MODERNIZING HEALTH CARE TO IMPROVE PHYSICAL ACCESSIBILITY

A PRIMER FOR PROVIDERS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ABOUT THIS PRIMER

The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) developed this primer to support clinical and non-clinical staff in health care settings as they collaborate to improve quality, satisfaction, and physical accessibility for people with disabilities. Physical accessibility refers to factors in the physical environment affecting access to care for individuals with disabilities. This primer offers strategies and resources to remove barriers and deliver high-quality, patient-centered care. While there are many other barriers to care for individuals with disabilities, including attitudinal bias and communication, technology, and programmatic barriers, this primer focuses primarily on addressing physical or structural barriers to health care, such as a lack of a wheelchair-accessible scale or examination table. While this primer does include some content specifically focused on individuals who are blind or have low vision and for individuals who are deaf or hard of hearing, it is intended to focus most on issues related to physical accessibility and the environment, rather than barriers to communication. CMS OMH has developed additional resources related to improving communication, which are available on the CMS OMH website.

ALSO FROM THE CMS OFFICE OF MINORITY HEALTH

The CMS Office of Minority Health provides health equity technical assistance to organizations working to achieve health equity. For help increasing accessibility, visit go.cms.gov/OMH or contact the Health Equity Technical Assistance Program at HealthEquityTA@cms.hhs.gov.

Other resources available on the CMS OMH website include:

- Modernizing Health Care to Improve Physical Accessibility: A Medicare Learning Network web-based training
- Modernizing Health Care to Improve Physical Accessibility: Resources Inventory
- Getting the Care You Need: A Guide for People with Disabilities
- Navigating Health Care with a Disability: Our Stories video vignettes
- Improving Communication Access for Individuals Who Are Blind or Have Low Vision
- Improving Communication Access for Individuals Who Are Deaf or Hard of Hearing

KEY FEATURES OF THIS PRIMER

This primer contains a variety of elements designed to enhance the learning experience, including hyperlinks, resources, exhibits, examples, key terms, and action steps.

In providing the information and resources herein, CMS does not intend to provide legal advice or to take a position on whether and to what extent Federal, state, or local law requires health care facilities and providers to undertake the measures discussed.

INTRODUCTION

Many Americans today live with a disability—whether congenital (existing at birth) or acquired during the course of life. In fact, approximately 25 percent of U.S. adults have at least one disability.[1] There are many definitions of disability. For example, the Americans with Disabilities Act (ADA) defines a person with a disability as someone who:

• Has a physical or mental impairment that substantially limits one or more major life activities, such as walking, hearing, seeing*
• Has a record (or past history) of having such an impairment
• Is regarded as having such an impairment.[2]

Alternatively, the Social Security Administration defines disability as not being able to engage in any substantial gainful activity because of a medically-determinable physical or mental impairment(s) that 1) is expected to result in death, or 2) has lasted or is expected to last for a continuous period of at least 12 months.[3]

Disability types can be categorized by either clinical diagnosis (focusing on the cause or source of the disability) or by functional status (the impact of the disability on the individual). For example, clinical categories of disability may include:

• Physical disabilities, such as lost limbs or spinal cord injuries.
• Sensory disabilities, such as deafness or blindness.
• Intellectual or developmental disabilities (ID/DD), such as autism or cerebral palsy.

Alternatively, examples of disabilities categorized by functional status may include:

• Mobility – difficulty walking or climbing stairs
• Hearing – deafness or serious difficulty hearing
• Vision – blindness or serious difficulty seeing, even when wearing glasses
• Cognitive – serious difficulty concentrating, remembering, or making decisions as a result of a physical, mental, or emotional condition.
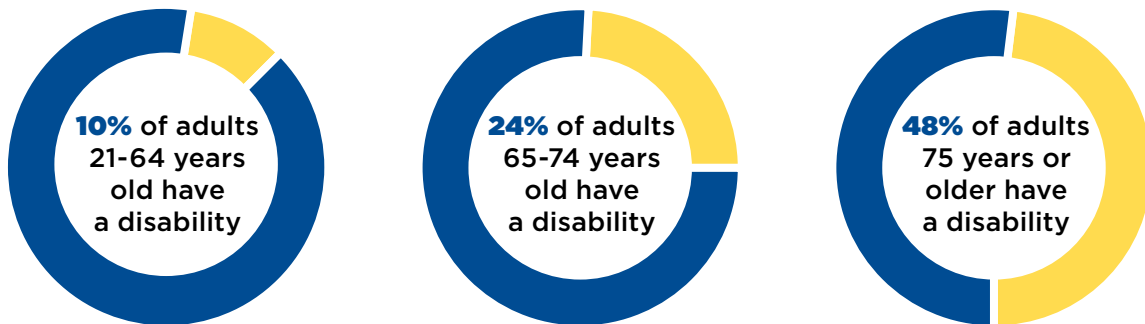
Although individuals with all types of disability experience barriers to health care, most of the content in this primer focuses on individuals with mobility-related disabilities, since this primer focuses primarily on addressing physical or structural barriers to health care. Similarly, preferences on terminology can also vary like definitions. For example, although it is used in many definitions of disability, the term impairment can be considered inappropriate and may be offensive to some individuals with disabilities. Instead of saying "people with hearing impairment" you could say "people who are deaf or hard of hearing." It is important to use someone's preferred terminology to show respect and build trust.

* The ADA Amendments Act (ADAAA), which was passed in 2008 to help clarify what disability meant, includes specificity about what constitutes "major life activities". Examples listed in the ADAAA include "breathing, walking, talking, hearing, thinking, seeing, sleeping, caring for one's self, performing manual tasks, and working. Major bodily functions are also included as major life activities in the ADA Amendments Act." More information can be found at: https://adata.org/factsheet/employer-view-ada

UNDERSTAND DISPARITIES AND DISABILITY

As illustrated in the graphic below, the prevalence of disability is highest among older age groups. Approximately 10 percent of people between the ages of 21 and 64 years report having a disability. That figure increases to 24 percent among people ages 65 to 74 and to 48 percent among people ages 75 and older.[4]

PREVALENCE OF DISABILITY AMONG DIFFERENT AGE GROUPS IN THE U.S.

10% of adults 21-64 years old have a disability

24% of adults 65-74 years old have a disability

48% of adults 75 years or older have a disability

Individuals with disabilities often experience worse clinical outcomes due, in part, to unique barriers they face accessing the health care services they need. Research indicates that, when compared to individuals without disabilities, individuals with disabilities are:

• Less likely to receive comprehensive preventive care[5,6]
• Less likely to have an annual dental visit[7]
• Less likely to receive diagnostic imaging[8,9,10]
• Less likely to receive recommended cancer screenings[11,12,13,14]

These disparities may be partly attributed to a variety of barriers faced by individuals with disabilities when trying to access care, including:

• A lack of physically accessible health care facilities and equipment
• Communication barriers and unintentional biases (including assumptions about what a person with a disability is or is not capable of)
• Programmatic barriers (policies, care processes, and service delivery)

Disability status can affect how a person lives, learns, and works, which can compound barriers to care and further influence health status. Social determinants of health—or the conditions in which people are born, live, learn, work, play, worship, and age—also contribute to disparities in health and quality of life for individuals with disabilities.[15,16] There are many indicators of social determinants of health, and while each can play an essential role in a person's health, some may be uniquely important to consider for people with disabilities. For example:

- **Poverty.** People with disabilities live in poverty at more than twice the rate of people without disabilities.[17]
- **Employment.** Only 32 percent of working-age people with disabilities are employed compared with 73 percent of those without disabilities.[18]
- **Transportation.** Many individuals with disabilities experience barriers associated with public transportation. In one study that explored barriers to transportation among individuals with disabilities, almost half of respondents said the local public transportation system they relied on was "inadequate."[19]

Understanding social determinants of health—how they affect each other and how they affect health—can help providers understand the challenges patients face in meeting health goals and allow them to meet patients where they are and provide the unique care they need. Equitable health care means that all individuals can achieve their highest level of health. Following the health care quality guidelines described by the Institute of Medicine in their seminal report *Crossing the Quality Chasm,* the needs, preferences, and safety of the patient should be central to a practice.[20,21] Improving physical accessibility of health care is an integral part of providing equitable health care. Working to address common barriers improves a provider's ability to deliver safe, high-quality care to all.

