Providing Health Care for Participants with Disabilities: Competency Planning Checklists

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The purpose of these gap analysis checklists is to assist health care professionals in evaluating their attitudes toward participants with disabilities, their current capacity to provide physical, communication, and medical equipment access, as well as care coordination for participants with disabilities. Health care providers can use these checklists as an actionable practice competency assessment. These tools should assist providers in complying with Centers for Medicare and Medicaid Services (CMS) expectations for care for Medicaid and Medicare populations with disabilities.

Health Plan professionals can use these checklists to check if their policies and procedures, as well as the training they offer is inclusive of these access elements. These questions are not meant to be graded, but rather to be used as a planning tools to help identify opportunities for improvements, set priorities, and to track improvements over time. Oregon Coordinated Care Organizations can use these completed checklists for supportive documentation for primary care/provider requirements for network standards outlined in CMS 2390 F or CFR 438.10 Information Standards.

Instructions:

1. Cross out the question if you feel the question does not apply.
2. Check **Unsure** if you do not know the answer and need to find out.
3. Definitions to refer to, if needed, are provided following each checklist.
4. Resources are provided at the end of the document.
5. Create an actionable plan based on items where you identify gaps!

Note: This tool uses the terms "participant" (versus patient, client or consumer) to refer to the person receiving care and support. This is important because it recognizes the participant as someone who is actively involved in the health care process, rather than a passive bystander. It also reflects changing the process from simply providing a diagnosis and treatment, to more holistically focusing on providing care and supports for maximizing function and independence, as well as addressing the barriers to integrated, accessible care. This is consistent with social and independent living (non-medical) models of disability. The National Quality Forum has adopted this standard in their reports to CMS on person- and family-centered care, and in other reports.

#	Attitudes	Yes	No	Unsure	Comments and follow up
A.	We identify our biases regarding participants with disabilities so that we can prevent them from leaking out by:				
A1.	• Periodic training (see Section H.)				
A2.	• Staff discussion and self-reflection				
B.	We are aware that our attitudes toward participants with disabilities can:				
B.1.	• Influence the quality of care participants receive.				
B.2.	• Be expressed through tone of voice, choice of words, and questions.				
B.3.	• Be read by body language, gestures and other subtle actions and behaviors.				
B.4.	We use disability respectful and neutral language to avoid terms and words that may be offensive or outdated. For example: • Individual with disability vs. crippled • Wheelchair user vs. wheelchair bound • Person with multiple sclerosis vs. MS victim				
B.5.	We ask participants if they need help before assuming they do. For example, "Is there anything I can do to assist you to get onto this exam table" or "what works best for you?"				
B.6.	We know that integrating the practice of asking, listening, learning, respecting, and incorporating the information learned from participants with disabilities is a critical health care competency.				
B.7.	We do not equate an individual's disability with their quality of life.				
B.8.	We involve participants with disabilities as partners in their health care.				
B.9.	We know that health, wellness, and disability can coexist and are as important to participants with disabilities and to those without disabilities.				
B.10.	We include training on attitudes in periodic and new staff training. (See Section H)				

Quality of Life: An individual's emotional, social and physical wellbeing, including their ability to function in the ordinary tasks of living[i]

[i] Wikipedia, Quality of Life (Healthcare)

#	Physical Access	Yes	No	Unsure	Comments and follow up
C.	We have completed a physical access survey of our health care providers' offices by trained surveyors.				
C.1.	These surveys cover: Directional signage, accessible pathways, parking, building exterior and interior, office reception areas, restroom, exam rooms, exam tables and scales. [See below: Checklist for Medical Clinics and Facilities in Oregon, 2010 ADA Standards for Accessible Design Oregon State Building Code]				If no, skip to the next checklist or schedule a time to complete a physical access survey in your gap analysis plan.
C.2.	As a result of this survey we have worked to:				
C.2.a.	• Remove identified barriers				
C.2.b.	• Have a list of barriers to be removed				
C.2.c.	• Have a list of barriers to be removed in order of priority				
C.2.d.	• Have a plan and projected budget to remove access barriers over a specific time frame				
C.3.	We can accurately answer participant's questions regarding the accessibility elements of the office.				
C.4.	We provide our Coordinated Care Organization details on our accessibility elements for the member provider directory.				
C.5.	We can make usable referrals to other providers whose offices meet the accessibility needs of the participant. Referrals are made for auxiliary/specialty services and not to avoid making needed access and accommodations in our facility.				
C.6.	We maintain frequently updated lists of accessible health care providers to use when making referrals for people with mobility disabilities.				

