Section 4. How Healthcare Providers Can Achieve Accessible Healthcare

According to the Centers for Disease Control and Prevention, approximately 26% of adults over the age of 18 – that is just over one out of every four persons – in the United States reported having a disability, with 12.4% reporting having a mobility disability.[1] Adults with physical disabilities, compared with adults without, reported being less healthy and having more chronic conditions, including diabetes, asthma and high blood pressure, and were significantly more likely to report unmet medical care, dental care or access to prescription drugs than those without physical disabilities.[2]

Persons with paralysis and mobility disabilities confront physical barriers that prevent them from receiving the same quality of care as provided to persons without physical disabilities. A 2017 survey of 432 wheelchair users revealed that while almost all, 97.2%, had a primary care appointment within the past year, most, 73.8%, encountered physical barriers while there.[3] During those primary care visits most participants, 76.1%, remained clothed for their primary care visits, and 69.7% were examined while the remain seated in their wheelchair.[4] More than half of the participants, 54.1%, felt they received incomplete care and 57% believed their physicians had no more than a moderate understanding of their disability specific medical concerns.[5] Physical barriers include inadequate disability parking, lack of

[1] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data [online]. [accessed Nov 7, 2020]. URL: https://dhds.cdc.gov

[2] E. Mahmoudi, PhD., et al, Disparities in access to healthcare among adults with physical disabilities: Analysis of a representative national sample for a 10-year period. Disability and Health Journal 8 (2015) 182 – 190.

[3] Stillman MD, Betocci G, Smalley C, Williams S, Frost KL. Healthcare utilization and associated barriers experienced by wheelchair users: a pilot study. Disabil Health J. 2017 Oct;10(4):502-508.

[4] *Id.*

[5] *Id*.

ramps, narrow doorways, lack of elevators, cramped waiting rooms, examination rooms that are too small to maneuver a wheelchair safely, examination tables that are not height adjustable, inaccessible diagnostic equipment, weight scales that cannot accommodate a wheelchair and inaccessible restrooms. All of those barriers have been identified as a significant reason why persons with physical disabilities utilize the healthcare system for disease management versus disease prevention.[6] To address these issues, healthcare providers should:

A. Understand their Federal Nondiscrimination Legal Mandates

Providers and their staff need to understand they are legally required under the ADA and Section 504 to provide accessible healthcare for persons across all categories of disabilities. As it pertains to persons with paralysis and mobility disabilities, that means:

- Understanding the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 are federal civil rights legislation that protect individuals with disabilities, including those with paralysis and mobility disabilities, against discrimination in their receipt of medical services, among other activities.

- Providers have a legal obligation under the ADA and Section 504 to make their healthcare services and facilities available in an accessible manner to persons with paralysis and mobility disabilities.

- Providers must make reasonable modifications to policies, practices and procedures when necessary to make their healthcare services available to persons with paralysis and mobility disabilities, unless the modification would fundamentally alter the nature of their services.

- Such policy modifications may include, among other things, for example: requiring staff to inquire during their first encounter with a patient whether the patient has

[6] *See,* Mele N, *et al. Access to breast cancer screening services for women with disabilities*. J Obstet Gynecol Neonatal Nurs. 2005;34(4):453e464; Scheer J, *et al., Access barriers for persons with disabilities*. J Disabil Policy Stud. 2003;13(4):221e230; Kroll T, *et al., Barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities: a qualitative inquiry.* Health Soc Care Community. 2006;14(4):284e293; and Harrington AL, *et al., Assessment of primary care services and perceived barriers to care in persons with disabilities*. Am J Phys Med Rehabil. 2009;88(10):852e863.

a disability and inquiring what assistance they may require at their appointment; allowing for additional time for appointments to account for the extra time that may be needed by persons with paralysis and mobility disabilities to complete admission paperwork, to change into medical gowns, to transfer onto examination tables or chairs, or to ask and have questions answered; ensuring the availability of at least one examination and treatment room in a medical office is, and at least 10% of examination and treatment rooms in each clinical department not specializing in treatment of mobility related conditions are, and 100% of examination and treatment rooms in each clinical department specializing in treatment of mobility related conditions of a healthcare facility are, large enough to accommodate a person utilizing a mobility device with adequate clear floor space inside the room for side transfers and the use of lift equipment; ensuring an accessible route to and through accessible examination and treatment rooms; and ensuring an entry door with adequate clear with, new maneuvering clearance and accessible hardware.

