Christopher & Dana Reeve Foundation

Accessible Healthcare Position Paper

Introduction

It has now been 30 years since the passage of the Americans with Disabilities Act and nearly 50 years since the passage of the Section 504 of the Rehabilitation Act of 1973, both, in their respective time, landmark civil rights legislation for persons with disabilities – one promising full inclusion into every aspect of society for persons with disabilities, and the other prohibiting disability-based discrimination by those receiving federal financial assistance. While significant progress has been made to integrate persons with disabilities into every aspect of society, there is one segment where persons with disabilities still struggle for acceptance and inclusion, and that struggle puts their health and well-being at risk.

In *Healthy People 2020*, setting decennial national health priorities for 2010 to 2020, the United States Department of Health and Human Services documented that people with disabilities were more likely than those without disabilities to experience difficulties or delays in getting healthcare they need, not have had a mammogram in the past 2 years, not have had a Pap test within the past 3 years, not have had an annual dental visit, not engage in fitness activities, use tobacco, be overweight or obese, have high blood pressure, and experience symptoms of psychological distress.[1] An April 2018 paper published by the *National Academies of Sciences, Engineering, Medicine, Compounded Disparities: Health Equity at the Intersection of*

[1] *Healthy People 2020: disability and health*. Washington, DC: Office of Disease Prevention and Health Promotion. Available at: http://www.healthypeople.gov/2020/topics-objectives/ topic/disability-and-health.

Disability, Race, and Ethnicity,[2] highlights that people with disabilities have much poorer preventable health outcomes. Specifically, obesity rates are 58% and 38% higher among adults and youth with disabilities than their nondisabled peers; the annual number of new cases of diabetes is almost three times as high among adults with disabilities relative to adults without disabilities (19.1 per 1,000 vs 6.8 per 1,000); disability status is a high risk factor for early onset cardiovascular disease (rates of 12% vs 3.4% among 18 to 44 year old's with and without disabilities); adults with disabilities are much more likely to experience cardiovascular disease during young adulthood as well as older years.[3] A May 2020 study published in the *Disability and Health Journal*, found that although colorectal cancer is the second leading cause of cancer-related mortality, screenings do not meet the recommended rates or frequency, and that is particularly true of persons with spinal cord injuries.[4] Citing previous studies that found that persons with spinal cord injuries may actually be at an increased risk for colorectal cancer – due to behavioral and lifestyle risk factors, such as obesity and physical inactivity; the use of laxatives and insufficient sensation in the abdomen; heightened risk of neurogenic bowel and other colorectal disorders, such as irritable bowel syndrome, which have been linked to an increased risk of colorectal cancer[5] – the inaccessibility of primary care doctors' offices, among other things

[2]Yee, Breslin, yeah *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity,* National Academies of Sciences, Engineering, Medicine, published April 13, 2018 http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities.aspx. Citing Centers for Disease Control and Prevention. *Disability and Obesity.* http://www.cdc.gov/ncbddd/disabilityandhealth/obesity.html. Accessed February 13, 2021; Krahn GL., *et al., Persons with disabilities as an unrecognized health disparity population*. Am J Public Health. 2015; 105:S198-206. doi:10.2105/AJPH.2014.302182.

[3] *Id.*

[4] Solenberg AK Jr., Hall JP, Brooks JV, *Barriers to Colorectal Cancer Screening for People with Spinal Cord Injuries and/or Disorders: A Qualitative Study,* Disability and Health Journal, https://doi.org/10.1016/j.dhjo.2020.100950.

[5] *Id.*, citing Weaver FM, *et al*., *Preventive care in spinal cord injuries and disorders: examples of*

– were identified as barriers to integrating colorectal cancer preventive screening into the care of persons with spinal cord injuries.[6] The study noted inadequate examination tables, the absence of transfer equipment, and persons having to remain in their wheelchairs during examinations as common factors noted in primary care physician offices.[7]

Despite the decades-long existence of federal nondiscrimination mandates, persons with disabilities, in general, and persons with paralysis and mobility disabilities, specifically, confront accessibility barriers daily at hospitals, doctors' offices, dental clinics, eye care clinics, behavioral health facilities and at other facilities where medical, dental, eye care, mental health and other health related services are provided. Barriers in the form of inaccessible examination rooms, insufficient space inside examination rooms for a person with a mobility device to independently maneuver without causing injury to themselves or damage to their mobility device, the absence of lift and transfer equipment, the absence of wheelchair accessible weight scales, and the absence of height adjustable examination tables and accessible diagnostic equipment.

Persons with disabilities utilize the healthcare system for disease management versus disease prevention, its intended purpose. That is explained in part by the fact that people with

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research and implementation. Physical medicine and rehabilitation clinics of North America. 2007;18(2):297-316; Lynch A, *et al*., *Bowel dysfunction following spinal cord injury: a description of bowel function in a spinal cord-injured population and comparison with age and gender matched controls.* Spinal Cord. 2000;38(12):717; Sanovic S, *et al*., *Damage to the enteric nervous system in experimental colitis.* The American journal of pathology. 1999;155(4):1051-1057; and Sharkey KA, *et al*., *Consequences of intestinal inflammation on the enteric nervous system: neuronal activation induced by inflammatory mediator*s. The Anatomical Record: An Official Publication of the American Association of Anatomists. 2001;262(1):79-90.

[6] Id. citing Stillman MD, *et al*., *Health care utilization and barriers experienced by individuals with spinal cord injury*. Archives of physical medicine and rehabilitation. 2014;95(6):1114-1126(finding 76.9% of people with spinal cord injuries were seen in offices with inadequate examination tables, 69.4% of offices did not have transfer equipment, and 85.2% of their study sample remained in their wheelchair during examinations).

[7] *Id.*

disabilities tend to avoid places that are not welcoming. And thus, we generally only seek medical attention when we absolutely need it. And we don't seek dental care unless we absolutely must have it.

The purpose of this position paper is to articulate The Christopher & Dana Reeve Foundation's (CDRF) statement on the critical importance of Accessible Healthcare to its members. As we continue our unwavering commitment to Tomorrow's Cure®, Today's Care® requires that we address the decades long struggles of persons with paralysis and other mobility disabilities in attempting to obtain basic healthcare and other health related services.

This Position Paper is organized as follows:

6	COVID-19 Lessons Learned and Moving Forward *A. Disproportionate Effect Upon Persons with Disabilities* *B. Hospital Visitor Policies* *C. Medical Scarce Resource Rationing Policies* *D. Telemedicine as an Alternative to In-Person Visits* *E. COVID – 19 Screening Guidelines* *F. De-prioritization in Vaccination*	