DEFINITIONS

Mobility aids: Cane, crutch, walker, wheelchair, mobility scooter

RESOURCE

Checklist for Medical Clinics and Facilities in Oregon, 2010 ADA Standards For Accessible Design Oregon State Building Code, 10/2013, Northwest ADA Center University of Washington, http://nwadacenter.org/toolkit/accessibility-checklists

#	Accessible Medical Equipment	Yes	No	Unsure	Comments and follow up
D.	For participants with mobility limitations, we use **exam and procedural tables and chairs** that: [See Resources below]				
D.1.	• Are height adjustable with a minimum of 17-19 inches from the floor to the top of the cushion?				
D.2.	• Have extra wide cushion tops, 24 inches or greater to accommodate larger participants				
D.3.	• Have higher weight capacities, 400 lbs. or greater to accommodate larger participants				
D.4.	• Have adjustable handrails and/or side rails				
D.5.	• Have foot/leg supports than can be adjusted and locked (i.e., articulating knee crutches for table only)				
D.7.	When scheduling appointments, we always ask participants to identify or reconfirm assistance and accommodations needs. (See G.1.)				
D.8.	Accessible medical equipment is placed in accessible exam rooms with maneuvering space for participants using mobility aids (See RESOURCES)				
E.	Designated staff get annual training on safe transfer techniques.				
E.1.	• We provide participants transfer assistance on and off of equipment (this includes use of lift equipment when needed).				
E.2.	• Lift equipment is available to assist staff with transfers (portable, overhead, or ceiling mounted)?				
F.	**Weight Scales** have:				
F.1.	• Sturdy hand rails				
F.2.	• Higher weight capacity (400-800lbs+)				
F.3.	• Large and easy to read display (digital)				
F.4.	• Scale platforms accommodate large power wheelchairs.				
F.5.	• Instructions next to or attached to the weight scale on how to weigh a person using a mobility aid.				

DEFINITIONS

Mobility Aids: Cane, crutch, walker, mobility scooter, wheelchair.

Positioning Aids: Pillows, wedges, protective padding, positioning straps, Velcro, side rails, knee crutches.

#	Communication Access	Yes	No	Unsure	Comments and follow up
G.	**Processes, Procedures, and Policies**				
G.1.	When scheduling appointments, we always ask participants to identify or reconfirm assistance and accommodations needs. We ask "will you need any assistance with getting on and off a table, walking, seeing, reading, hearing, filling out forms, communicating, speaking, during your appointment? Will you need an interpreter?"				
G.2.	• We record these accommodation needs in the participant's health record in a consistent, easy to find, and prominent place.				
G.3.	We add reminder flags or alerts to health records, such as: • Needs help filling out forms • Needs information in large print • Needs longer appointment • Schedule sign language interpreter				
G.4.	We refer to this health record information, and prepare to meet these needs, before and during each appointment.				
G.5.	We update this information by asking before each appointment if any of the participants' needs have changed.				
G.6.	We ask and do not assume that people who are hard of hearing or deaf can read lips, use their voice, or read written notes.				
G.7.	When written notes are appropriate and usable by a participant who is deaf or hard of hearing, we limit them to very brief and simple communication				
H.	We provide staff and provider training on:				
H.1.	Asking ALL participants if they will need assistance during an appointment, regardless of an apparent or hidden disability.				
H.2.	Identifying disability biases (See Section B.)				
H.3.	Ensuring attention to the aids and services listed above (We are at risk of not understanding participants and their symptoms or causing harm unless we do so).				

#	Communication Access: Cont'd	Yes	No	Unsure	Comments and follow up
H.5.	We provide training regarding:				
H.5.a.	• Where to locate resources on communication access methods / tools				
H.5.b.	• When to use communication access methods / tools.				
H.5.c.	• How to access communication methods / tools.				
H.5.d.	• How to make the public aware of our communication access services.				
H.5.e.	• How to enter and update communication access needs in participants' medical records.				
I.	We have processes, procedures, policies focused on how to provide accessible communication. In meeting communication access request, it is clear:				
I.1.	• Who is responsible for what				
I.2.	• How will this happen				
I.3.	• How long it will take to meet the request				
J.	We have a clear process and staff know how to schedule, provide and/or arrange for (in a timely way):				
J.1.	• Qualified or certified American Sign language interpreters				
J.2.	• Qualified or certified oral interpreters				
J.3.	• Assistive listening devices				
J.4.	• Computer Assisted Real Time Transcription (CART)				
J.5.	• Print materials in alternative formats (See Section K.)				
J.6.	• Staff assistance when reading documents when needed				
J.7.	• Letter, word, picture and translator boards				
J.8.	• Health education materials in usable formats to take home or use in the appointment (see Section K. and Section L.)				
J.9.	We keep captions on televisions in public areas on and staff know how to turn them on.				
J.10.	We do not assume or assign communication access options without consulting with participants regarding their needs.				