FEDERAL STANDARDS AND OTHER GUIDANCE ON ACCESSIBILITY

Outside of providing high-quality care for all, there are other reasons to ensure accessibility in health care settings, including that health care organizations that are not accessible may be subject to lawsuits or discrimination complaints. Most health care programs, activities, and services are subject to federal regulations prohibiting discrimination on the basis of disability. These regulations include Section 504 of the Rehabilitation Act of 1973 (Section 504), the ADA, and Section 1557 of the Affordable Care Act (Section 1557). The U.S. Department of Health and Human Services (HHS) Office for Civil Rights provides additional information of these regulations.

Many resources are available that describe federal standards and provide guidance related to the ADA and other relevant requirements. For example:

- Access to Medical Care for Individuals with Mobility Disabilities, from the U.S. Department of Justice (DOJ) and the HHS Office for Civil Rights, provides information on ways that health care facilities can meet their legal obligations.
- The 2010 ADA Standards for Accessible Design, also from the U.S. DOJ, sets minimum requirements for newly designed and constructed or altered state and local government facilities, public accommodations, and commercial facilities to be readily accessible to and usable by individuals with disabilities.

More information on these and other resources are available in a CMS OMH Resources Inventory that is complementary to this primer.

STATE AND LOCAL REQUIREMENTS

In addition to federal disability rights laws, state and local laws may impose accessibility requirements on facilities.[22] For example, New York State parking requirements specify the aisle beside a designated accessible parking space be at least eight feet wide, whereas the federal requirement is five feet wide.[23] When state and federal laws differ, the more stringent of the provisions applies.

It is important to make sure that architects, builders, and/or contractors are aware of applicable codes and commit to following them. Hiring licensed workers can help improve the likelihood of compliance, but it is important to specify the applicable standards, require written assurances, and check compliance. ADA consultants can also help clarify ambiguities that may exist in working within federal, state, and local regulations. For example, California has a searchable list of specially trained experts called Certified Access Specialists (CASp) that can advise businesses about making architectural accessibility improvements.

Although progress has been made to improve physical accessibility of health care facilities, patients with disabilities continue to encounter barriers, particularly inside physician suites.[24,25,26,27,28,29] Research indicates that providers may not be fully aware of or fully understand the extent of their legal obligations to provide accommodations to patients with disabilities.[30]

The sections that follow, discuss ways to assess and increase the accessibility of a health care facility, assess and address patient and caregiver needs, and use available resources to support these efforts. The Resources list at the end of this document provides additional resources, including links to the ADA National Network, which offers guidance and resources to help health care providers interpret and implement the ADA, Section 504 of the Rehabilitation Act, and other federal requirements.

ASSESS ACCESSIBILITY OF THE FACILITY

Now that you understand some of the challenges individuals with disabilities face when accessing care, it's time to take action and make improvements. To begin with, you will want to assess gaps in care and outcomes among your patients with disabilities and begin to assess how accessible your health care setting is now.

The CMS Disparities Impact Statement may be a useful tool to help you assess gaps in care and plan to address them. It was developed to walk health care organizations and providers through a five-step process to identify and address health disparities.

• The first part of a Disparities Impact Statement involves identifying the priority population(s) and health disparities within your patient population or service area – in this case, this means looking at your data to understand more about the individuals you serve who have disabilities.

• Second, you will define your goals, including what you aim to do, by when, and for whom.

• Third, you will establish your organization's health equity strategy. This will entail identifying the actions needed to achieve your goals and what specific changes you will need to make to address the disparities you see. Based on what you see, solutions might include adding accessible parking or a ramp to enable access to your facility, or providing training to staff.

• Next, you will identify what your organization will need to implement its health equity strategy, such as policy changes, or purchasing a height-adjustable examination table.

• Lastly, you will establish what you will measure and develop a plan to monitor and evaluate your progress.

In conjunction with the Disparities Impact Statement, you will want to evaluate how accessible your health care setting is now. Doing so can help you identify barriers you did not know existed, and help you work to address them. As practices consider alterations to their facilities, it may help to think about common barriers, such as those described in Exhibit 1.

EXHIBIT 1: COMMON BARRIERS

• Parking
  – No van-accessible parking spaces in the facility parking lot
  – No accessible route to get from a parking space to an accessible entryway, or route blocked by cars, equipment, or other objects

• Ramps
  – Areas where ramps change direction are too narrow/short to accommodate a wheelchair
  – Ramps that have a steep slope and/or do not have handrails or other mechanisms to protect users from falling off the edge

• Stairs
  – Handrails on stairs do not extend horizontally at landings at the top and bottom of the staircase

• Doors
  – Doors do not open with sufficient clearance for users to get through
  – Doorways are too narrow
  – Handles or latches make doors too difficult to open
  – Doors are too heavy
  – The building entrance lacks a level landing in front of the door

• Bathrooms
  – Only one of the bathrooms in the facility is physically accessible, limiting the number of available bathrooms and/or causing people to travel far to use another accessible bathroom
  – Larger bathrooms with six or more stalls do not include a sufficient number of physically accessible stalls

Adapted from:

• Great Lakes ADA Center, Archived Accessibility Online Webinar Sessions.

As you work to evaluate the accessibility of your health care setting, it is critically important to consider barriers that a person with disabilities may encounter at every point of their visit, from arrival to departure. This means assessing the accessibility of areas including:

• Approach and entrance to the facility.
• Within the building and navigating to the provider's office.
• Navigating specific elements of the provider's office, such as:
  – Patient check-in.
  – During clinical examination.
  – Use of restroom facilities.

Checklists like the one below (see Exhibit 2) and others referenced throughout this primer can be used to help you assess the physical accessibility of your facility and think through different areas where a patient may experience barriers. There are many different checklists available to providers as a starting point to assess facility accessibility. Checklists may focus on accessibility in general, or on a specific aspect of accessibility such as parking and drop-off areas, routes of travel, ramps, and building entrances.

Importantly, checking items off a list does not necessarily equate to ADA compliance. By including this and other checklists, CMS does not intend to take a legal position on whether or not the items included are required by law, but instead aims to raise awareness of patient needs and many potential accessibility barriers. Checklists are not substitutes for compliance with federal, state, or local regulations, but can provide a good starting place for assessment. Whether each item is required by law is dependent on many issues outside the scope of this document. Practices and providers can consult the resources list at the end of this document for additional information about space and facility requirements, including ADA requirements. In addition to using these checklists, talking with experts, and gathering input directly from patients with disabilities and discussing possible changes with them may help identify additional barriers and needs.

