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Center for Disability Issues and the Health Professions

IMPORTANCE OF ACCESSIBLE EXAMINATION TABLES, CHAIRS and WEIGHT SCALES

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- Review of Legal Research on Accessible Medical Equipment
- Health Care Facilities Access
- Choosing and Negotiating an Accessible Facility Location
- Providing Information in Alternative Formats
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INTRODUCTION

Health care providers should have accessible examination tables, chairs and weight scales for these reasons:

1. Improve quality of care for people with disabilities and activity limitations;
2. Comply with legal obligations under Title II or Title III of the Americans with Disabilities Act;
3. Serve Individuals with disabilities and activity limitations who represent a sizable portion of the population;
4. Reducing health care professionals' workplace injuries; and
5. Take advantage of the federal tax incentives for improving accessibility.

1. a. IMPROVED QUALITY OF CARE FOR PEOPLE WITH DISABILITIES AND ACTIVITY LIMITATIONS

When a physician is unable to perform an appropriate examination because a patient cannot get onto an examination or procedural tables and chairs, or be weighed on a standard scale, the patient may receive a lesser quality of health care. The patient might be misdiagnosed, because the physician may not have sufficient information. Alternatively, the patient might miss the benefit of early detection of a developing condition such as cancer. By providing accessible examination tables, physicians improve the quality of care provided to people with disabilities and activity limitations. In addition, the use of an accessible exam table may also reduce the frequency and time required in using a lift team, lift equipment and/or providing transfer assistance from staff.

In addition to getting on the table…the low height of the table allows many people to sit with their feet still on the floor, eliminating strain on their back and legs. It also allows people who prefer a chair to remain in the chair while waiting for the provider and then to easily move on to the table. … Exam tables with greater height flexibility decrease the need for staff assistance and help the patient's maintain their independence, confidence and dignity.[i]

Lack of accessible equipment may cause doctors and other health professionals to forgo, omit, or not recommend procedures or elements of procedures for people with disabilities. Whereas, having these procedures are otherwise commonplace for people without disabilities and limitations. For example,

> "When a wheelchair user began to have irregular vaginal spotting, she tried to ignore it. She had not had a pelvic exam for a number of years because she wasn't able to find a facility where she could get on the examination table. When she finally did find such a facility, after much searching, she was diagnosed with endometrial cancer. Had accessible exam tables been in routine use in gynecological clinics and offices, this woman might have been diagnosed and treated earlier."[ii]

1. b. INDIVIDUALS WITH DISABILITIES REPRESENT A SIZABLE PORTION OF THE POPULATION

According to the US Census of 2000 people with disabilities represent 19.3 percent of the 257.2 million people who were aged 5 and older in the civilian non-institutionalized population or nearly one person in five. **Fifty percent of people over age 65 have some form of disability.**[vi]

With the average age of patients on the rise, more people will require easier access to equipment. The average life span today is 75 years, and is projected to rise to 85 years by 2050. The Census Bureau cites that the two highest factors of disabilities include arthritis or rheumatism and back or spinal injuries. All of these conditions can cause patients difficulty in getting on and off an exam tables, chairs, and weight scales.[vii]

In addition to improved access for people with physical disabilities and activity limitations, accessible medical equipment makes life easier and safer for everyone.

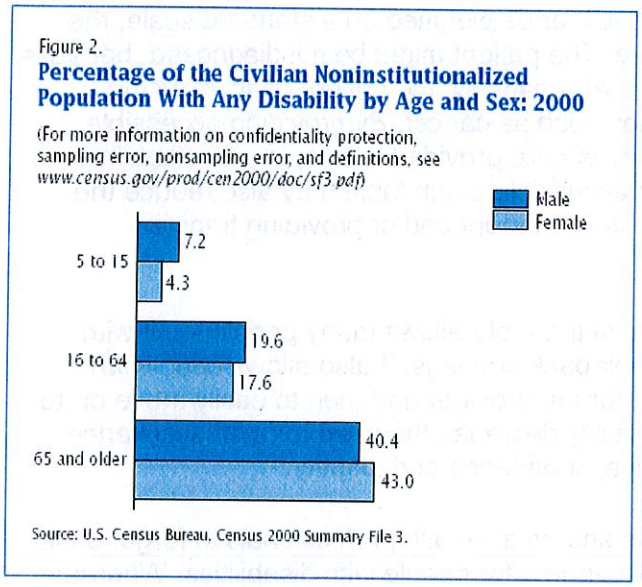


Figure 2. (Above left) Percentage of Civilian Non-institutionalized Population with any Disability by Age and Sex 2000

