

Access to medical care for people with mobility disabilities

Persons with disabilities face many secondary health problems, yet they are less likely to get routine medical care than people without disabilities. In most cases, the reasons are clear: the facilities impede those with mobility disabilities. While this may be commonplace, accessibility is a legal requirement.

In 1990, Congress passed the Americans with Disabilities Act of 1990 (ADA), a law prohibiting discrimination against persons based on disability. It applies to every day activities – including medical services. Section 504 of the Rehabilitation Act of 1973 is a civil rights law that prohibits discrimination

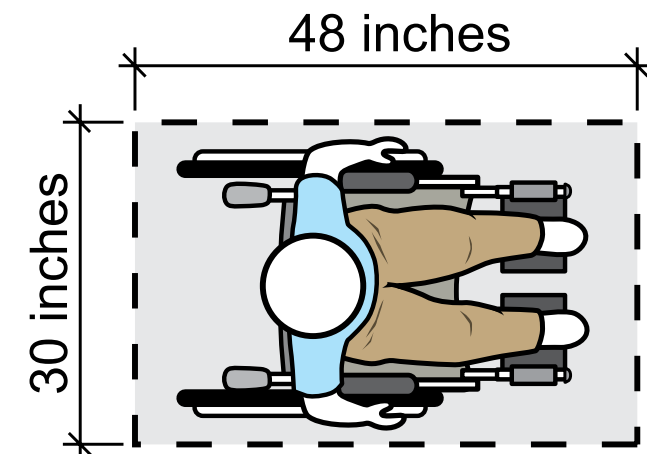
against persons with disabilities on the basis of their disability in programs and services that receive federal financial assistance.

Basically, the ADA requires providers to give persons with disabilities full and equal access to their healthcare services and facilities – in an accessible way. To achieve this, providers must make reasonable modifications to their policies, practices and procedures. The law extends to buildings and existing facilities, both of which are also subject to accessibility requirements. To help you comply, here are a few guidelines:

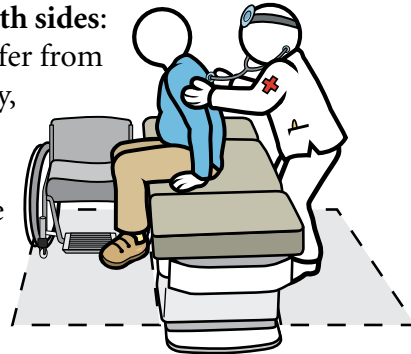
How to make your exam room accessible

With a few changes, your exam room can be accessible for people with mobility disabilities. Start with an accessible path to and through the room, allowing patients (and those who use a wheelchair) to enter the exam room, move about and use accessible equipment. Here are some more features:

- **A wide entry door:** It should offer enough clear width, maneuvering clearance and accessible hardware. Under the ADA Standards for Accessible Design, an accessible doorway must have a minimum clear opening of 32 inches when the door is opened 90 degrees.
- **Enough floor space next to exam table:** The minimum amount required is 30 by 48 inches. This allows a person using a wheelchair to approach the side and transfer onto exam table. Clear floor space is needed along (at least) one side of an adjustable height exam table.



- **Clear floor space on both sides:** Some persons can transfer from the right or left side only, so provide clear floor space on both sides. If you have more than one exam room, reverse the furniture layout.
- **Turning space:** The room should have enough turning space for a person using a wheelchair to make a 180-degree turn using a clear space of 60-inches in diameter or a 60-by-60 inch T-shape. To give enough floor space to move about, exam room chairs and other objects should be movable.
- **Exam table:** For most people with a mobility disability, a fixed-height exam table is too high. They need an adjustable-height table, allowing them to transfer from their wheelchair. Besides featuring a support rail along one side, this accessible table should lower to the height of a wheelchair seat, 17-19 inches (or lower) from the floor. It should have elements, such as rails, straps or cushions, to stabilize and support a person during transfer and while on the table.



Physician Newsletter

Flu vaccine update 2010-11

The Advisory Committee on Immunization Practices (ACIP) has issued new recommendations and changes on the use of the influenza vaccine. Here's a brief look:

1. Routine flu vaccination is recommended for all persons 6 months of age and older.
2. Children 6 months to 8 years old should receive 2 doses of a 2010-11 seasonal flu vaccine (minimum interval: 4 weeks) if they meet the following criteria:
 - Vaccine status unknown
 - Never received seasonal flu vaccine
 - Received seasonal vaccine for first time in 2009-10 but only 1 dose in first year of vaccination
 - Did not receive at least 1 dose of influenza A (H1N1) 2009 monovalent vaccine regardless of previous flu vaccine history

3. 2010-11 trivalent vaccines will contain A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like antigens.