- Conduct a survey to determine areas not in compliance with the ADA standards and then develop a definitive plan to remove physical barriers that are readily achievable (*i.e.*, easily accomplishable without too much difficulty or too much expense). The New England ADA Center, Institute for Human Center Design and the ADA National Network have developed a comprehensive checklist for existing facilities that is a very good resource for providers to use to conduct initial assessment of their facilities. The checklist – ADA Checklist for Existing Facilities – is available at https://www.adachecklist.org/doc/fullchecklist/ada-checklist.pdf, covers priority areas from parking facilities; exterior accessible routes; curb ramps; ramps; entrance; interior accessible routes; interior ramps; elevators; platform lifts; signage; interior doors; rooms and spaces; controls, light switches, intercom systems, etc.; reception area; dressing room; service counters; restrooms; drinking fountain; among other elements.

- Providers must understand that it is discriminatory to examine persons with paralysis and mobility disabilities while they remain in their mobility devices for examinations and treatments that would require a patient without a disability to be examined on an examination table or in an examination chair. Conversely, persons with paralysis and mobility disabilities should only be examined while they remain in their mobility devices when it is clinically appropriate to do so.

B. Appoint a Disability Access Coordinator

While required for healthcare facilities owned by public entities employing 50 or more persons under Title II of the ADA[7] and by healthcare providers and facilities that receive federal financial assistance who employ 15 or more persons under Section 504 of the Rehabilitation Act of 1973,[8] it is critically important that all healthcare providers appoint at least one person to be responsible to ensure compliance with their legal obligations to provide accessible healthcare.

Depending upon the size of a healthcare facility, the Disability Access Coordinator position should be a full-time position that serves as a highly skilled resource for healthcare facilities to ensure their compliance with the minimum requirements of their federal nondiscrimination mandates. The Disability Access Coordinator should: have the responsibility of educating the healthcare provider's applicable staff on the requirements of their federal nondiscrimination mandates; be the single point of contact for patients and their family members to inquire about accessibility features and offerings at the healthcare facility; be the person to investigate and respond to complaints about the lack of accessibility; serve as a liaison between the healthcare facility and the disability community in its service area; and ensure the availability of accessible medical and diagnostic equipment, including the availability of lift and transfer equipment and for training applicable staff on its proper use.

[7] 28 C.F.R. § 35.107.
[8] 45 C.F.R. §84.7

C. Follow the Department of Justice and Department of Health and Human Services Guidance on Access to Medical Care for Individuals with Mobility Disabilities

Originally issued on July 22, 2010, and last updated on February 28, 2020, the Department of Justice and Department of Health and Human Services published a comprehensive guide for healthcare providers to assist them in enhancing access to medical care for individuals with mobility disabilities. The guide, *Americans with Disabilities Act, Access to Medical Care for Individuals with Mobility Disabilities* (Access to Medical Care for Individuals with Mobility Disabilities (ada.gov)), provides an overview and a summary of the general requirements under the ADA to provide accessible healthcare for persons with mobility disabilities. It also includes commonly asked questions and responses, specific requirements of an accessible examination room, complete with specific measurements required by the applicable ADA Standards; and a detailed section regarding the importance of accessible medical equipment, providing examples of such equipment, how it is used and the benefits of having the equipment available.

D. Voluntarily Acquire Height Adjustable Examination Tables, Lift and Transfer Equipment, Wheelchair Accessible Weight Scales

Providers should not wait until the Department of Justice or the Department of Health and Human Services adopt the US Access Board's standards for accessible medical and diagnostic equipment. The availability of such equipment is often the difference between a thorough examination and not, a welcoming physician – patient encounter and not, and a safe physician – patient encounter and not.

Section 5. How Healthcare Providers Can Achieve Accessible Healthcare

Examination tables are used for a wide range of purposes, to perform routine care such as routine physical examinations for men and women, pelvic exams for adult or sexually active women, and prostate exams for men.[9] Standard, nonadjustable examination tables – those that cannot lower to 17 – 19 inches above the finished floor – are typically too high for safe transfer from a wheelchair to the table surface. In addition, tables that lacks some form of stabilization or support, such as rails, straps, boasters or footrests, as appropriate, make it difficult for some patients to stay safely and comfortable on the table surface. When the patient cannot safely get or stay on an examination table, a physician cannot perform an appropriate or thorough examination.[10] Companies such as Medical Accessibility, LLC in Arizona, Hausmann Industries in New Jersey and Midmark Corporation in Ohio all manufacture and sell height adjustable accessible exam tables.