#	Communication Access: Cont'd	Yes	No	Unsure	Comments and follow up
K.	**Print Materials in Alternative Formats**				
K.1.	Print materials offered in alternative formats include:				
K.1.a.	• Audio recordings				
K.1.b.	• Braille				
K.1.c	• Large print (Size 18 font minimum per CMS)				
K.1.d.	• Electronic text/disk/CD/flash drive				
K.1.e.	We incorporate a statement such as "If you need this information in large print, Braille or in audio, please contact xxx-xxx-xxxx." into all our print materials.				
K.2	We provide information in alternative formats, on request, and via our website, to participants, family members and/or companions:				
K.2.a.	• We email, mail and have available on the internet copies of forms to be completed prior to scheduled appointments, if participants request copies of the forms because it would be easier to fill out at home before their appointment.				
K.2.b	• Types of programs and/or services provided in the form of brochures, pamphlets and application materials				
K.2.c.	• Medication Instructions (dose, instructions for how and when to take, side effects, food or drug interactions)				
K.2.d	• Information regarding: Diagnosis / prognosis / tests, referrals, and treatments				
K.2.e.	• Follow-up care instructions, treatment, therapies, other recovery directions				
K.2.f.	• Information on member rights and process to file grievances or complaints				
K.2.g.	• Preventive health reminders				
K.2.h.	• Health education information				
L.	**Media (Film, Video, etc.)**				
L.1.	Film and video access options offered include:				
L.1.a.	• Audio visual-descriptive narration (audio description)				
L.1.b.	• Captions				
L.1.c.	• Signed				
L.2.	When purchasing new media products, we specify that they include:				
L.2.a.	• Audio description				

#	Communication Access: Cont'd	Yes	No	Unsure	Comments and follow up
L.2.b.	• Captions				
L.2.c.	• Signed				
L.3.	If we produce media products we integrate these access features:				
L.3.a.	• Audio description				
L.3.b.	• Captions				
L.3.c.	• Signed				
M.	**Telecommunication / Phone /E-Communication**				
M.1.	Telecommunication and Phone access options we offer when communicating with participants include:				
M.1.a.	• Email				
M.1.b	• Text messaging				
M.1.c.	• Speech-to-speech				
M.1.d.	• TTY				
M.1.e.	• Video				
M.1.f.	• Telecommunications Relay Services (711)				
M.2.	**Websites**				
M.2.a.	We ensure our websites including participant portals are accessible by following web site accessibility guidelines (See Resources).				
M.2.b.	We provide forms for participants to fill out in advance of appointments via our website.				
N.	**Purchasing/Ordering Policies**				
N.1.	We purchase health education material that is available in alternative formats as well as media (with captioning for people with hearing disabilities and audio descriptions for people with vision disabilities).				
N.2.	We request that vendors/suppliers provide participant materials in alternative formats (e.g., Braille, large print, DVD, audio) and that they not charge extra for this service (unless complying with the request would involve substantial additional labor).				
N.3.	When our vendors/suppliers of participant materials will not supply materials in alternative formats on request, we add a requirement to the purchasing agreement that they will provide an unlocked PDF or Word or text file, and that they include the right to convert their materials into alternative formats (large print, audio, Braille.)				
O.	**Longer Appointments**				////
O.1.	We schedule longer appointments when participants are identified as needing additional time to communicate with health care provider.				

#	Communication Access: Cont'd	Yes	No	Unsure	Comments and follow up
P.	**Messages and Signs**				
P.1.	Messages and signs are displayed with easy to understand print instructions as well as pictures.				
P.2.	We provide signage in key prevalent languages, especially regarding the right to free interpreter services in the language of the participant or for those needing American Sign Language. (This signage meets health literacy as defined in OAR 410-141-3300).				
Q.	**Ensuring Language Access**				
Q.1.	The participant's primary language, means of communicating, and ethnic/cultural competencies are considered in identifying specific members of the interdisciplinary team (IDT). Having IDT members with these competencies, when feasible, can increase the trust between participants and their IDT.				
Q.2.	We follow guidelines noted in Section K, L, M and strive to ensure notes, handouts, brochures, consent forms, health education materials, instructions and other materials where needed to ensure patient care standards are translated and available in prevalent languages and alternative formats.				