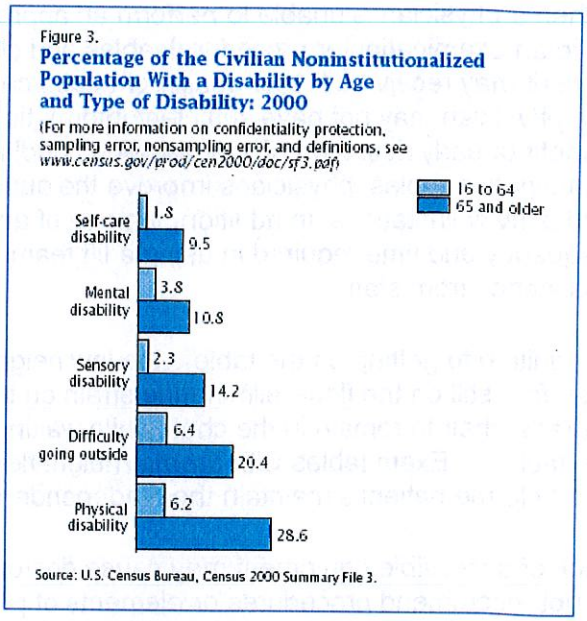
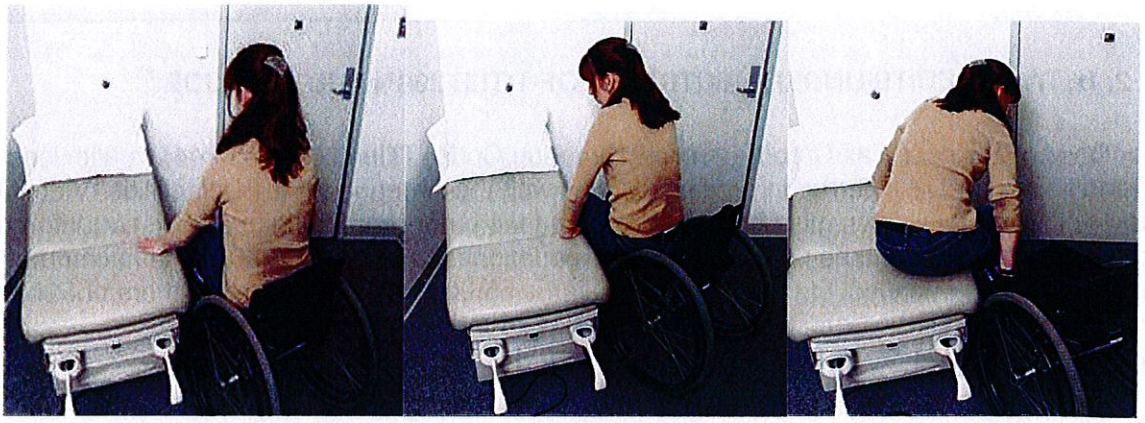


Figure 3. (Above right) Percentage of Civilian Non-institutionalized Population with a Disability by Age and Type of Disability: 2000

When tables and chairs can be lowered to 17"-19" from the floor making transferring easier for wheelchair users and people with activity limitations. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions); use mobility devices (e.g. canes, crutches, walkers); and have temporary activity limitations such as post surgical restrictions, or orthopedic injuries.