EXHIBIT 2: ACCESSIBILITY REVIEW – ASSESSING YOUR HEALTH CARE FACILITY

PATIENT ARRIVAL

Getting patients *to* the facility

❑ If the facility has a parking lot, is it accessible to patients with mobility issues?
  ❑ Are there clearly marked accessible parking spaces to accommodate people with mobility disabilities?
  ❑ How many spaces are there, and is the number enough to meet ratio requirements for accessible parking spaces and van-accessible spaces? You may need to go beyond required minimums based on your patient population and the types of medical services provided (e.g., orthopedics, geriatrics).
  ❑ Do designated parking spaces and access aisles meet minimum width requirements?
  ❑ Are there curb cuts (a dip in the curb to allow smooth transition from the street to the sidewalk)?

Getting patients *into* the facility

❑ How will patients reach the building entrance from either the parking lot or public transit route?
  ❑ Is the pavement smooth and easy to travel across?
  ❑ Are there clear walkways from the accessible parking spots to the front door?
  ❑ Are there steps to the entrance? If so, is there an accompanying ramp with an accessible slope, or a nearby accessible entrance? If there is a nearby accessible entrance, is there appropriate signage directing individuals to it?
  ❑ Are there handrails along the stairs?
❑ How will patients enter the facility?
  ❑ Are the doors wide enough (32-inch wide clearance)?
  ❑ Are the door handles operable with one hand and with a loose grip? Or are power doors with pushbuttons available?
  ❑ Are thresholds 1/4" high or less, or beveled if they are between 1/4" and 1/2"?

Getting patients *around* within the facility

❑ Can patients move easily throughout the facility?
  ❑ Do the doorways have enough space around them to maneuver a wheelchair?
  ❑ Do the doors have a closer or some mechanism to ensure a slower close time?
  ❑ Are the aisles or hallways wide enough for a wheelchair (a minimum width of 36 inches)?
  ❑ Are all interior accessible routes to examination rooms clear of protruding objects (e.g., water fountain, hand sanitizer dispensers)?
  ❑ If the building is multiple stories, is there an elevator or chair lift? Is the lift independently operable?
❑ Is there appropriate lighting and signage for those with vision impairment?
❑ Will patients be able to meet their non-health care needs in the facility?
  ❑ Are restrooms accessible (appropriately positioned grab bars, sufficient aisle width, large stall or single-use toilets, accessible sinks and paper towels/dryers)?
  ❑ Are there water fountains that are lowered or otherwise accessible?
  ❑ If ATMs are provided, can the keypads be reached by people who use wheelchairs? For those with vision disabilities, do the ATMs have speech output and tactile numbers and symbols? (Continued on the next page)

EXHIBIT 2 CONTINUED: ACCESSIBILITY REVIEW – ASSESSING YOUR HEALTH CARE FACILITY

PATIENT EXAMINATION

Getting patients *into* the examination rooms

❏ Are the examination room entrances accessible?
  ❏ Do the doorways to the examination rooms have at least a 32-inch wide clearance?
  ❏ Do the pull and the push sides of doors have adequate space in front of and to the sides of doorways so that people using wheelchairs can position themselves to easily and safely open the door? Is space kept free of objects such as boxes and equipment?
  ❏ Are the heights of thresholds at examination room doorways 1/4" or less, or beveled if they are between 1/4" and 1/2"?
  ❏ Do examination room doors have a handle that does not require tight grasping, pinching, or twisting to operate (for example, a lever handle), and can the door be opened with five pounds or less force?
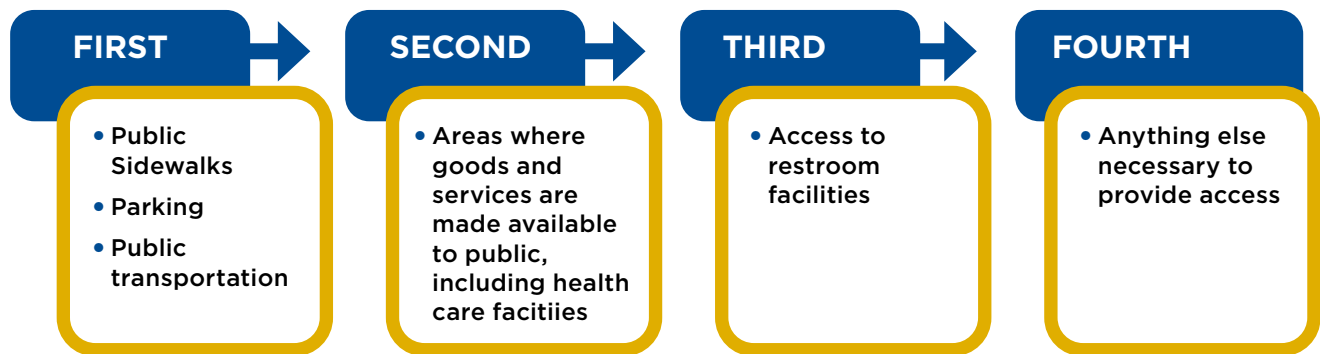
Getting patients examined *in* the rooms

❏ Are the examination rooms accessible?
  ❏ Is there adequate space for individuals in wheelchairs to turn around (circular space of five feet [60 inches]; or T-shaped space that provides a 60-inch square minimum with arms and base of wheelchair or other mobility device having a minimum width of 36 inches)
  ❏ Is there adequate floor space next to the medical equipment (30 by 48 inches minimum)?
❏ Is the examination equipment accessible?
  ❏ Are the examination tables adjustable to different heights (minimum transfer height of 17 to 19 inches)? Do they have an adequate transfer surface (minimum width of 28 inches and depth of 28 inches for side transfer)? Is adequate space provided for wheelchair transfer and for use of a lift?
  ❏ Are transfer supports provided? Are head and back supports provided?
  ❏ If examination chairs are available, does at least one provide adjustable transfer heights (minimum transfer height of 17 to 19 inches); adequate dimensions for transfer surface (minimum width of 21 inches and depth of 17 inches); and do they provide for unobstructed transfer?
  ❏ Does the equipment, including mammography machines, allow sufficient knee and toe clearances for wheelchairs (for example, 25 inches deep minimum and 28 inches deep maximum for breast platforms)?

Adapted from:

• U.S. Department of Justice. (2010). ADA Standards for Accessible Design. Available at: https://www.ada.gov/2010ADAstandards_index.htm
• Northwest ADA Center. (2013). Accessibility Checklist for Medical Clinics and Facilities in Oregon. Available at: http://nwadacenter.org/toolkit/accessibility-checklists
• U.S. Access Board. (2017). Standards for Accessible Medical Diagnostic Equipment. Available at: https://www.access-board.gov/mde/
• ADA National Network (2017). Accessible Parking. Available at: https://adata.org/factsheet/parking

CONSIDERATIONS FOR FACILITY MODIFICATIONS

After completing a checklist to assess physical accessibility needs, the next steps are to prioritize solutions vital for compliance in the short term and develop a work plan, timeline, and budget to address barriers that are more challenging over the longer term. As you consider what steps to take and when, with respect to your facility's physical accessibility capacity, keep in mind the ADA regulations for private entities specify the following order of priorities for "barrier removal."[31]

FIRST	SECOND	THIRD	FOURTH
• Public Sidewalks • Parking • Public transportation	• Areas where goods and services are made available to public, including health care facitiies	• Access to restroom facilities	• Anything else necessary to provide access

Practices may consider prioritizing accommodations or equipment/infrastructure upgrades that might remove barriers or enhance safety when providing care to patients with physical limitations. For example, a combination height-adjustable/ weight scale examination table can reduce the risk of injuring staff and patients during transfers, improve weight-based medication dosing, and improve workflow (e.g., vital signs and patient transfers). If a provider lacks a height-adjustable examination table, a working mechanical lift can help if there are staff appropriately trained to transfer a patient safely with this equipment.