DEFINITIONS

Assistive Listening Devices: Help participants who are hard of hearing by making the voice or sound louder. They reduce background noise, make the voice clearer and easier to understand.

Audio Visual-descriptive Narration (audio description): Film and video description (also called audio description) makes television and other visual media accessible to people who have difficulty seeing. Narrative descriptions of a program's key visual elements such as actions, graphics and scene changes are recorded and carefully blended into natural pauses in the program soundtrack, creating an additional mixed audio track that is broadcast or shown simultaneously with the program. [i]

Captioned Films and Videos include spoken words that appear in text on the bottom of the screen, as in subtitles. "Open" captions can be seen by everyone while "closed" captions are visible only when activated by the viewer.

Communication Access: Means providing content in ways that are understandable and useable by people with reduced or no ability to: See, hear, read, learn, move, speak, remember and understand.

Companions: A person who is "legally allowed to make health care decisions on behalf of the participant, or chosen by the participant to communicate with health care providers about the participant, the participant's needs, condition, history, or symptoms, or is authorized to help the participant act on information or instruction." [i]

Computer Assisted Real Time Transcription (CART): A service similar to court reporting in which a transcriber types what is being said into a computer that projects the words onto a screen. This service, which can be provided on-site or remotely, is particularly useful for people who are deaf or have hearing loss but do not use sign language.

Print Materials: Include but are not limited to, audio recordings, Braille, electronic text/disk/CD-ROM/flash or thumb drive, large print

Signed Films and Videos: include spoken words translated to sign language using live on-screen interpretation.

Speech-to-Speech: Relay services that provide **Communications Assistants (CAs)**[i] for people with speech disabilities, including those who use speech generating devices, who have difficulty being understood on the phone. CAs have strong language recognition skills and are trained participants familiar with many different speech patterns. The CA makes the call and repeats the words exactly.

Telecommunication and Phone: Includes but are not limited to, e-mail, instant messaging, short message service, TTY.

Telecommunications Relay Services: A free nationwide service, reached by calling 7-1-1, uses communications assistants (also called CAs or relay operators) who serve as intermediaries between people who have hearing or speech disabilities who use a text telephone (TTY) or text messaging and people who use standard voice telephones. The communications assistant tells the telephone user what the other party is typing and types to tell the other party what the telephone user is saying. TRS also provides speech-to-speech transliteration for callers who have speech disabilities.

Video relay service (VRS): A free, subscriber-based service for people who use sign language and have videophones, smart phones, or computers with video communication capabilities. For outgoing calls, the subscriber contacts the VRS interpreter, who places the call and serves as an intermediary between the subscriber and a person who uses a standard voice telephone. The interpreter tells the telephone user what the subscriber is signing and signs to the subscriber what the telephone user is saying.

Video remote interpreting (VRI): A fee-based service that uses video conferencing technology to access an off-site interpreter to provide real-time sign language or oral interpreting services for conversations between hearing people and people who are deaf or have hearing loss. The new regulations give covered entities the choice of using VRI or on-site interpreters in situations where either would be effective. VRI can be especially useful in rural areas where on-site interpreters may be difficult to obtain. Additionally, there may be some cost advantages in using VRI in certain circumstances. However, VRI will not be effective in all circumstances. For example, it will not be effective if the person who needs the interpreter has difficulty seeing the screen (either because of vision loss or because he or she cannot be properly positioned to see the screen, because of an injury or other condition). In these circumstances, an on-site interpreter may be required.

If VRI is chosen, *all* of the following specific performance standards must be met:

- Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
- A sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the face, arms, hands, and fingers of the person using sign language, regardless of his or her body position;
- A clear, audible transmission of voices; and
- Adequate staff training to ensure quick set-up and proper operation.
- Clear instruction to the participant in the room on use of VRI