2. ACCESSIBLE EQUIPMENT IN MEDICAL FACILITIES

2. a. REDUCTION OF WORKPLACE INJURIES

When the height of an examination table or diagnostic chair is not adjustable, wheelchair users and people with other activity limitations may need to be lifted or assisted onto he equipment. This type of lifting can cause back or other musculoskeletal injuries to staff. Once the patient is on the equipment an adjustable-height feature also enables health care providers to elevate the equipment to a comfortable height for conducting an examination or procedure, thus, decreasing the risk of back strain or other injuries to these health care professionals.[viii]

> "The Occupational Safety and Health Administration (OSHA) estimated that 1.8 million US workers develop work-related musculoskeletal disorders. According to the US Department of Labor's Bureau of Labor Statistics, healthcare-related services reported over 59,000 musculoskeletal injuries in 1999. The majority of the injuries reported were strains and sprains to the back and shoulder caused by overexertion in lifting and resulted in the employee being off of work for several days."[ix]

Nursing is one of the riskiest occupation in the US, because it is most associated with work-related musculoskeletal disorders and back injuries. Nursing has the second-highest incidence of all types of non-fatal work-related injuries. 1998 injury data show that nearly 12 out of 100 nurses in hospitals and 17.3 out of 100 nurses working in nursing homes report work-related musculoskeletal injuries, including back injuries, which is about double the rate for all other industries combined.[x]

One of the responsibilities of many nurses is getting patients onto (and often, off of) the examination table. The height of the table determines how much bending and reaching is required to accomplish these tasks. However, the height of nurses varies, and so a simple-to-operate, height-adjustable table is important to allow the height to be appropriately adjusted to the nurse's height, to suit the nurse and facilitate a safer transfer for the patient.[xi]

> *"…this equipment allows us to give quality care that is safe for the patient as well as safe for us"*[viii]
>
> **Linda Kent, Certified Radiology Technician**
> **Kaiser Permanente, Folsom, CA**

2. b. TAX CREDITS UNDER SECTION 44 OF TITLE 26 IN THE IRS CODE:[xii]

The "Disabled Access Tax Credit" (Internal Revenue Code, Title 26, Section 44), is allowed for expenditures that are incurred in order to comply with the Americans with Disabilities Act (ADA). This enables an eligible small business to elect to take a nonrefundable tax credit equal to half of the expenditures it makes on eligible accommodations that exceed $250. The maximum credit a business can elect to take in any tax year is $5,000 for eligible expenditures of $10,250 or more. (See: **CDIHP Brief: Disability Access Tax Incentives - www.cdihp.org/briefs/brief6-tax-incentives.html)**

2. c. MEDICAL CARE DISABILITY DISCRIMINATION CASES

Since the 90s', a growing number of private and public disability discrimination cases have been successfully filed over the past ten years. Individuals with disabilities and the disability community have become increasingly public and diligent in asserting their civil rights to equal access, specifically, requiring the courts to enforce ADA requirements in the health care field.

Several examples from the Department of Justice include:

- A Virginia medical center allegedly refused to treat a wheelchair user during her scheduled appointment because staff said they could not lift her on to the examining table. As a result, the medical center:
  - Completed a survey of current examination tables;
  - Developed a capital budget to purchase motorized exam tables; and
  - Provided training to staff on ADA requirements.[xiii]

- A Washington, D.C. Radiology practice allegedly failed to provide adequate assistance to a wheelchair user to help her transfer to an examination table. The practice:
  - Purchased an additional height-adjustable examination table; and
  - Designated three lead medical assistants as ADA patient advocates to help people with mobility disabilities receive services as quickly and efficiently as other patients.[xiv]

- Georgetown University Hospital allegedly failed to reasonably accommodate a wheelchair user by providing assistance to help her transfer to an examination table in its obstetrics and gynecology clinic. After being sued, Georgetown agreed to:
  - Pay the plaintiff $15,000.00;
  - Pay the United States a civil penalty in the amount of $10,000; and
  - Undertake a facility-wide review of related accommodation and accessibility problems.[xv]

- A wheelchair user recommended to her California Family Practice physician that they borrow or purchase an adjustable examination table; the practice allegedly advised the patient to obtain her yearly examination from another physician, because the practice was "unable to

readily purchase an adjustable exanimation table or lift because of budget constraints." As a result, the practice agreed to:

- Purchased a 17-19" from floor height-adjustable examination table;
- When scheduling appointments, staff will ask if the patient needs: modifications of a policy, special assistance, and/or auxiliary aids or services because of a disability; and
- All staff will receive training in: Disability sensitivity and awareness, ADA Title III, and techniques for lifting and transferring people with mobility disabilities. [xvi]

➲ In November 2005, a settlement was reached with the largest private hospital in the nation's capital, *Washington Hospital Center.* This settlement is one of the first of its kind to address *access to hospital facilities* and equipment for patients with mobility impairments and other disabilities Under this settlement the hospital will:

Some of the term of the agreement include Washington Hospital Center will:

- Remove barriers throughout the hospital,
- Procure accessible exam tables for every department that uses exam tables (after the date of the agreement, all new exam tables and chairs purchased by WHC will be accessible),
- Survey all equipment and purchase accessible equipment where needed,
- Review and revise its polices, implement special procedures for patients with spinal cord injuries, and
- Provide training to its staff to ensure implementation and use of its new policies and equipment.[xvii]

PRIVATE ACTIONS

➲ In a private action, *Metzler v. Kaiser Permanente of California*, 2001, an agreement settled a class-action lawsuit filed against Kaiser Permanente, on behalf of all its California Members with disabilities. The lawsuit argued that Kaiser discriminated against patients with disabilities by giving inferior medical care.[xviii] Some of the term of the agreement include:

- Removal of architectural barriers;
- Installation of accessible medical equipment, including wheelchair accessible scales;
- Review of Kaiser Permanente's policies, procedures and programs to improve access to quality health care for people with disabilities; and
- Develop a training program to educate its health care professionals about treating people with disabilities;
- Development of a complaint handling system to meet the needs of the people with disabilities.

2. d. COMPLYING WITH THE ADA

The major pieces of federal legislation governing equal access to health care services for individuals with disabilities are the Rehabilitation Act (Rehab Act) and the Americans with Disabilities Act (ADA). These laws constitute a national mandate prohibiting discrimination based on disability in the provision of goods and services available to the public.

Section 504 of the Rehab Act prohibits any organization that receives federal financial assistance from denying individuals with disabilities equal access to the services. For example, hospitals, clinics, and other health care facilities that accept Medicaid, Medicare, or any other form of federal funding must comply with the Rehab Act. Section 504 states, "No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." If the provider serves just one Medicare or Medicaid beneficiary, that provider's entire operations must comply with the Rehab Act. Medicare and Medicaid managed care plans must provide programmatic access to all its enrollees with disabilities. [xix]

ADA's Title II extends the Rehab Act's requirements to all state and local government activities. All health care providers who offer health care services, either directly or through contractual arrangements, to Medicare or Medicaid beneficiaries must comply with the Rehab Act because Medicare and Medicaid funding is considered federal financial assistance.[xx]

ADA's Title III states: "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation."

All health care providers, including hospitals, nursing homes, psychiatric and psychological services, private physicians' offices, diagnostic centers, physical therapy centers, and health clinics, are places of public accommodations and therefore must comply with Title III.[xxi]