4. For children at least 9 years old, only one dose is needed.

Vaccines for persons 65 years old and over

This year, a new vaccine (Fluzone High-Dose) has been approved for all persons 65 and over. ACIP recommends all persons 65 and over receive an inactivated 2010-11 seasonal influenza vaccination, but it has not expressed a preference for Fluzone High-Dose or any other inactivated influenza vaccine for use in persons 65 and over.

It is unknown whether the higher post-vaccination immune responses observed among Fluzone High-Dose vaccine recipients will result in greater protection against influenza. High-Dose vaccine should not be administered to persons 65 and under.

For more details, go to <http://www.cdc.gov/flu/>

IEHP Enrollment

As of September 2010

Medi-Cal.....	396,463
Healthy Families.....	57,877
Healthy Kids.....	6,402
Medicare DualChoice HMO SNP	3,894
Total.....	464,636

Questions?

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The Heartbeat

Physician Newsletter, Issue #13

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Services available for IEHP patients with a chronic illness or behavioral health issue

People with disabilities comprise 20 percent of the U.S. population. In the last 20 years, their needs have captured more attention than ever before. At IEHP, we have responded to this growing sector of our membership by crafting support programs and services aimed at helping people with a chronic illness, physical disabilities or a behavioral health issue.

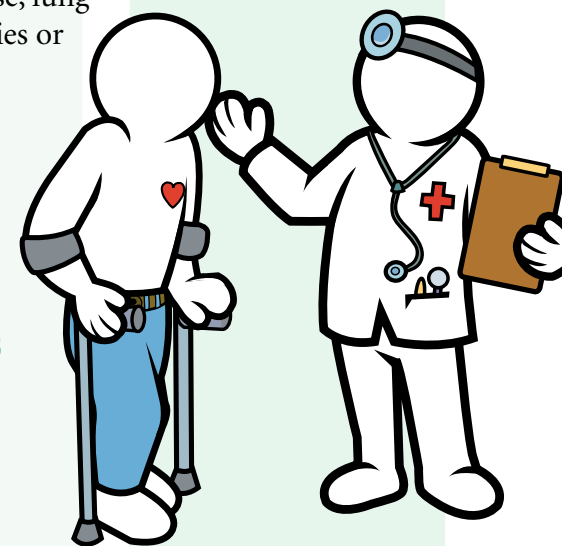
To augment the effectiveness of care you give to IEHP patients with a chronic illness – we offer you 10 support programs and services.

1 Complex Care Management

Our Care Management nurses help your IEHP patients who have heart disease, lung disease, kidney disease, spinal injuries or other chronic health illnesses. Our nurses work with you, Specialists, and your patient, helping to manage his or her health, manage medication and even assist in acquiring medical equipment.

2 Accessibility Consultations

Learn how to make your office accessible, allowing people with disabilities to use your facilities without strain. You'll also be complying with federal legal requirements.



The key ingredient in treating patients with chronic pain

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3 Wheelchair Seating Assessment

Before your IEHP patient receives a wheelchair, we can ensure the right custom fit, helping reduce strain, skin problems and other secondary health issues.

4 Prescriptions

We help your IEHP patients get their medicine, so they can stay on your treatment plan. We have over 600 pharmacies; some with home delivery; others include big retail chains like CVS.

5 Living Well with a Disability

This class is taught by people with disabilities for your IEHP patients with disabilities. The focus: patients learn how to stay healthy, be active, positive and ensure their health needs are met. Plus, the class promotes peer support, which is meaningful to people with disabilities.

6 24-Hour Audio Health Library

If your IEHP patient needs more details on a specific health topic, point to our Audio Library, complete with hundreds of plain language health messages from medical experts.

1-888-222-2708.

7 24-Hour Nurse Advice Line

When your IEHP patients are unable to reach you during after-hours, our nurse will be there, giving help and advice until they can see you.

1-888-244-4347 or

1-888-880-0833 for TTY users.

8 Free Interpreter Service

We offer an interpreter for spoken or sign language – at no cost to you or your IEHP patients. Your patients just need to call five days before the scheduled appointment.

