know if a doctor they will be visiting is located at an accessible office location. If this information is required and known, MCOs must actively decide that it is acceptable and necessary to accept particular PCPs in their networks who are located above the first floor in a building without an elevator.

Recommendation: Incorporate an elevator reference in the 2019 guidelines document so it is congruent with the elevator reference in the survey document.

Sanitary Facilities

We support the 2019 addition of a reference to alternative restroom accommodations such as one "shared within a building" because we recognize that restroom facilities

within individual provider offices are often inaccessible. In these instances, the presence of a fully accessible restroom on the same floor or even another floor within the same building in which the provider is located should be noted. However, we oppose the reference to “nearby office” as an acceptable alternative location for an accessible restroom. The language suggests that the restroom could be located in a different building from the one where the provider office is located, which does not practically or legally satisfy the requirement for an accessible restroom.

Recommendation: Remove the reference to “nearby office” in relation to the sanitary facilities criterion.

We also question the assertion appearing in both the 2014 guidelines and the proposed 2019 guidelines that a urinal, bedpan or commode are reasonable alternatives or adequately substitute for an accessible toilet. While disabled people can elect to use such items if they wish to instead of using an accessible toilet, the devices do not substitute affectively for an accessible sanitary facility. Practically speaking, as anyone who has ever used a bedpan or female urinal knows, they almost always must be used while lying supine, thus requiring wheelchair users or others with limited functional mobility to be placed on a gurney or exam table in order to use them. This process requires a height adjustable exam table in many instances. Yet recent research shows that only 19.1 percent of almost 4000 PCP offices in California MCO networks have height adjustable exam tables and only 5.9 percent have patient lifts that disabled people need if they cannot transfer independently.⁸ These data illustrate the impracticability of substituting bedpans and urinals for accessible restroom facilities, even if they could be a reasonable alternative in other contexts. While state and federal disability antidiscrimination laws permit certain alternative methods to be used to deliver services, these are not acceptable or effective choices in the context of primary care physician offices.

Recommendation: Remove the reference in the draft guideline to the provision of a urinal, bedpan or commode as examples of reasonable alternatives to an accessible toilet.

Point Assignments

The 2014 Full Scope Site Review assigns 25 possible points for I. Access/Safety criteria out of a total of 140 points for all sections of the Site Review. The 2019 draft assigns 30 possible points for I. Access/Safety criteria out of a total of 144 for all sections of the site review, an increase of five points for the accessibility criteria. We suggest that the point assignment be recalculated if DHCS and the advisory group adopt our recommendation that height adjustable exam tables and accessible weight scales be added.

⁸ Mudrick, N.R., Breslin, M.L., and Swager, L.C. (2018). Equal Care: Accessibility of health care settings for people with disabilities across two time periods. Presentation at the Society for Social Work and Research annual meeting, Washington, DC, January.

Personnel Reviewer Guidelines

Training

Criterion G. under Section II. Personnel Reviewer Guidelines concern personnel training about member rights. Extensive research has revealed that one of the leading problems people with disabilities experience when they try to access health care is lack of provider and staff training and awareness about disability, accessibility and related accommodations that individuals might require in order to receive effective, equitable care. Without such training providers cannot effectively inform patients about their right to accommodations, plan for and provide such accommodations when they are needed, and address physical barriers to and within their offices.

Recommendation: The guidelines should include a reference within criterion G that includes personnel training about member rights under the 1990 Americans with Disabilities Act and relevant state law regarding physical access, accommodations, policy modifications, and effective communication in healthcare settings.

Office Management Reviewer Guidelines

Language Access

Criterion D. of Section III. Office Management Reviewer Guidelines, relates to required 24-hour access to language interpreter services, but does not spell out that Sign Language interpretation falls under 24-hour access to interpreter services, even though there is such a reference in the related survey criteria.

Recommendation: Add a reference to Sign Language interpreters to criterion D., section III. Office Management Reviewer Guidelines so the survey and guidelines are congruent.

COMMENTS: 2019 Proposed Full Scope Site Review Survey

Site Accessibility

The 2012 and 2019 Site Access/Safety Survey Criteria for the category entitled, "1. Access/Safety" includes an introductory sentence stating that, "Sites must have the following safety accommodations for physically disabled persons..." While we recognize that the entirety of Section I. relates to safety as well as accessibility, the accessibility features listed (parking, ramps, doorways, etc.) are not intended to be primarily safety elements, though improved safety could well be a product of their presence. Rather, people with disabilities require these elements to be present so they can have equitable and effective access to health care services and programs rather than be excluded from care due to their absence. The intent of the legal provisions that require these access elements in health care settings is rooted in civil rights principles of equality of opportunity and inclusion. By retaining the safety language following subsection A., disability stereotypes are reinforced and DHCS and MCOs miss an opportunity to promote the principle that accessibility represents a best practice in the delivery of

health care for people with disabilities. Conversely, when access elements are absent, not only are barriers to care likely to be present, they also constitute one of many social determinants of health disabled people face that minimize their access to care and health outcomes.

Recommendation: Remove the reference to safety from the sentence, “Sites must have the following safety accommodations for physically disabled persons...”

Elevators: The 2019 draft survey retains a reference to accessible passenger elevators, yet the guidelines for this access criterion is missing.

Recommendation: Add the reference to elevators to the guidelines so the survey and guidelines are congruent.