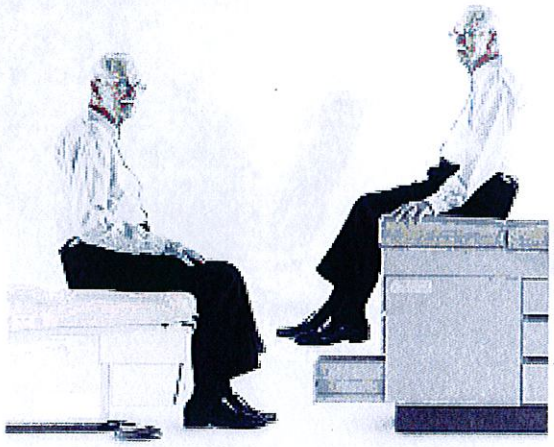
3. EXAMINATION, PROCEDURAL, AND DIAGNOSTIC TABLES AND CHAIRS

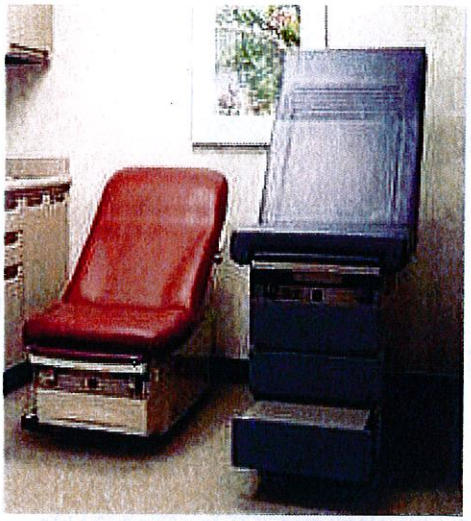
3. a. SIDE-by-SIDE COMPARISON

ACCESSIBLE Height-adjustable examination table (below left) lowering from 18 inches (ground to top-of-cushion)

vs.

NON-ACCESSIBLE - Standard (box) examination table (below right) fixed height of 34 inches (ground to top-of-cushion)





3. b. SAMPLES OF EXAMINATION TABLES AND CHAIRS

Below are examples of height adjustable tables and chairs lowering to a minimum of 17 to 19 inches from ground to top-of-cushion.

i. Standard Examination Tables
ii. Bariatric Examination Tables
iii. Procedural Tables
iv. Treatment Tables
v. Procedural Chairs
vi. Ophthalmology Chairs
vii. Specialty Chairs

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i. Standard Examination Tables

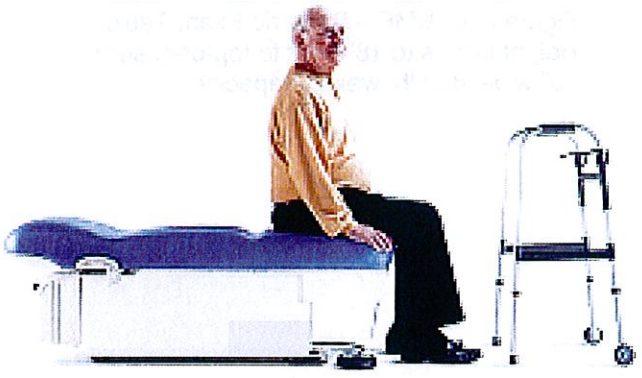


Figure 3. i. Midmark Barrier-Free Examination Table. Lowers to 18" floor to top-of-cushion. 400 lb. weight capacity.

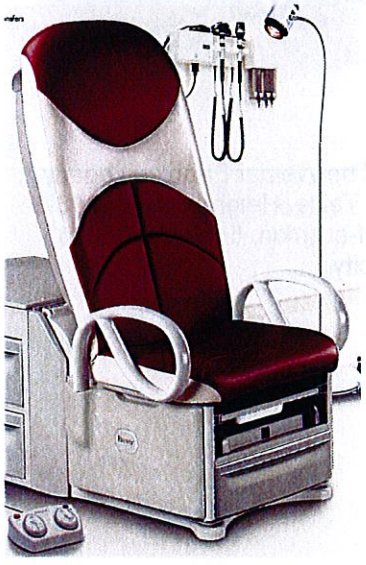


Figure 3. ii. Brewer Power Access Examination Table. Lowers to 18" floor to top-of-cushion. 450 lb. weight capacity.

ii. Bariatric Examination Tables

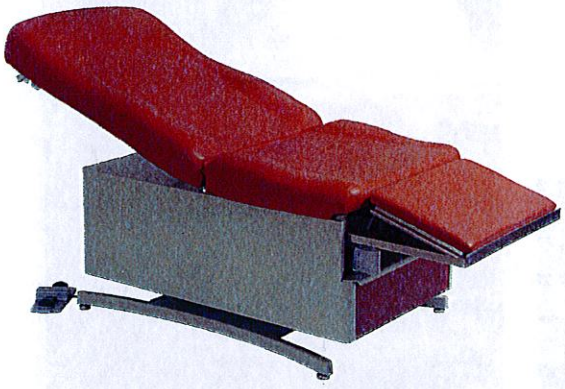


Figure 3. iii. UMF 4070 Power Exam Table. Lowers to 19" floor to top-of-cushion. 600 lb. weight capacity.