#	**Care Management / Care Coordination** (Adapted and excerpted from Disability-Competent Care Self-Assessment Tool)	Yes	No	Unsure	Comments and follow up
R.1.	The interdisciplinary care team (IDT) develops an individualized, respectful, professional relationship with participants, honoring their preferences, goals, values, and their decisions including the right to take risks. [See below definition of dignity of risk]				
R.2.	We check with participants to see it they have an existing participant plan of care (IPC) care plan that they would be willing to share with the primary care IDT. (i.e. from APD/AAA Long-term Services and Supports or Developmental Disability Care Planning, or other specialty providers the member may be seeing for care).				
R.3.	The primary care home IDT coordinates with care managers involved with individuals outside of the primary care homes (such as at the coordinated care organization (CCO) or APD/AAA staff (Aged and people with disabilities, Area Agencies on Aging) to ensure services are integrated and coordinated.				
R.4.	If a participant's decision is inconsistent with the IDT's recommendation, their choice should be respected while the IDT continues to educate and advocate for recommended options.				
R.5.	We ensure that participants can designate a family member or other person to be involved in IDT-related communications including program planning and implementation.				
R.5.a.	• We document this in the individual plan of care (IPC) and communicate this to all IDT members.				
R.5.b.	• This designated person can include a guardian, conservator and other designated lead.				
R.6.	When participants have difficulty identifying or asserting their preferences, IDT members consistently seek their perspective and preferences.				
R.7.	The IDT or a designated team member is able to meet, either in person or virtually, within 24 to 48 hours if the participant's needs or situation changes?				

#	**Care Management / Care Coordination** (Adapted and excerpted from Disability-Competent Care Self-Assessment Tool)	Yes	No	Unsure	Comments and follow up
R.7.a.	• The need for timeliness will vary depending on the urgency of the situation, so IDT members maintain flexibility in their daily schedules to be able to address emerging concerns.				
R.7.b.	The assessment, IPC and current notes are available to anyone providing afterhours coverage.				
R.7.c.	We upload key information to real-time systems (such as EDIE/Pre-Manage or other HIE [Health Information Exchange]) and access real-time hospitalization or care reports from other providers.				
R.8.	**Comprehensive and Multidimensional Assessment**				
R.8.1.	The initial assessment is comprehensive and multidimensional, incorporating all aspects of the participant's life. Areas to cover include, but are not limited to:				
R.8.1.a.	• Participant's strengths, goals, and priorities				
R.8.1.b.	• Demographic, contact, financial, and eligibility information				
R.8.1.c.	• Social activities				
R.8.1.d.	• Functional assessment (activities of daily living [ADL], instrumental activities of daily living [IADL], or copy of assessment participant provides that was completed already (ASK!)				
R.8.1.e.	• Medical diagnoses and history				
R.8.1.f.	• Behavioral health screening (s).				
R.8.1.g	• Nutrition (food access, preparation, diet, etc.)				
R.8.1.h.	• Document all health-related services (including behavioral management, exercises, medications, equipment use, skilled therapies, rehabilitation therapies) and all current providers				
R.8.1.i.	• Long-term services and supports (LTSS)				
R.8.1.j.	• Home and community environment, safety, accessibility, and health risks				
R.8.1.k.	• Formal, informal, and social supports				

#	**Care Management / Care Coordination** (Adapted and excerpted from Disability-Competent Care Self-Assessment Tool	Yes	No	Unsure	
R.8.2.	The assessment identifies additional expertise needed for the participant's care. The Interdisciplinary Team (IDT) incorporates the expertise of other clinicians or care providers as needed, including rehabilitation therapists, behavioral health providers, dieticians, peers, LTSS providers, or specialists (such as palliative care practitioners)., either on an ongoing or consulting basis.				
R.8.3.	We identify participants' transportation needs as part of the initial assessment.				
R.8.3.a.	• Transportation scheduling support is available for participants.				
R.8.3.b.	• Transportation services are available 24/7 to meet urgent needs.				
R.8.3.c.	• Policies regarding transportation assistance to health care appointments are clear.				
R.8.3.d.	• Participants are given information regarding how to provide feedback to the CCO on transportation concerns.				
R.8.3.e.	• IDT advocates when issues that arise to ensure safe, dependable, and accessible service.				

Definitions

Dignity of risk - the right of participants to choose to take some risk in engaging in life experiences, even if that choice is not one recommended by a health professional (e.g., choosing to smoke).

EDIE: Emergency Department Info Exchange: EDIE provides emergency departments with real-time notifications and key care summaries for patients who visit the emergency department frequently, with the goal of reducing avoidable hospital utilization and improving health outcomes. Real-time notifications allow clinicians to identify patients who visit the emergency room often and those with complex care needs, which helps them to direct patients to outpatient and other care settings when appropriate. In Oregon, see **EDIE** information: http://www.orhealthleadershipcouncil.org/our-current-initiatives/emergency-department-information-exchange-edie