Capturing accurate weight measurement is critical and the inability to obtain accurate weight measurements for persons with paralysis and mobility disabilities who cannot stand on a traditional upright weight scale compromises the quality of care they receive and can place their health and welfare in serious risk. [11] According to the National Institutes of Health, height and weight should be measured at every examination.[12] A number of conditions and diseases such as high blood pressure, diabetes, cardiovascular disease, cancer, reproductive and hormonal problems are linked to weight gain and obesity.[13] Moreover, conversely, conditions

[9] *See* Pendo, E., *Reducing Disparities Through Health Care reform: Disability and Accessible Medical Equipment*, 2010 Utah L. Rev. 1057 (2010)
[10] *Id.*
[11] Pharr, J. et al., Accessibility and accommodations for patients with mobility disabilities in a large healthcare system: How are we doing? Disability and Health Journal 12 (2019) 679-684, March 21, 2019
[12] See Pendo, E. Health Care Reform and Medical Equipment, 2010 Utah L. Rev. 1057, 1063 (2010)
[13] *Id.*

like depression, infection and cancer can be detected by weight loss.[14] Accurate weight measurement is also critically important for prenatal care.[15]

The availability of a wheelchair accessible weight scale is an important part of a providers' obligation to provide accessible healthcare for persons with paralysis and mobility disabilities. The failure to capture accurate weight measurements for persons with paralysis and mobility disabilities, when it is clinically necessary or appropriate, is discriminatory as it denies persons with paralysis and mobility disabilities healthcare services that are not equal to those afforded persons without disabilities whose weights are captured when clinically necessary or appropriate.

As discussed herein, the availability of lift and transfer equipment is a vital part of providers' obligations to provide accessible healthcare. Lift and transfer equipment facilitate the transfer of persons from their mobility devices onto examination tables, examination chairs and diagnostic equipment. The requirement for persons to remain in their wheelchairs for the absence of lift and transfer equipment often results in incomplete or less thorough examinations, which also denies persons with paralysis and mobility disabilities the equal opportunity to obtain a healthcare provider's services as compared to those who are not disabled and are examined on examination tables and chairs when clinically appropriate.

[14] *Id.*
[15] *Id.*

E. Adopt Safe Patient Handling Policies and Procedures

When a person with paralysis or mobility disabilities cannot independently transfer from their mobility device onto an examination table or an examination chair, they are examined while they remain in their mobility devices and receive less than thorough examinations than they would otherwise if examined on an examination table or an examination chair. Eleven states have enacted Safe Patient Handling legislation. Texas was the first state to do so in 2005. Since then, California, Hawaii, Illinois, Maryland, Minnesota, New York, New Jersey, Ohio, Rhode Island and Washington have all enacted safe patient handling laws. Safe Patient Handling laws came into being in an effort to address and mitigate the most common cause of injuries – back injuries – to nurses and other healthcare workers. Persons with paralysis and mobility disabilities were the secondary beneficiaries of such legislation. While the requirements of those laws vary from jurisdiction to jurisdiction, common requirements include:

- the designation of one or more persons trained on the techniques of safe patient handling and safe patient transfers;
- the availability of an array of lift and transfer equipment at a healthcare facility, to include transfer boards, lift equipment such as Hoyer Lifts or other mechanical lift equipment; and
- trained lift teams who are specifically trained on how to properly and safely physically lift persons from their mobility devices onto examination tables, examination chairs and other surfaces.

In those 11 states that have enacted Safe Patient Handling laws, the vast majority apply to hospitals, nursing homes and other long-term care facilities, but do not – mainly because of lobbying efforts – extend to doctors' offices.

Regardless of which jurisdiction a healthcare provider is located, all healthcare providers should voluntarily adopt safe patient handling policies and procedures not only to reduce the prevalence of back injuries to their workforce, but also to ensure the safety, and to enhance the ability, of persons with paralysis and mobility disabilities to receive thorough examinations and treatment through a safe transfer from their mobility devices onto examination and treatment tables and chairs, as well as onto, diagnostic equipment when it is clinically appropriate. Such policies and procedures should include provisions respecting the rights of patients with paralysis or mobility disabilities to determine whether they will transfer from their mobility devices, the manner in which the transfer will occur, and informing those patients of their rights to refuse to be transferred or to request to be transferred safely.

F. Utilize Disability Etiquette

Communication is of critical importance in a patient - provider relationship. Effective communication is linked to many positive medical outcomes, like patient adherence to treatment, control of symptoms, control of pain and patient satisfaction. Effective communication is bidirectional - patients need to be able to convey information about their health complaints and health concerns, and healthcare workers must be able to adequately understand and interpret that information in order to treat health concerns appropriately.[16]

Far too often healthcare professionals do not know how to interact and communicate with persons with disabilities, generally, and persons with paralysis or mobility disabilities,

[16] *See* Ratna H., *The importance of effective communication healthcare practice*. Harvard Public Health Review. 2019; 23. Available at: http://harvardpublichealthreview.org/healthcommunication/

specifically. They tend to see the mobility device before recognizing the individual and if the person is accompanied by someone who is not disabled, the conversation tends to be directed to the nondisabled companion. Healthcare providers should understand the basic disability etiquette involves treating people with disabilities with respect.[17]