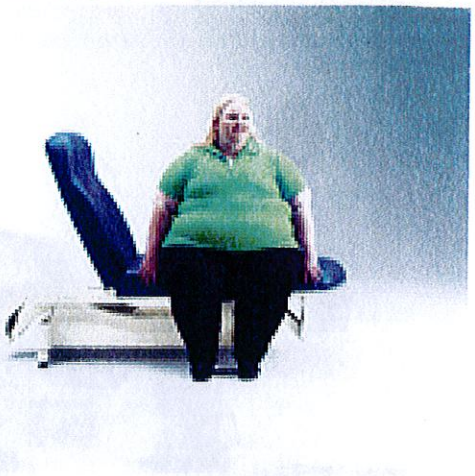


Figure 3. iv. Midmark Bariatric Examination Table. Height lowers to 18" floor to top-of-cushion, 54" wide, 800 lb. weight capacity.

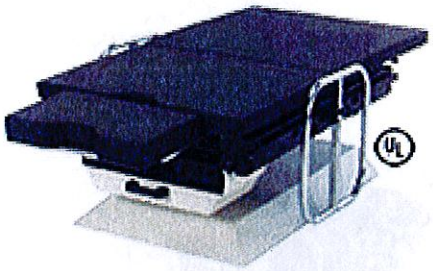


Figure 3. v. The Welner Enabled Legacy Examination Table. Height lowers to 18" floor to top-of-cushion, 54" wide, 650 lb. weight capacity.

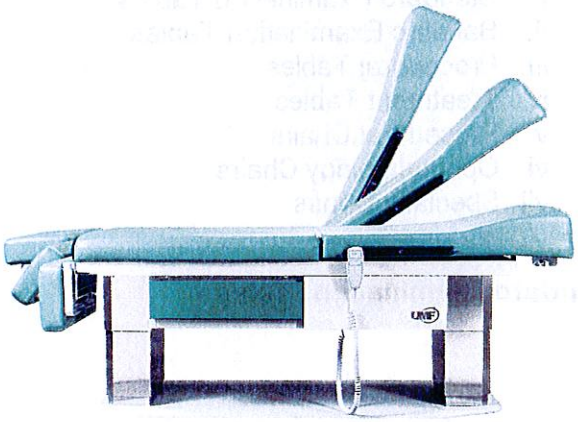


Figure 3. vi. UMF – Bariatric Exam Table. Height lowers to 18" floor to top-of-cushion, 30" wide, 800 lb. weight capacity.

iii. Procedural Tables and Chairs (Dermatology, ENT, Podiatry)

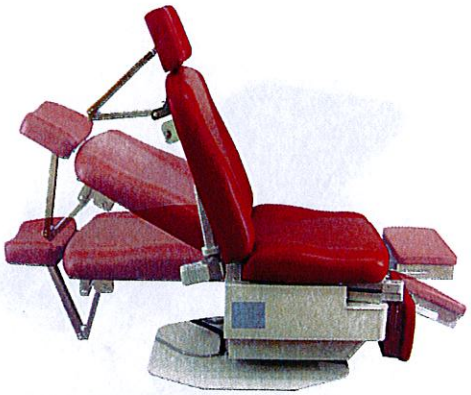


Figure 3. vi. UMF 4010 Power Procedure Table. Height lowers to 19" floor to top-of-cushion width 27," 600 lb. weight capacity.