HIE: Health Information Exchange: Health information exchange (HIE) allows doctors, nurses, pharmacists and other health care providers to securely share a patient's medical information electronically - reducing the need for patients to transport or relay their medical history, lab results, images or prescriptions between health professionals. HIE can also reduce orders for duplicate procedures or tests, as well as enabling smoother transitions of care because providers, hospitals and long term care facilities can more easily share information. In Oregon, see **Care Accord** information: https://www.careaccord.org/hie-in-oregon/overview.shtml or for Jefferson/AllCare see: http://jhie.org/

#	Preventive Care and Health Education	Yes	No	Unsure	Comments and follow up
S.1.	We know that health, wellness, and disability can coexist and are as important to people with disabilities and to those without disabilities We do not assume that secondary conditions such as physical decline, illness, pain, weight gain, or other conditions are inevitable when living with a disability.				
S.2.	We ask people with disabilities about diet, exercise, smoking, drug use, heavy alcohol use, unprotected sex, and sexually transmitted diseases, birth control, etc. We do not avoid doing so just because people have disabilities.				
S.3.	We do not focus only on participant's disability. We are aware that when we do, we may risk overlooking critical services such as scheduling routine preventive screenings and making usable referrals for these screenings that take into account physical, communication and equipment access.				
S.4.	The interdisciplinary team (IDT) provides usable referrals to community wellness resources.				
S.5.	The IDT knows existing resources and ensures participants have the support and accommodations needed for successful participation in these programs (See the above Checklists: Physical Access, Accessible Medical Equipment, and Communication Access).				
S.6.	Participants are provided with health promotion and self-care education specific to their needs and preferences. (see previous sections)				
S.7.	The participant plan of care (IPC) includes a health and wellness plan, including:				
S.7.a.	• Accessing primary care				
S.7.b	• Routine preventive health services and screenings				
S.7.c.	• Prevention of secondary conditions of disability				
S.7.d.	• Management of conditions associated with existing disability and chronic conditions/referral to programs to strengthen management of chronic conditions				

S.7.e.	• Opportunities for appropriate and accessible physical activities/referral to community programs for physical activity.				

RESOURCES Section:

Physical Access

Resources found at http://www.hfcdihp.org/products.html

- Choosing and Negotiating an Accessible Facility Location
- Improving Accessibility with Limited Resources
- Health Care (clinic/outpatient) Facilities Access
- Tax Incentives for Improving Accessibility
- Using a Fitness Center Does Not Have to be an Exercise in Frustration: Tips for People with Mobility and Visual Disabilities
- Inclusive Fitness Equipment: Resource listings

Physical Accessibility Survey Tools:

Oregon:

Checklist for Medical Clinics and Facilities in Oregon, 2010 ADA Standards For Accessible Design Oregon State Building Code, 10/2013, Northwest ADA Center University of Washington, http://nwadacenter.org/toolkit/accessibility-checklists

California site review tools:

Physical Accessibility Review Survey (primary care providers) 3/8/11

Revised Facility Site Review Tool (supersedes PL 11-013) PL 12-006 (PDF) 8/9/12
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL%2012-006.pdf

Ancillary Services Physical Accessibility Review Survey (For purposes of this tool, Ancillary Services refers to Diagnostic and Therapeutic services such as, but not limited to: Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy, Occupational therapy , Speech therapy ,Cardiac rehabilitation, Pulmonary testing.) 10/2015

Community Based Adult Services (CBAS) Physical Accessibility Review Survey (primary care providers) 10/2015
Facility Site Review Tools for Ancillary **Service and Community-Based Adult Services Providers** APL 15-023 (PDF) 10/28/15
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-023.pdf

Physical Access to Care - If you use a wheelchair or have a hard time walking, you must have access to your doctor's office or medical equipment.

Link to fact sheet: Physical Access to Care also see if no link https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/DisabilityAccess.aspx#.V3lFkJDrszt

Accessible Medical Equipment

Importance of Accessible Examination Tables, Chairs and Weight Scales http://www.hfcdihp.org/products

Exam Room Selection for Accessible Examination Tables & Chairs

PDF , Word

http://hfcdhp.org/?s=Exam+Room+Selection+for+Accessible+Examination+Tables+%26+Chairs

Access To Medical Care For Individuals With Mobility Disabilities, U.S. Department of Justice http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

Before & After a Fitness Center Makeover, http://www.nchpad.org/fitnessCenter/index.html

Communication Access

Effective Communication - The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for Title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

https://www.ada.gov/effective-comm.htm

Available at:

https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/DisabilityAccess.aspx#.V3lFkJDrszt

Communication Assistance - Hearing
If you are hard-of-hearing, deaf, or have a speech disability, make sure you understand your health care. Link to fact sheet: Communication Assistance - Hearing