Action Step 1. Assess Facility Accessibility and Identify Priorities for Barrier Removal

❑ Identify specific vulnerable populations, health disparities, and goals to address those disparities
❑ Explore different areas in which patients may encounter barriers
❑ Consider the order for barrier removal that is specified in the ADA regulations

While some equipment and facility modifications will require significant costs, other adjustments are relatively inexpensive (low or no cost) and can provide short-term or interim solutions. Inexpensive and practical ways to increase office accessibility may include:

• Rearranging furniture to create a consistently clear pathway for people who use wheelchairs.
• Removing obstacles that might prevent a person in a wheelchair from being able to easily access the reception area.
• Retrofitting doors with u-shaped handles or levers (as little as $10 each).
• Oiling door hinges and making adjustments to spring mechanisms.[32]
• Fixing loose seams and edges of carpeting, vinyl tiles, linoleum, or other flooring.[33]
• Installing sound absorbing materials (e.g., curtains, ceiling tiles) to minimize background noise for patients with hearing loss.[34,35]

- Reducing glare from lighting.
- Encouraging staff to welcome patients with obvious disabilities and discuss how to solve accessibility issues.

As an important note, if a provider leases an office from a property owner, the responsibility of ensuring physical accessibility for different parts of the space may fall on either the owner or the provider. The lease may include specific details about the responsibilities of each individual, but typically the provider, as a tenant, is responsible for reception areas and examination rooms, while the property owner is usually responsible for communal spaces shared by multiple businesses.

ADDRESS BARRIERS ON THE APPROACH TO THE FACILITY

As noted above, the first priority for barrier removal is to address how someone can enter a health care facility. Access from public transportation (such as bus stops) or patient drop-off locations, as well as sidewalks to navigate to the entrance to the building should be accessible.

> **Action Step 2. Address Barriers to Approaching the Facility**
>
> ❑ Take action to address barriers a patient might experience as they approach the facility, such as parking, sidewalks, ramps, building entrance/landing, and building doors

Facility parking, as well as various aspects of the facility entrance itself, such as ramps, doors, and landings should be considered as well. As you work to take action, you'll want to consider how people with disabilities will be able to get to your facility and what barriers they may encounter that you can address. To identify elements you may need to change at patient drop-off locations, sidewalks, building landings, and entryways, you can consider the questions posed in a detailed assessment checklist like the one above in Exhibit 1. For example, when you think about the sidewalks that people will use to navigate to the building, consider whether curb cuts allow unobstructed access to the sidewalk. You may identify ways to improve accessibility in these locations such as adding adequate designated parking spaces, installing curb cuts, using lever handles rather than knobs for doors, and ensuring entrance ramps have level landings and sheltered entryways.

ADDRESS BARRIERS RELATED TO NAVIGATING WITHIN THE BUILDING TO THE PROVIDER'S OFFICE

> **Action Step 3. Address Barriers to Navigating within the Building**
>
> ❑ Consider the use of universally recognizable symbols and assessed things like whether doors and hallways are wide enough to accommodate wheelchairs and other assistive devices

Once a patient enters a building, they will, at minimum, need to be able to find where their provider is located and get to their office. To address barriers related to moving through the building to the provider's office, you'll want to consider a variety of elements related to accessibility, much like you did when modernizing the approach to the facility. For

example, consider whether there are universally-recognized symbols such as a wheelchair or information symbol, to indicate access to information. If these are not being used, consider adding them so that anyone who needs directions is able to find them easily. Consider the use of well-lit, large-print and braille directional signage, using high-contrast and matte finish, to assist those individuals with low vision as they navigate through the building. Additional questions to ask may include items like:

- Is signage at the right height to be visible to individuals who use assistive devices, such as wheelchairs?
- Are light switches and emergency/fire alarm boxes at the right height to make them accessible to individuals who use assistive devices?
- Do alarm systems include visual as well as audio-based navigation beacons?
- Are doors and hallways wide enough to accommodate wheelchairs, scooters, walkers, and other assistive devices?
- Are building hallways clear of barriers, such as trash cans, equipment, and chairs?

As you think through various questions and checklists, you can take action to remove barriers that individuals might experience related to navigating through the building. You may also want to consider wayfinding concepts or systems, which are designed to help provide information and guide people through a physical environment.

ADDRESS BARRIERS AT PATIENT CHECK-IN

Once a patient arrives at a provider's office, they will need to check-in and find a spot in the waiting room. They may also need to fill out paperwork, and will need to be notified when the provider is ready to see them. Printed materials, such as intake forms, should be available in large print and braille. Let patients know they can request these formats by adding universally- recognized symbols to printed materials.

Action Step 1. Address Barriers at the Provider's Office

❑ Review the accessibility of elements related to patient check-in, such as filling out paperwork, counters that are an appropriate height to accommodate a wheelchair, effective communication regardless of disability status, and more

❑ Install features that may improve patients' safety and comfort in restroom facilities, such as raised toilet seats with appropriately placed grab bars, wide toilet stalls with doors that open outward, etc.

❑ Consider the accessibility of various elements of the examination room, such as the height of the examination table and necessary maneuvering clearances needed around doors, and followed specific guidance to increase accessibility within examination rooms

To address potential barriers at patient check-in, take a look at your waiting room. Reception areas that have a low window with open space underneath to accommodate a wheelchair can facilitate better access and communication. For individuals who use wheelchairs and other assistive devices, it is also important to have a waiting room with space for wheelchairs and open space close to the front desk with adequate floor space to maneuver.

When using technology such as touch screens for check-in, make them height-adjustable, or have stations available for people who use wheelchairs or others who are unable to stand. Ensure that screens are accessible or provide alternative options for those who have limited dexterity or are unable to see a touch screen. Have the means to communicate with individuals, regardless of disability status, and recognize that accommodations can take different forms, such as visual notifications for individuals who are deaf and oral notifications for individuals who are blind. For example, a visible or tactile signal such as a vibrating pager can help inform individuals who are deaf or hard of hearing when the clinician is ready for the appointment.[36]

ADDRESS RESTROOM ACCESSIBILITY

Another important part of modernizing physical spaces within the provider office is increasing accessibility of restroom facilities. The DOJ's 2010 ADA Standards for Accessible Design provides more information on features of an accessible restroom. Features that can improve patients' safety and comfort include:[37]

- Unobstructed entrances wide enough for a wheelchair or other assistive device;
- Accessible signage;
- Raised toilet seats with appropriately placed grab bars;
- Appropriate turning radius within the toilet stall to accommodate wheelchairs;
- Wide toilet stalls with doors that open outward;
- Mirrors, sinks, soap, sanitizer, specimen collection, and towel dispensers located so that they are usable by individuals from standing or seated positions.