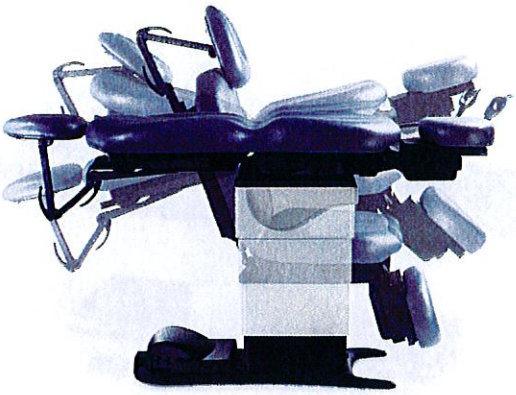


Figure 3. vii. Midmark 622/623 Procedural Table. Height lowers to 18" floor to top-of-cushion. 54" wide, 450 lb. weight capacity.

iii. a. Podiatry

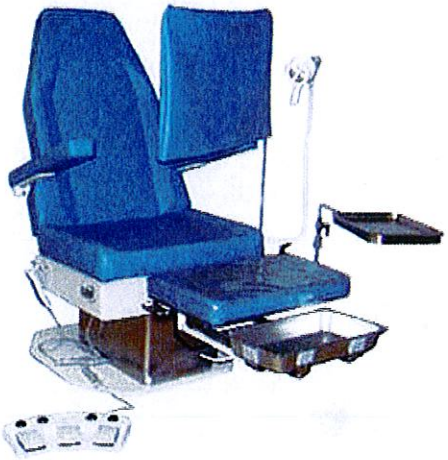


Figure 3. viii. UMF 5016 Power Podiatry Chair. Height lowers to 19" floor to top-of-cushion. 550 lb. weight capacity.

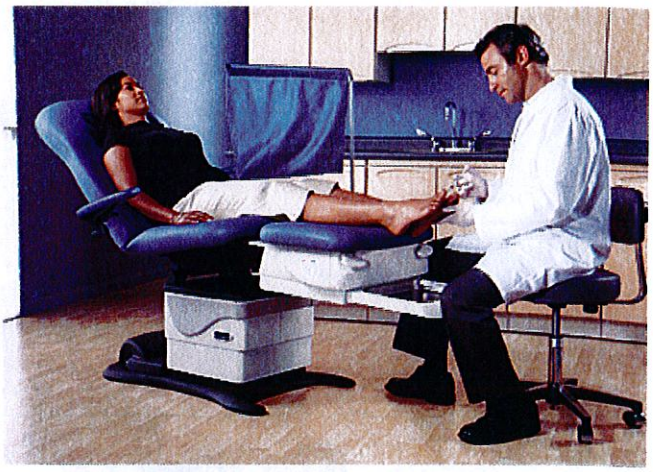


Figure 3. viii. Midmark 647 Barrier-Free® Power Podiatry Chair Height lowers to 19" floor to top-of-cushion. 450 lb. weight capacity.

iv. Treatment Tables (Physical Therapy, Orthopedics, Rehabilitation Medicine, Chiropractic, and Massage)

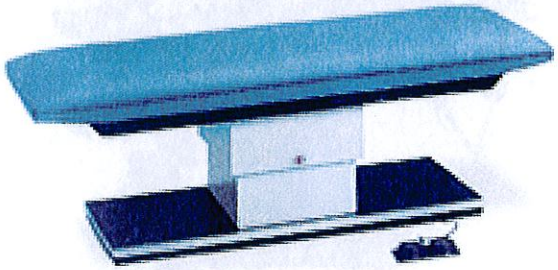


Figure 3. viii. Huasmann Model 4756 Powermatic Table. Height lowers to 19 in. floor to top-of-cushion, 27" wide, 400 lb. weight capacity.

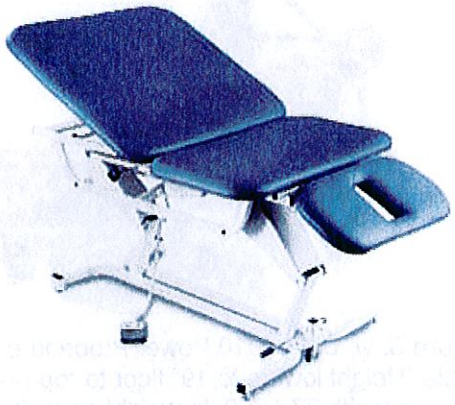


Figure 3. ix. Chattanooga Group Adapta® 340 Treatment Table - Three Section. Height lowers to 18" floor to top-of-cushion, 32" wide.