9 Wellness Programs

They support your treatment plan, teaching IEHP patients how to better care for their health. Topics: High Blood Pressure, Diabetes, Asthma, Healthy Heart and more. To refer a member, go to www.iehp.org.

10 Behavioral Health Program

Our in-house program integrates the Behavioral Health Specialist into the IEHP health care team, covering all aspects of behavioral health, from depression to substance abuse. This program is for IEHP Members enrolled in Healthy Families, Healthy Kids or IEHP Medicare DualChoice (HMO SNP).



A healthy look at change



Dr. William Henning
Chief Medical Officer

They say change is not merely necessary to life – it is life. These words of wisdom come into play in the midst of the biggest change in healthcare since Lyndon B. Johnson was President.

The reality is this change means more attention, and rightfully so, given to both people with a disability and people with a chronic illness. Both of these groups

require special services and support systems all based on a patient's needs, which change over time. If you are treating an IEHP patient with a disability or a chronic illness, I encourage you to call us or visit our Provider website at www.iehp.org.

Discover all of our programs and services designed to assist you in extending the right care – and the best care. This level of support is what you can expect and is what we will deliver. And on behalf of all of us here at Inland Empire Health Plan, we appreciate your support.

Treating pain calls for a dose of compassion

Facing one of the most serious problems in modern medicine, physicians are torn between the right approach to treat patients with chronic pain.

With a slew of new, powerful pain medications on the market, some physicians prescribe them with confidence; others move cautiously amid an anti-drug climate. Of particular concern among physicians is a patient's dependence on opioids.

To treat chronic pain, we believe a good plan starts with compassion, relying on the basic diagnostic and therapeutic techniques we use each day. After diagnosis, we espouse a multimodality, multidisciplinary approach, complete with non-pharmacologic methods, such as physical therapy.

In addition, seek out disease-specific specialists, psychiatrists and pain-management specialists. In severe cases – and for chronic, non-malignant pain – opioid analgesics may be needed.

However – before prescribing opioids, encourage your patient to sign an “Agreement” document, highlighting the responsibilities on both the patient and the physician. For example, it may read something like this:

Patient agrees to...

- Get medication from one source only
- Take responsibility for their treatment
- The understanding that “lost” or “stolen” prescriptions are rarely replaced

Physician is committed to...

- Providing effective treatment and careful ongoing reassessments

Most patients embrace this approach to managing pain. At the same time, it helps you spot red flags that lead to abuse, such as insisting on brand names or early requests for refills. If you suspect substance abuse, these patients deserve care and respect, just as other patients. In many cases, psychiatric evaluation is needed, given the high prevalence of mental disorders in these patients.

Treating patients with chronic pain can be a challenge, but the right approach can make it a fulfilling one.

Excerpts from *Cortlandt Forum*, editorial by Patrick G. O'Conner, MD, MPH (2003)

When a patient has TB

One of the most dreaded diseases of the 19th century is making a comeback among vulnerable populations of any age group. It's TB. If one of your IEHP patients has been exposed to a person with active, infectious pulmonary tuberculosis, coordinate all your actions with the Centers for Disease Control and Prevention (CDC), using their latest guidelines.

The CDC recommends that you conduct an evaluation, including a tuberculin skin test and symptom review. Here's an overview on IEHP guidelines for tuberculosis services:

Policy: PCPs must perform a skin test. Initial diagnostic work-up should be done based on CDC guidelines. PCPs and IPAs must refer confirmed highly suspected active TB cases to Local Health Departments (LHD).

Screening procedures: For all new IEHP patients, a risk assessment for developing TB must be performed within 120 days of enrollment into IEHP. For patients 0-21 years old, perform a skin test based on American Academy of Pediatrics (AAP) guidelines.

Tests: Use the Mantoux test. Trained staff must read and record results (in millimeters). Patients who test positive yet lack evidence of active TB must be evaluated for TB preventive therapy and treated.

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Q&A – Accessibility

For making accessibility changes to my medical office, are there tax breaks?

Yes. Federal tax credits and deduction are available (subject to IRS rules) to private businesses to offset expenses incurred to comply with the ADA. For details, go to the IEHP Provider website at www.iehp.org.

If a patient who uses a wheelchair is unable to get on the exam table without help, can he or she remain in their wheelchair during my exam?

Yes – if the exam does not require the patient to lie down. However, examining a patient in their chair is less thorough. To pursue equal medical treatment, we suggest using a table that adjusts down to the level of a wheelchair, approximately 17-19 inches from the floor.