ADDRESS ACCESSIBILITY OF EXAMINATION ROOMS

Addressing the accessibility of the routes to the examination room from common use and public spaces (e.g., reception) are an important step in ensuring the examination is accessible. Additionally, appropriate medical equipment in the examination room should allow patients to safely access the health care and treatment they need. It can also help providers deliver comprehensive, equitable care. For example, accessible equipment such as height-adjustable examination table and chairs, weight scales, and radiological and imaging equipment can:

- Help more patients access care
- Improve patient satisfaction
- Reduce risk of injuring staff and patients during transfers
- Ensure patients are assessed and diagnosed appropriately
- Alert providers to weight loss or gain and improve weight-based medication dosing
- Improve workflow (for example, vital signs and patient transfers)

It is also important to have staff who are trained to safely use the medical equipment, including any patient lift devices. If an examination is most effective when a patient is lying down on the examination table, then a patient with a disability should be able to access an examination table. Without proper equipment and training, transferring a patient who uses a wheelchair on and off a weight scale or an examination table may present safety issues for both patients and staff.

The Access Board issued [Standards for Accessible Medical Diagnostic Equipment] in January 2017, which contain details about a variety of elements related to accessible examination rooms. Some specific features of an accessible exam room you may want to consider are:[38]

- An accessible and sufficiently wide entry door;
- Maneuvering clearances at the door to the room with no obstructions, such as stored boxes or equipment;
- Height-adjustable exam table with transfer supports, as well as head and back supports;
- Lift equipment for staff to use to transfer patient onto exam table;
- Floor space adjacent to the exam table that is kept clear of all equipment (including waste bins) and an accessible route to the table that make a side transfer possible;
- Enough space between the examination table and the wall to allow staff members to assist with patient transfers and positioning from both sides.

Considerations Related to Specialty Care

Specialty care, including obstetrics and gynecology, radiology, ophthalmology, and dentistry, may present additional considerations for accessibility. Some of these types of health care may involve specific equipment or positioning requirements that can pose extra challenges, especially for individuals with mobility disabilities. To meet patient needs, practices may need to make modifications based on disability type and functional status.

For example, obstetrics and gynecological care may require accommodations to safely transfer and correctly position people who use wheelchairs on the examination table. A mechanical lift and height-adjustable examination table that tilts when needed may help accommodate a patient with muscular dystrophy whose cervix cannot easily be reached for a Pap smear. Mammography and/or other radiologic examinations may require not only height-adjustable equipment that can accommodate appropriate positioning for patients who use wheelchairs and patients with balance concerns, but also Velcro straps to hold arms in place for patients with limited limb control. As another example, colored lights or other visuals might be needed to signal to patients who are deaf or hard of hearing when they should take certain actions (for example, hold their breath and resume normal breathing).[39]

To assess and address accessibility, providers who work in specialty care can consider all aspects of a care visit, for example thinking about the types of barriers that may be encountered by an individual who uses a wheelchair or an individual who is deaf or blind. While there may be some unique accessibility considerations related to specialty care, the end goal remains to effectively meet patient needs and provide high-quality and equitable care.

DESIGN POLICIES AND PROCEDURES
TO MEET PATIENTS' NEEDS

The layout of the facility and the presence of certain equipment are not the only issues that impact physical accessibility. Even with modernized infrastructure and equipment, a practice's policies and procedures can still make accessing care difficult and ultimately, administrative processes may inadvertently create barriers. Using appropriate equipment for a patient may take more time than standard schedules allow, or intake forms may not adequately collect or explain accessibility needs. It may be important to ensure that you have a plan in place to accommodate a variety of situations, including space for personal assistants or service animals, and individuals who may arrive late due to inaccessible transportation or difficulty with ADLs.

To help identify gaps and barriers, start by reviewing your policies and procedures from a disability lens, considering questions such as:

- Do staff know where accessible equipment and accessories are stored, and what is available for use?
- Do staff members know how to use accessible equipment and how to maintain it properly?
- Are there procedures in place to reschedule patients in the event that necessary accessible equipment is not functional or being repaired? Are staff aware of these procedures?
- Do staff know how to modify their standard operating procedures to meet patients' needs (e.g., processes for safe transfer of patients who use wheelchairs to examination tables to ensure an appropriate examination)?
- Do patient intake forms include an area to capture patient needs related to accessibility?
- Do staff send intake forms to patient ahead of the appointment, either by mail or electronically, to avoid potential communication barriers associated with completing forms in the waiting room?
- Do appointments allow sufficient time to accommodate patients with accessibility needs?
- Do staff routinely ask when scheduling appointments if the patient needs any accommodations? Are staff able to act on the information, for instance, by booking a specific room or additional time for the appointment?

It is important to do regular maintenance on lifts, keep slings of different sizes, and make staff aware of where lifts are stored. Obtaining input from individuals with disabilities can help identify changes needed to administrative procedures.

UPDATE STANDARD OPERATING PROCEDURES

Once accessibility gaps related to policies and procedures have been identified, updates can be made to standard operating procedures. Organizations can consider challenges patients with disabilities may encounter at each step of the patient experience, including scheduling an appointment, checking in, and at the point of care (i.e., in exam rooms).

Scheduling an Appointment

Patient needs vary from person to person. Rather than making assumptions about what an

individual may or may not need simply because of their disability, staff should ask all patients if they need assistance, and if so, the best way to meet those needs.[40,41] When an appointment is scheduled, staff members should ask patients or referring physicians whether any specific accommodations will be needed during their visits. Scripts can help guide staff in asking appropriate questions. Exhibit 3 includes useful questions to integrate into a practice's procedures.

EXHIBIT 3: ASKING QUESTIONS WHEN SCHEDULING APPOINTMENTS

When an appointment is scheduled and prior to a patient's arrival, front office staff can ask questions to better understand a patient's needs, such as:

1) Will you need any assistance or accommodations during your visit?

2) Will you need any auxiliary aids (e.g., tools or resources for the provision of effective communication such as those described in Section 36.303 of the ADA) during your visit?

3) Will you need assistance in the waiting room or examination room? (For example, do you need help filling out forms or getting onto the examination table?)

4) Will you need extra time at this appointment to discuss your concerns, or for dressing or undressing?

5) Would you like to meet with a care coordinator to discuss health insurance, coordination of benefits, or referrals for specialty care, therapies, or other services?

6) How would you prefer to receive intake forms before the appointment (i.e., by mail or email)?

Adapted from: M. Kalichman, Exam Strategies and Priorities for Patients with Physical and Cognitive Disabilities

Documenting responses to these questions in the patient's medical record will help meet ongoing patient needs. Alerts can be built into registration and medical record systems to help staff members identify and address the need for accommodations before a patient arrives. Understanding needs ahead of time can allow the office to provide accessible care proactively, rather than in a reactive manner.

Checking in

Once a patient arrives in the waiting room, they will need to be able to navigate the check-in process. Additionally, at patient intake, staff can verify information about patient needs that was collected during the scheduling process. Some considerations regarding physical accessibility and patient check-in include:

Action Step 6: Modernize Intake Materials

❑ Update intake paperwork to include questions about disability, with particular focus on the need for accommodations

❑ Ensure that materials and signage are culturally and linguistically appropriate and easily understood regardless of literacy level, and address the needs of patients with disabilities

- Is the check-in counter an appropriate height to accommodate a wheelchair?
- For individuals who are blind or have low vision, are there accommodations available to facilitate patient check-in?
- Are there visual cues for individuals who are deaf or hard of hearing?