Personnel Reviewer Survey

Training

Criteria G. of Section II. Personnel, concerning staff and training on member rights should include a citation to the Americans With Disabilities Act (28 CFR parts 35 and 36) and a reference to training or information on disabled members’ right to physical access and accommodations along with related grievance procedures.

Recommendation: Criteria G. of Section II. Personnel, concerning training on member rights should include a citation to the Americans With Disabilities Act (28 CFR parts 35 and 36). The guidelines and the survey criteria should contain congruent language on training concerning grievance and complaint processes for people with disabilities.

Office Management/Interpreters

Language Interpreters

Criteria D of Section III. Office Management, relate to language interpreter services and specifically spell out that Sign Language interpretation falls within required 24-hour access to interpreter services and therefore ASL interpreter services are required.

Recommendation: Align the survey criteria and related guidelines so each references ASL interpretation as required under the 24-hour language interpreter services.

COMMENTS: 2019 Proposed Medical Record Review Guidelines

Many primary care practices, diagnostic centers and facilities, clinics, and hospitals Lack capacity to provide impairment-related accommodations for disabled people. These barriers frequently prevent patients from obtaining needed care and treatment.⁹

⁹ Pharr JR. Accommodations for patients with disabilities in primary care: a mixed methods study of practice administrators. *Glob J Health Sci.* 2013;6(1):23–32. Published 2013 Oct 8. doi:10.5539/gjhs.v6n1p23.

Revisions to the Medical Record Review Guidelines offer an opportunity to begin evaluating the capacity of PCPs within MCO networks to recognize the need to collect accommodation information from individual patients and record that information in their medical record. This is a critical first step in preparing for an office visit for someone who needs an accommodation and ensures that administrative and clinical staff alike have the specific details about what the person requires.

Recommended New Additions to Medical Record Review Guidelines

Key Personal Information

Criteria B., Individual personal biographical information, for section I. Format Reviewer Guidelines, requires key personal information to be contained in the medical record. This category provides an opportunity to note that both information about a person's functional limitation and related accommodations that they might need are recorded in the record (paper or electronic health record). For example, the person might require a height adjustable examination table in order to transfer from a wheelchair or scooter onto the table. If only one such table is available in a provider's office, then staff should be alerted to this patient's need in order to assign them to the appropriate examination room.¹⁰ (NOTE: information about the right of a person to be provided an ASL interpreter is already included in the language access criteria. This is an example of an accommodation that a Deaf person requires for effective communication. Similarly, the need for other types of accommodations can be included within the guidelines for criteria B., and potentially elsewhere. See below.)

Recommendation: Include functional limitation information along with specific accommodation needs for typical office visits. As a starting point, functional limitation information could be recorded using the American Community Survey disability questions set.^{11,12} Such information could be added to Criteria B., Individual personal biographical information, for section I. Format Reviewer Guidelines, or a new category could be added following criteria G. It should also be listed in section II. Documentation Reviewer Guidelines, within criteria B. where chronic problems and/or significant conditions are listed. Clinicians are more likely to view information listed under Section II's Criteria B about chronic problems, while office staff may pay earlier initial attention to Section I's Criteria B on personal biographical information. Any additions should include additions to the corresponding survey items to make them congruent.

Recommendation: Add a reference to Sign Language interpretation to criteria F. thus making the guidelines congruent with the survey.

¹⁰ Pharr JR. Accommodations for patients with disabilities in primary care: a mixed methods study of practice administrators. *Glob J Health Sci.* 2013;6(1):23–32. Published 2013 Oct 8. doi:10.5539/gjhs.v6n1p23.

¹¹ United States Census Bureau, <https://www.census.gov/topics/health/disability/criteria /data-collection-acs.html>

¹² Morris, M. A.; Schliep, M.; Liesinger, J.; Cameron, K. A. Collection of patients' disability status by healthcare organizations: Patients' perceptions and attitudes. *The Journal for Healthcare Quality (JHQ)*: [July/August 2017 - Volume 39 - Issue 4 - p 219–229](#)

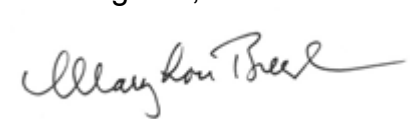
Long-Term Services and Supports

Coordination/Continuity of Care criteria and guidelines, pediatric criteria and guidelines, and adult criteria or guidelines fail to include any mention of Long-term services and supports (LTSS). Unmet LTSS need can lead to increasingly compromised functional capacity, leaving older individuals and individuals with disabilities vulnerable to increasingly poor physical and mental health, decreased independence, and the risk of unnecessary institutionalization. DHCS must include a criteria on LTSS for both children and adults to ensure that LTSS needs are assessed, and further LTSS procedures initiated or appropriate referrals are made, to help individuals remain living at home.

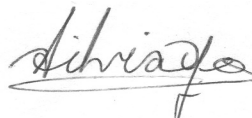
Recommendation: Add additional criteria between current criteria C and D in Section III. Coordination/Continuity of Care of the survey tool that addresses whether there is a current LTSS assessment, whether there are observations concerning additional LTSS needs after changes in functional limitations or life changes, and whether appropriate referrals were made in a timely fashion. Align the MRR guidelines to the LTSS criteria added to the survey tool.

Thank you for considering these recommendations. Please contact Silvia Yee at 510-644-2555 x5234 or at syee@dredf.org if you have any questions or require additional information concerning the above..

Best regards,



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