Diagnosis of active TB: Initiate the diagnostic work-up for members suspected of having active TB.

Symptoms: Potential TB cases can include Purified Protein Derivative positive persons (unless infected with HIV). TB signs can include:

- Abnormal chest x-ray not typical for pneumonia, notably upper lobe disease
- Bronchitis or pneumonia unresponsive to antibiotics
- Persistent, explained constitutional symptoms such as weight loss, fever, night sweats; Hemoptysis or persistent productive cough not due to asthma, bronchitis or pneumonia

Diagnostic evaluation – for potential active TB. Per the CDC, perform a chest x-ray (include lordotic views). Other methods: Sputum smear or culture for mycobacteria; bronchoscopy with biopsy, washings, smear and/or culture; chest CT scan and lymph node biopsy if you suspect cervical TB lymphadenitis.

Case Management: Inform your IPA Case Management (CM) staff of all members referred to the LHD TB program. For all suspected and active TB cases, we provide monitoring and direction to IPA CM, even assisting with the notification process.

Direct Observed Therapy (DOT): Both IEHP and the LHD provide care and treatment – and DOT if needed. Inform the LHD on changes in the patient's condition or response to medical treatment.

Reporting: You are required to comply with State laws and regulations pertaining to reporting confirmed and suspected TB cases to LHD within one day, as per CCR Title 17, Section 2500.

After Evaluation: On the same day, report persons suspected of having active tuberculosis to the LHD in the county where the IEHP patient resides: • *Riverside* (951) 358-5042 • *San Bernardino* (909) 383-3287.

Testing, treatment recommendations for persons exposed to active TB disease

Patient	Risk	Initial TST	More Exams	If initial and repeat TST is negative (-)	If initial or repeat TST is positive (+)
Children under 5 years old	Able to progress rapidly from primary infection to disseminated disease, including meningitis.	Place a Mantoux method tuberculin skin test (TST) and read in 48-72 hours.	Regardless of TST results, evaluate child with clinical and CXR exams.	If active disease has been ruled out and TST, by the Mantoux method, is 0-4mm: • Start treatment for presumptive LTBI immediately. • Repeat TST 8-10 weeks after contact with the infectious patient has ended. • If the repeat TST remains 0-4 mm, discontinue treatment 1.	If initial or repeat TST is 5 mm or greater and active disease has been ruled out: • Initiate or continue LTBI treatment. • If using Isoniazid (INH), the recommended treatment course is 9 months.
Immunocompromised Person • HIV-positive persons • Patients receiving immunosuppressive therapy (e.g. chemotherapy, anti-TNF, organ transplant recipient, equiv. to 15mg/day of prednisone for 1 month)	Able to rapidly progress from primary infection to disseminated disease. May be unable to develop a positive TST reaction even if infected.	Place a Mantoux method TST and read in 48-72 hours.	Regardless of TST results, evaluate patient with clinical and CXR exams.	If active disease has been ruled out and the TST, by the Mantoux method, is 0-4mm: • Start treatment for presumptive LTBI. • Repeat TST 8-10 weeks after contact with the infectious patient has ended. • If repeat TST remains 0-4 mm, re-evaluate continuation of therapy in consideration of patient's level of exposure, current immune status, and final results of suspected source case's evaluation.	If initial or repeat TST is 5 mm or greater and active disease has been ruled out: • Initiate or continue LTBI treatment • If using INH, recommended treatment course is 9 months.
All Other Persons	Risk of progressing from TB infection to TB disease is high within the first two years after becoming infected.	Place a Mantoux method TST and read in 48-72 hours.	Regardless of TST results, evaluate the patient for any signs or symptoms of TB disease.	If patient has no signs or symptoms of active TB disease and TST, by Mantoux method, is 0-4 mm: • Treatment for presumptive LTBI need not be started. • Repeat TST 8-10 weeks after contact with the infectious patient has ended. • If repeat TST remains 0-4 mm, no further action is needed.	If initial or repeat TST is 5 mm or greater and active disease has been ruled out: • Evaluate person for LTBI treatment • Must have a CXR prior to LTBI treatment. • If using Isoniazid (INH), the recommended treatment course is 9 months.
A person with a documented positive TST prior to current exposure	Reinfection is possible, but limited risk in immunocompetent contacts.	Obtain verification of the past positive skin test.	Obtain CXR to rule out current disease.	Note: Patient may be a candidate for treatment of LTBI based on pre-existing TB infection, unrelated to recent exposure.	