EXHIBIT 4. INTAKE MATERIALS

Updating your intake materials and processes can also be important. Consider how, if at all, your procedures might change if the patient brings their check-in forms with them or sends them ahead of time. How will you ensure that the information is used and the patient's needs accommodated?

Practices can also add questions to intake materials to capture specific information to help serve patients with disabilities. These may include specific questions about disability status, such as the 6 questions used in the HHS minimum data standard, use of specific devices (e.g. wheelchair, glasses, etc.), and whether assistance of accommodations might be needed during an appointment, such as help filling out forms or need for an interpreter.

At the point of care

Lastly, and importantly, consider your standard operating procedures at the point of care. Ensure that staff are prepared to safely respond to patient needs and are aware of how to find and use any accessible equipment on site. Assess whether your staff know what to do when a patient with a disability presents for an appointment and needs an accommodation that has not been planned for ahead of time. See Exhibit 5 for a list of questions that might be appropriate to ask at the point of care.

EXHIBIT 5. ASKING QUESTIONS AT THE POINT OF CARE

Staff should communicate directly with each patient (rather than a caregiver, companion, or interpreter who might be present), and keep in mind that each patient is an expert on their own needs. Consider asking (as appropriate):

1) Are there specific ways I can help you move or transfer?

2) Do you need help undressing, dressing, or cleaning up?

3) What examination positions are the most or least comfortable for you?

4) Do you need assistance in collecting a urine sample?

DOCUMENT PATIENT NEEDS

Asking relevant questions is only helpful if the collected information gets used. Electronic health records (EHRs) increasingly provide opportunities to collect, record, and use data about patient needs. For example, the EHR may be used at patient intake to collect data, including disability status; the need for assistance with ADLs, or instrumental activities of daily living (IADLs); or the need for accommodations (including extra time) at health care appointments. Alerts can then be built into registration and medical record systems to help staff identify and address accommodation needs prior to a patient's arrival.

Staff should ask all patients if they need accommodations, explaining that they ask all patients this question so that staff can plan for their visit. Because needs can change over time, staff should ask at each appointment whether individuals have any changes or updates with respect to their accommodation needs. For example, providers could explain this policy in welcome letters for new patients or make it available in provider directories. Staff could then record responses in the patient record and set up alerts in the EHR to help staff and providers be more responsive to patient needs.

It is important for practices to stratify collected data by disability status to identify and explore potential quality of care issues (e.g., missed preventive screenings) that may disproportionately affect people with disabilities. This sort of analysis may help practices identify specific accessibility issues and target efforts to make improvements. If there are gaps in existing data, practices may have to probe more deeply to understand why the current processes may not be working and to develop a solution. Staff may be asking appropriate questions but struggling to document them because the scheduling system does not easily integrate the information. One option might be talking to the EHR vendor about setting up alerts that pop up during the scheduling process to remind staff that a patient has accessibility needs and may need more time at the visit. Vendors can work with providers to add structured fields, patient alerts, or other mechanisms. This will streamline workflow, reduce bottlenecks, reduce potential safety issues, and improve patient experience. Staff also may not be asking the questions at all because they feel uncomfortable, and would benefit from additional guidance in having conversations about accessibility needs.

Accessible kiosks and mobile devices may be useful tools for collecting information about needed accommodations directly from patients in a clinical setting. At present, data collection tools outside EHRs, such as personal health records, portals, and mobile collection methods, are not necessarily designed to collect disability or functional status information and allow use by patients with disabilities (e.g., visual impairment, limited dexterity) or other barriers (e.g., limited English proficiency). Expanding data collection and improving patient-facing design have the potential to improve collection of disability-related information, increase patient engagement, and enhance health equity.[42,43] The Inventory of Resources for Standardized Demographic and Language Data Collection, developed by CMS OMH, includes a section on disability data collection resources that provides recommendations and frameworks for collecting disability data.

DEVELOP STAFF KNOWLEDGE AND DISABILITY COMPETENCY

People with disabilities may experience differences in health care access and health status because of physical and other barriers, but it is important to remember that having a disabling condition does not define individuals, their talents and abilities, or health behaviors. Staff knowledge, attitudes, and communication skills can all cause barriers to care for patients with disabilities. Developing staff knowledge, providing training, and building disability competency of clinicians and staff is a key element to making health care more accessible and welcoming for people with disabilities.

Action Step 7. Develop Staff Knowledge and Disability Competency

❑ Provide/attend different types of training for clinicians and staff to build disability competency and help ensure care that is respectful and accessible to patients with disabilities

Providers and staff can support each other and patients through training on disability-competent care.[44] Disability-competent care is participant-centered, provided by an interdisciplinary team, and focused on achieving and supporting maximum function. As described by Resources for Integrated care, "disability-competent care recognizes and treats each individual as a whole person, not a diagnosis or condition, and is structured to respond to the participant's physical and clinical needs while considering his or her emotional, social, intellectual, and spiritual needs."[45] Training staff on disability competency can take different forms. There is no one-size-fits-all approach to training. The guiding principle for providing disability-competent care is to remain respectful of all patients and not make any assumptions about their abilities. Patients have different needs and preferences about types and degrees of assistance.

Usually, organizations provide training during onboarding or new staff orientation, but refresher education is also important to ensure ongoing emphasis on meeting accessibility needs. Ideally, learning should be incorporated into the practice culture with specific time allotted to training in which everyone participates. The training itself should be integrated into regular training provided to staff. This approach emphasizes the importance of this topic and allows the team to share best practices with each other. For example, providers can:

• **Build a 30-minute training session** into the schedule once a month. During this session, share training materials; ask staff what inexpensive, short-term things they can be doing now (e.g., clearing hallways); and consider how to tackle the more significant issues next.
• **Pursue a "grand rounds"- style approach** where staff talk through patient care/accessibility scenarios, discussing what went well, and what could have been done differently.
• **Ask staff with specialized training (like physical therapists) to train co-workers** on new equipment for transferring patients or conducting an exam (e.g., a height-adjustable table).

When practices alter existing facilities or acquire new accessible equipment to serve their patients better, staff should receive training on the use of the equipment and how it will help provide better care to patients with disabilities. Equipment that is not used, or not used properly, does not benefit patients or staff.

Both staff and patients should be aware of available accommodations and auxiliary aids. In addition, staff should be trained and refreshed on using the equipment to assist individuals transferring to and from the examination table or with proper positioning for an exam.[46] If a practice neglects to make staff aware of accessible equipment or to provide guidance on how to use equipment appropriately, staff will not likely incorporate the equipment into workflows.[47] Further, conflicts can occur when practices lack policies or do not train staff on appropriate accommodations for service animals, including how to ensure sufficient physical space for service animals.[48] The ADA requirements for service animals provides details about service animals, including the definition under the ADA, as well as guidance on where they are allowed and what specific questions can be asked about them.

Staff should also receive training on how to collect information on disability needs prior to a visit or at the point of care, as well as how to use that information to best accommodate the patient's needs. For example, proper documentation of patient needs in the EHR can help staff recognize the need to book an appointment in an accessible examination room or allocate additional time to meet a person's needs (for example, to allow for assistance transferring to and from the examination table). If an office has only one examination room with a height-adjustable table, providers can implement scheduling procedures to verify that the accessible room is available when needed for a patient who uses a mobility device. To ensure consistency of data entry and use, providers should specify exactly where and how staff should collect disability information (e.g., manual, EHR, or hybrid system) and where staff should look for this information when scheduling future appointments. If providers and staff learn about a patient's needs during an appointment, they can also incorporate that information into the patient's record.