Communication Assistance - Hearing-Deaf
If you are deaf, use a sign language interpreter to make sure you understand your health care.
Link to fact sheet: Communication Assistance - Hearing-Deaf

Communication Assistance - Vision
If you are blind or have low vision, make sure you have communication access.
Link to fact sheet: Communication Assistance - Vision

Communicate Assistance
https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/DisabilityAccess.aspx#.V3lFkJDrszt

Health Care Access – Communication
http://hfcdhp.org/health-care-disable/health-care-access-communication/

Questions to Ask for Identifying Communication and Accommodation Needs pdf Word
http://hfcdhp.org/long-disability-literacy/customer-service/

Video: Improving Participant-Provider Communication (2010)
http://www.jointcommission.org/multimedia/improving-participant-provider-communication—part1-of-4/

The Joint Commission and the U.S. Department of Health & Human Services (HHS) Office for Civil Rights worked together to support language access in health care organizations with the video Improving Participant-Provider Communication: Joint Commission Standards and Federal Laws. The video series highlights what is required by Joint Commission standards as well as Federal civil rights laws with respect to participants who are deaf/hard of hearing or limited English proficient.The video highlights what the Joint Commission standards require as well as Federal civil rights laws with respect to participants who are deaf or hard of hearing, or have limited English proficiency. A list of resources and tools that health care organizations can use to build effective language access programs accompany the video.

Accessible Web sites

http://www.section508.gov/content/training:

Designing Accessible Web Sites (4 hours Web based course) at also check out new stuff webinars from the Access Board

For webmasters in charge of developing or revising web sites and managers who oversees the web development efforts. Covers what accessibility is all about, what the standards are, and how to design for 508 compliance by exploring the Web based course "Designing Accessible Websites".

Available at: http://www.adaconferences.org/CIOC/Archives/

Topic : Accessible Electronic Documents: Section 508 Basic Testing Guide for Making an Accessible PDF (Portable Document Format)
Archive Materials :
Presentation Materials:

- Accessible Electronic Documents: Section 508 Basic Testing Guide for Making an Accessible PDF (Portable Document Format) Handout - (RTF)
- Accessible Electronic Documents: Section 508 Basic Testing Guide for Making an Accessible PDF (Portable Document Format) Handout - 2 Slides Per Page (PDF)
- Accessible Electronic Documents: Section 508 Basic Testing Guide for Making an Accessible PDF (Portable Document Format) Handout - 3 Slides Per Page (PDF)

Click on the following link to access Webinar Recording

- ARCHIVE LINK: Accessible Electronic Documents: Section 508 Basic Testing Guide for Making an Accessible PDF (Portable Document Format)

Topic : Audio Description
Most people are familiar with captioning to some extent. However, audio description is less well understood. This webinar provides the basics about audio description, a method for making video content more accessible to people who are blind or low vision.

What is audio description? How did it come about? What difference does it make to individuals with disabilities? How is it developed? What does Section 508 require? Are there other legal requirements for audio description? How are some federal agencies managing these requirements? The answers to these questions will be covered, and you will be able to have your own questions answered.

Archive Materials :

Presentation Materials:

- Audio Description Handout - (RTF)
- Audio Description Handout - 2 Slides Per Page (PDF)
- Audio Description Handout - 3 Slides Per Page (PDF)

Click on the following link to access Webinar Recording

- ARCHIVE LINK: Audio Description

Topic : Accessible Electronic Documents: Authoring Guide for Making an Accessible Document in MS Word 2010

Archive Materials :

Presentation Materials:

- Accessible Electronic Documents: Authoring Guide for Making an Accessible Document in MS Word 2010 Handout - (RTF)
- Accessible Electronic Documents: Authoring Guide for Making an Accessible Document in MS Word 2010 Handout - 2 Slides Per Page (PDF)
- Accessible Electronic Documents: Authoring Guide for Making an Accessible Document in MS Word 2010 Handout - 3 Slides Per Page (PDF)
- Accessible Electronic Documents: Authoring Guide for Making an Accessible Document in MS Word 2010 Handout - Supplemental (PDF)
- Accessible Electronic Documents: Authoring Guide for Making an Accessible Document in MS Word 2010 Handout - Supplemental (RTF)

Click on the following link to access Webinar Recording

- ARCHIVE LINK: Accessible Electronic Documents: Authoring Guide for Making an Accessible Document in MS Word 2010

Accessible Video & Multimedia (2.5 hours)

Video and multimedia products can greatly enhance training and other programs in your agency. However, without the ability to hear what is being spoken, or to hear dialogue without the necessary visual context, these products can be confusing or useless to people with disabilities. Learn how to create and evaluate video and multimedia products that are accessible to all audiences. Specifically, you'll discover the elements and steps for adding audio descriptions and captioning to any product.