The United Spinal Association has developed a *Disability Etiquette* guide that is instructional to all persons, which healthcare providers may find helpful.[18] With respect to speaking with someone with a disability, the guide advises that persons think before they speak, don't make assumptions, and respond graciously to requests for accommodations. The Texas Department of Aging and Disability Services has developed the Best Practice Guidelines: Disability Etiquette, which is helpful to all, including healthcare professionals.[19] Its guidance includes:

- never assume you know what a person with a disability wants or needs
- if offering assistance, always wait for a response and then follow the individual's instructions
- when talking to a person with a disability, talk directly to that individual, not the friend, the companion or sign language interpreter with them
- respect all assistive devices (*i.e.,* canes, wheelchairs, crutches, communication boards) as personal property. Unless given permission, do not move, play with them or use them
- remember that people with disabilities are interested in same topics of conversations as individuals without disabilities

[17] *See,* in general, National Disability Navigator, Resource Collaborative "*What is Disability Etiquette?*" Available at*:* https://nationaldisabilitynavigator.org/ndnrc-materials/disability-guide/what-is-disability-etiquette/
[18] United Spinal Association, *Disability Etiquette, Tips on Interacting with People with Disabilities*. Available at: https://www.unitedspinal.org/pdf/DisabilityEtiquette.pdf
[19] Texas Department of Aging and Disability Services, *Best Practice Guidelines: Disability Etiquette*. Available at: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/QMP/disability-etiquette.pdf

- when introduced to a person with a disability, it is appropriate to offer to shake hands, people with limited hand use or who wear artificial limbs can usually shake hands. (Shaking hands with your left hand is an acceptable greeting.)

- if talking with a person using a wheelchair for any length of time, try to place yourself at their eye level. (This is to avoid stiff necks and "talking down" to the individual.)

- remember to show your face while talking with someone who is deaf or hard of hearing

- do not shout or raise your voice unless asked to do so

- if greeting someone who is blind or has a visual impairment, identify yourself and those who may be accompanying you

- do not pet or make a service dog the focus of conversation

- let the individual know if you move or need to end the conversation

- when interacting with a person who is visually impaired, follow their lead. If they need assistance, they will ask

- allow the person to negotiate their surroundings, e.g., finding the door handle, locating a chair, etc.

- treat adults as adults. Address people with disabilities by their first name only when extending the same familiarity to all others.

G. Incorporate Nondiscrimination Compliance under the ADA and Section 504 into Healthcare Providers' Compliance Program

Healthcare providers have a myriad of regulatory compliance obligations under applicable federal and state law, among them, compliance with fraud waste and abuse, the Anti-Kickback Statute, the physician self-referral law, the Emergency Medical Treatment and Labor Act, Clinical Laboratory Improvement Amendments, labor laws, among others. Compliance efforts are designed to establish a culture within a healthcare provider's organization that promotes prevention, detection and resolution of the instances of conduct that do not conform to

applicable federal and state law, federal state and private payer healthcare program requirements, in addition to a healthcare providers' ethical and business policies. A compliance program should effectively articulate and demonstrate the organizations commitment to the compliance process.

Compliance with federal nondiscrimination mandates under the ADA and Section 504 should be included as part of a healthcare provider's compliance obligations and compliance plans. Foremost, formal inclusion of disability nondiscrimination obligations into a healthcare providers compliance plan articulates – to its employees and the community at large – the organization's commitment to providing its services and ensuring that its facilities are accessible to persons across all categories of disabilities.

H. Create a Disability Advisory Board or Committee

Healthcare systems, hospitals and large practice groups should establish a disability advisory board or disability advisory committee consisting of persons across all categories of disabilities from the community that the healthcare system, hospital or practice group serves. The purpose of the advisory board or advisory committee is to serve as a resource on matters relating to accessibility for the healthcare system, hospital or large practice group, and to advise their administration on healthcare and wellness services and initiatives from the disability community's perspective. Involvement of the disability community can help improve the healthcare services provided to the community and thereby improve the health of the community.

Section 5. How Healthcare Providers Can Achieve Accessible Healthcare

I. Prominently Post Accessibility Information on Your Website

Healthcare providers, regardless of size, should post, prominently, accessibility information on their websites. Accessibility information should, at a minimum, include:

- the name and contact information for the Disability Access Coordinator
- identification of accessible parking and entrances
- a summary of the accessible features of the healthcare facility; and
- a list of accessible policies adopted by the healthcare facility, together with a link for persons to review those policies.

By prominently posting such information on its website, a healthcare provider signals to the disability community that it serves that it is disability conscious and is welcoming to the community.