EXPLORE RESOURCES TO SUPPORT PRACTICE CHANGES

Changes related to modernizing health care to address physical accessibility require resources, whether monetary or otherwise. To achieve your goals, consider various approaches related to assistance, including:

• Establish collaborations or partnerships
• Negotiate payment for extended visits
• Explore tax incentives

ESTABLISH COLLABORATIONS OR PARTNERSHIPS

Consulting with or establishing relationships with other practices as well as advocacy groups, local disability organizations, or other community groups can lead to sharing technical information, product reviews, and even possible funding sources to decrease the burden of planning and making changes, including purchasing new equipment. For example, state or local Centers for Independent Living (CILs) are nonprofit, nonresidential entities across the United

States run by and for people with disabilities. Many CILs offer accessibility assessments or may be able to help recruit health care consumers willing to test or review the accessibility of a provider facility. The ADA National Network and Regional ADA Centers can provide technical assistance with prioritizing and implementing barrier removal plans. More information on these organizations is available in the resources list at the end of this primer.

Pooling resources is another way providers may be able to increase access to care. For example, if it is expensive for a health care organization or provider to purchase a height- adjustable examination table, providers may consider collaborating with others to purchase an accessible table and arranging to share it.[49] Sharing a height-adjustable examination table may work best if there are multiple providers in the same building who can effectively coordinate the use of the table when it is needed. Disability organizations, such as a local ADA Regional Center, may be able to provide information and/or connections to other organizations interested in resource-sharing. Providers may also benefit from pursuing collaborations with community-based organizations to identify and implement additional changes they want to make.

AVAILABILITY OF EXTENDED VISIT PAYMENT CODES

Providers will need to take extra time to ensure patients with disabilities receive a comprehensive evaluation and examination. Increasingly, payers recognize that these extended visits cost more to provide, but help ensure better care to all patients. It may be worthwhile to talk to insurers and try to negotiate alternative payment approaches. For example, enhanced payments may be an option for extended visits for patients with disabilities, who often need additional time during their appointments for assistance throughout the exam or to navigate and address complex health needs. Consider discussing with insurers the importance of longer visits for patients with accessibility needs. They may be willing to consider alternative payment approaches for extended visits, as adequate preventive care and treatment can provide longer-term cost benefits.

Action Step 8: Explore Resources for Practice Change

❑ Consider various resources that might help support physical and programmatic changes, such as establishing collaborations or partnerships, negotiating payment for extended visits, or exploring tax incentives

To improve access to eligible preventive services for people who require longer visits and to facilitate additional payment to account for extended visits, CMS finalized a payment policy change in the Medicare Physician Fee Schedule (PFS) effective on January 1, 2018. This policy allows providers to receive additional payment, at no additional cost to patients, when certain preventive service visits extend approximately 30 minutes or more beyond the typical time allotted for those services. Providers can use two Healthcare Common Procedures Coding System (HCPCS) G-codes (G0513 and G0514) in addition to the preventive service codes to bill for the prolonged preventive services. The Medicare Physician Fee Schedule webpage provides details on specific preventive services that may be eligible for extended payment.

TAX INCENTIVES

Providers may qualify for tax incentives for accessibility alterations or may be able to use partnerships to share costs. Accessible examination equipment can also provide cost savings in workflow improvements and reduced risk of injury. To offset costs, there are two federal tax incentives available to eligible businesses:[50]

- The Disabled Access Credit, available to small businesses, allows for a credit of up to 50% of the amount of a business's yearly eligible expenditures (between $250 and $10,000) to offset costs. Eligible expenditures include removing barriers to access to facilities (for example, widening a doorway or installing a ramp), purchasing or modifying equipment to improve accessibility, and providing accessibility services (such as sign language interpreters) or materials in alternate formats (such as large-print or braille).
- The Architectural Barrier Removal Tax Deduction, available to businesses of any size, is a business expense deduction of up to $15,000 per year for costs associated with removing barriers to facilities or vehicles.

Both the Architectural Barrier Removal Tax Deduction and Disabled Access Credit can be used in multiple tax years if a business is eligible. In some cases, as described in the document ADA Quick Tips – Tax Incentives, small businesses may be eligible to use both the deduction and the credit if expenses meet the requirements of each. More information is available on the Internal Revenue Service (IRS) website and is summarized in a DOJ resource on Tax Incentives for Businesses.

Some states also offer tax incentives, whether credits or deductions. For example:

- California offers a Disabled Access Credit, which is very similar to the federal credit with the same name. Available only to eligible small businesses, it allows for a credit of up to $125 per taxable year for the same types of expenses covered under the federal credit. These include removing barriers to facilities, providing or changing equipment, and providing accessibility services or materials in alternative formats.
- Since tax laws change over time it is recommended that reputable resources such as IRS.gov be consulted before beginning any renovations or other facility updates. Regional ADA centers or individual state tax offices can also provide details on state-specific incentives.

CONTINUOUS QUALITY IMPROVEMENT

Costs, legal requirements, and specific patient needs may make it necessary for facilities to prioritize certain accessibility upgrades over others in the short term. However, after health care providers or organizations make initial changes to help increase accessibility, the job is not done. Providers should periodically reassess for barriers that remain or have been reintroduced inadvertently. Accessibility should be part of a continuous quality improvement workflow that entails:

- Assessing the facility by collecting information on patient accessibility needs.
- Taking stock of available resources at local and regional networks – for example, Quality Innovation Network – Quality Improvement Organization (QIN-QIOs) – and local provider resources.
- Developing an action plan and timeline.
- Implementing solutions.
- Monitoring the impact of changes.
- Making adjustments where appropriate.

You can measure your progress by:

- Checking in with patients, asking if they feel their needs are being sufficiently and consistently met, if they have suggestions for addressing unmet needs, and if they can provide examples of issues they encounter when making or checking in for appointments.
- Checking in with staff by communicating about new scheduling processes and any adjustments that might improve their ability to document patient needs.
- Checking whether the practice is actively using the information collected from patients to improve patients' experiences; if not, discovering why and what improvements can be made.
- Providing refresher trainings for the whole staff about accessible equipment, scheduling procedures, and other issues at least annually and during staff onboarding.
- Reviewing any changes that have been made to the physical environment for effectiveness, and assessing the need for updates.

While increasing physical accessibility in health care settings is a continuous quality improvement process, the cycle can be streamlined. The checklists[51] referenced earlier and available in the resources list at the end of this document can be reviewed during the assessment and planning stages. These resources can provide a quick window into the basic elements providers may need to consider first as they work toward providing high-quality care for all of their patients.

CONCLUSION

This primer summarizes actions providers and staff can take to improve physical accessibility, and support high-quality, person-centered health care. Changes to the physical environment to increase accessibility benefit a wide range of people. For example, curb cuts or automatic push button doors can benefit people who use wheelchairs or walkers, people with luggage, and parents pushing children in strollers. Large-print and well-lit signage—useful to people with limited vision, including older persons—can be equally helpful for people reading from a distance. Height-adjustable examination tables and wheelchair-accessible scales can be useful for many individuals, not just those who use mobility devices. While critically important to reducing health disparities for people with disabilities, increasing physical accessibility of health care facilities can also help achieve safe, equitable, and high-quality care for all.