Accessible Meetings, Events, and Conferences, July 2015, Digital updated version of June Isaacson Kailes and Darrel Jones' 1993 work, A Guide to Planning Accessible Meetings. The Mid-Atlantic ADA Center and TransCen Inc. sponsored

this update and publication in recognition of the 25th anniversary of the transformational Americans with Disabilities Act (ADA) of 1990. The updated version includes both regulatory updates (from the 2010 update to the Act) along with practical actionable guidance

http://www.adahospitality.org/accessible-meetings-events-conferences-guide/book

Health Literacy:

Attributes of A Health Literate Organization: https://www.jointcommission.org/assets/1/6/10attributes.pdf

National CLAS Standards: Think Cultural Health HHS Webpage & Resources
https://www.thinkculturalhealth.hhs.gov/content/clas.asp

Care Management / Care Coordination

Disability-Competent Care Self-Assessment Tool
From CMS Medicaid-Medicare Coordination Office Resources for Integrated Care Webpage
https://www.resourcesforintegratedcare.com/node/101
The purpose of the Disability-Competent Care Self-Assessment Tool is to help health plans and health systems evaluate their present ability to meet the needs of adults with functional limitations and to identify strategic opportunities for improvement. Resources for Integrated Care has worked with a variety of experts to identify promising practices to better serve these individuals with complex care needs.

Disability Competent Care Webinar Series

Leading Healthcare Practices and Training: Defining and Delivering Disability-Competent Care
https://www.resourcesforintegratedcare.com/webinar/series/leading-healthcare-practices-and-training

The CMS Medicare-Medicaid Coordination Office (CMMO) facilitated an optional webinar series for interested providers and health care professionals, front-line staff with health plans and practices, and stakeholders to introduce and explore the many uses of the Disability-Competent Care (DCC) Model. Meeting the needs of persons with disabilities is of increasing importance as individuals live longer and the prevalence of adults with functional limitations and disabilities rises. The DCC model, developed by providers serving adults with disabilities, is a resource for providers, health plans, and healthcare organizations to enhance capacity to integrate care for adults with disabilities. Webinars were tailored by audience and topic within this subject area.

1. Disability-Competent Care -- What Is It and Why Is It Important?
2. The Lived Experience of Disability
3. The Care Coordination Relationship
4. Providing Disability-Competent Primary Care
5. Managing Transitions
6. Flexible Long Term Services and Supports
7. Disability-Competent Care Planning: The Individualized Plan of Care
8. Building a Disability-Competent Provider Network
9. Preparing for New Roles & Responsibilities -- Individual and Provider Readiness

Disability-Competent Care Webinar Roundtable Series: Training in Disability-Competent Care and Supports
https://www.resourcesforintegratedcare.com/webinar-roundtable-series

1. Dignity of Risk
    1.1.1. Target audience: Individuals who work with persons with disabilities, particularly care coordinators in AAA's, disability resource centers, and demonstration health plans.
    1.1.2. Discussion regarding understanding and respecting the concept of dignity of risk and will teach the audience how to engage an individual in a discussion respecting individual choice within the context of informed risk-taking.

2. Strategies to Stimulate and Support Individual Engagement
    2.1.1. Target audience: Individuals who work with persons with disabilities, particularly consumer advocates.
    2.1.2. Discussion regarding understanding what makes for meaningful individual involvement, the benefits of individual and advocate engagement and multiple strategies for individual engagement and involvement of advisory groups.

3. Mobility and Seating Assessments, and Equipment Procurement
    3.1.1. Target audience: Individuals who work with persons with disabilities, particularly consumer advocates and DME suppliers.
    3.1.2. Discussion regarding understanding the process of assessing mobility needs of individuals, the opportunity for improved procurement process within Dual Integrated Care models, and Understanding prevention of secondary conditions as a primary goal of mobility equipment assessments

4. Using and Maintaining Mobility Equipment
    4.1.1. Target audience: Individuals who work with persons with disabilities, particularly consumer advocates, DME suppliers.
    4.1.2. Discussion regarding understanding the need for mobility training and the benefits of wheelchair maintenance

5. Meeting the Transportation Needs of Enrolled Individuals
6. Providing Home Modifications
7. Building Partnerships between Health Care (Plans & Providers) and Community-based Organizations
8. Integrating Behavioral Health Competency within Disability-Competent Teams