APPENDIX A: KEY TERMS

- **Access to health care** for people with disabilities is influenced by several factors, including "physically accessible facilities, accessible messages and communication services, accessible medical equipment, providers with disability knowledge, respectful attitudes, and expectations of good health for people with disabilities, programs that plan for accommodation for clinical, preventive, and health promotion services, adequate insurance coverage, available and accessible transportation, [and] health promotion programs that are effective for people with disabilities."[52]

- **Accessibility (or ADA) assessments** are a way to determine if a facility has barriers to access by people with a variety of disabilities. They assess what barriers exist and suggest possible changes to make.[53]

- **Activities of Daily Living (ADLs)** refer to people's daily self-care activities. Clinicians often use ADLs to assess functional status, particularly for individuals with disabilities. They include bathing, dressing, transferring to and from a chair, walking, using the bathroom, and eating.[54]

- **The Americans with Disabilities Act (ADA)** is a law passed in 1990 that protects the rights of individuals with disabilities, prohibiting discrimination against them with respect to jobs, schools, transportation, and generally within "all public and private places that are open to the general public," including health care.[55]

- **ADA Standards for Accessible Design** are the specific enforceable accessibility regulations for Title II and Title III of the Americans with Disabilities Act.[56]

- **Auxiliary aids** are "services or devices that enable persons with a sensory, manual, or speaking impairment to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency."[57] For example, these include but are not limited to screen readers, Braille materials, amplifiers, and interpreters.

- **Disability** is any condition or impairment of the body or mind that makes it more difficult for someone to do certain activities (activity limitation) and interact with the world around them (participation restrictions). As defined in Title III of the ADA, disability means "a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment...." Disabilities can be congenital or acquired. There are many types of disabilities, including mobility and physical impairment, hearing impairment or deafness, low vision or blindness, cognitive and learning disabilities, and psychiatric disabilities, as well as disability-related to conditions like chronic pain or chronic fatigue. Disabilities that are not outwardly apparent are known as invisible disabilities.[58]

• ***Disability-competent care*** is "the ability to provide person-centered and appropriate treatment, services, supports, and accommodations to individuals with disabilities, while ensuring that the individual's goals, values, interests, and preferences inform the design and delivery of care."[59]

• ***Equitable health care*** are used to assess a person's capacity for independent living, including their ability to prepare meals, manage money, shop for groceries or personal items, perform light or heavy housework, and use a telephone."[60]

• ***Instrumental Activities of Daily Living (IADLs)*** are used to assess a person's capacity for independent living, including their ability to prepare meals, manage money, shop for groceries or personal items, perform light or heavy housework, and use a telephone."[61]

• ***Impairment*** is a term that is used in many legal definitions of disability, but it is considered offensive to many individuals and should generally not be used when describing individuals with disabilities.

• ***Physical accessibility*** refers to factors in the physical environment that impact access to care for individuals with disabilities.†

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† Definition adapted from the DHHS Nondiscrimination in Health Programs and Activities Final Rule, ADA Title III's *New Healthcare Regulations Impose Accessible Technology Requirements*, and FEMA's Including People with Disabilities and Others with Access and Functional Needs in Disaster Operations.

APPENDIX B: RESOURCES

UNDERSTANDING LAWS AND REGULATIONS

- The U.S. Department of Justice (DOJ) and HHS document Access to Medical Care for Individuals with Mobility Disabilities provides information on ways that health care facilities can meet their legal obligations.

- The ADA National Network, funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), part of the Administration for Community Living (ACL), provides information, training, support, and technical assistance to stakeholders around the country on how to meet requirements of the ADA. Ten ADA centers located in different regions of the United States help guide implementation of the ADA. The ADA Knowledge Translation Center is another part of the network; it works with the ADA Regional Centers to provide training, referrals, and resources to educate about state laws and regulations about the ADA:

  — Current training programs are available on the ADA Training webpage.

  — ADA Publications and Fact Sheets are available online.

  — The Network also provides webinars and resources on landlord/tenant ADA access compliance.[62]

- The ADA Standards for Accessible Design[63] set minimum requirements for newly designed and constructed or altered state and local government facilities, public accommodations, and commercial facilities to be readily accessible to and usable by individuals with disabilities.

- The CMS Office of Minority Health developed an issue brief focused on Increasing the Accessibility of Health Care Facilities. The brief explains why physical accessibility is important, discusses laws in place to promote accessibility, provides examples of state and federal efforts to increase accessibility, and offers suggestions for improving accessibility in health care facilities.

- The ACL website includes a large research and resources section on a variety of topics under the tab Aging and Disability in America, as well as information on many authorizing statutes under the tab About ACL.

ASSESSING ACCESSIBILITY

- The Centers for Disease Control and Prevention (CDC)'s Disability and Health Information for Health Care Providers page provides publicly available accessibility guidelines and checklists for ways to remove physical barriers in health care facilities, and suggestions on how to provide accessible medical services. Providers or administrators in medical practices may also find useful resources about universal design, an approach to make facilities accessible to everyone.

- CDC's Right to Know Campaign provides information on the importance of accessible breast cancer screening for women with disabilities, particularly about accessible diagnostic medical equipment.

- The directory of Centers for Independent Living (CIL) lists nonprofit, nonresidential entities across the United States run by and for people with disabilities. Many CILs, ADA Technical Assistance Centers (referenced above), and consultants offer ADA assessments.

- ADA Checklist for Existing Facilities from the New England ADA Center helps identify potential physical barriers that may hinder access to a building. The Introduction includes steps for using the checklist ("How to Use this Checklist"), which may be particularly helpful for those just starting the evaluation process.

DEFRAYING COSTS

- Information regarding the Disabled Access Credit and deductions associated with the Barrier Removal Tax Deduction is available on the IRS website and is summarized in a DOJ resource on Tax Incentives for Businesses.

- 2018 payment policy changes to the Medicare Physician Fee Schedule (PFS) allow for the use of two specific Healthcare Common Procedures Coding System (HCPCS) G-codes (G0513 and G0514) that may be billed in 30-minute increments for services that extend beyond the typical time assumed for eligible preventive services. These codes may be billed in addition to preventive service codes. A list of eligible preventive services is available through the PFS webpage.

EDUCATION AND STAFF TRAINING

- The ADA National Network website includes a page on ADA Training, with an events calendar listing scheduled trainings by topic, region, and audience, as well as links to online trainings, including workshops and webinars. Information is adaptable, even if it is not specific to health care settings.

- Archived webinars on accessibility are available from the Great Lakes ADA Center.

- The U.S. Access Board, an independent federal agency providing leadership on accessible design for people with disabilities, offers webinars and training on federal accessibility guidelines and standards.

- The Disability-Competent Care Self-Paced Training Assessment Review Tool and other resources about provider readiness to support disability-competent care are available from Resources for Integrated Care. Search the Resource Library concepts for "disability-competent care" to view related tools and resources.

- Communicating With and About People with Disabilities from the CDC provides suggestions for "people-first language" and "language to avoid."

DATA COLLECTION AND SOURCES

- Inventory of Resources for Standardized Demographic and Language Data Collection is a CMS resource that links to and describes standards, reports, guides, toolkits, and articles focused on standardized data collection, including a section on disability data collection.

- Data to Improve Health Care for People with Disabilities is an issue brief from the CMS Office of Minority Health that outlines data sources that health care organizations and researchers can use to better understand the impact that social determinants of health have on people with disabilities. It also provides data sources and examples of how data is useful in identifying opportunities for quality improvement in health care.

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