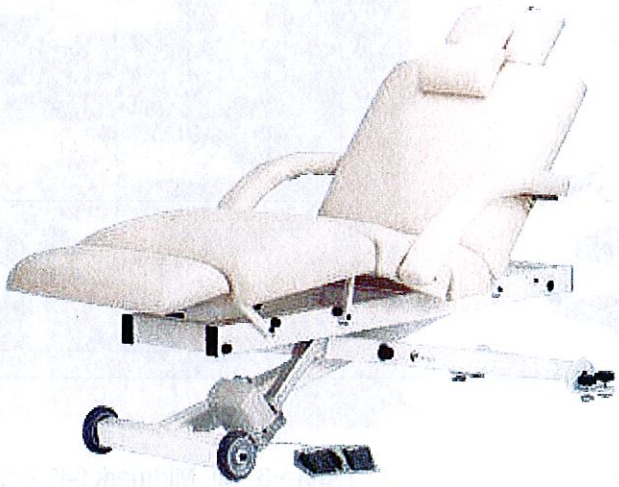


Figure 3. x. Earthlite - Ellora Spa and Salon Massage Table. Height lowers to 17" floor to 36" top-of-cushion. Widths 25", 27", and 30," 650 lb. weight capacity

v. Ophthalmology Chair

Figure 3. xi. Reliance Model 980 Optometry Chair. Height lowers to 19" floor to top-of-cushion (with low base option). 400 lb. weight capacity.

vii. Infusion Recliners

Figure 3. xii. Winco Medical Swing Away Arm CareCliner - 694N. Seat height 21" floor to cushion. Swing away arms provide access and ease of entrance and exiting for persons with mobility limitations, wheelchair and scooter users.

3. c. CHOOSING AN ACCESSIBLE EXAMINATION TABLE OR CHAIR:

Desirable features of accessible examination tables and chairs include:

- ✓ **Height adjustable, with a minimum height of 19 inches, or, preferably 17 inches** from the floor to the top of the cushion. Provides many wheelchair and scooter users to laterally transfer with less physical lifting from staff, in addition to easier access for other people with mobility limitations including pregnant patients, seniors, and larger patients. (*see page 9, i. Standard Examination Tables for samples)*
- ✓ **Extra-wide cushion top (24 inches or greater)** and higher weight capacities (400 lb. or greater) for larger patients.
- ✓ **Adjustable handrails and/ or side panels**. Handrails and side panels provide added safety, balance, and stability assistance for getting onto and off the table, in addition to stability and maintaining positioning once and the table.

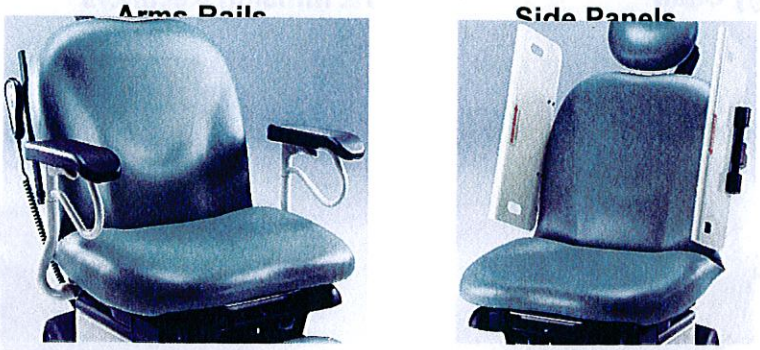


Figure 3. xiii. Midmark accessories offered for Barrier Free model 222/ 2223 Examination Table and 623/623 Procedural Table includes adjustable arm rails, and side panels.

- ✓ **Foot/ leg supports that can be adjusted and locked.**

In addition to the above, the following accessories should be considered for patient safety and comfort:

- ✓ **Pillows** that can provide assistance with positioning and stability,
- ✓ **Velcro positioning straps** may be needed by some people for added for stability,

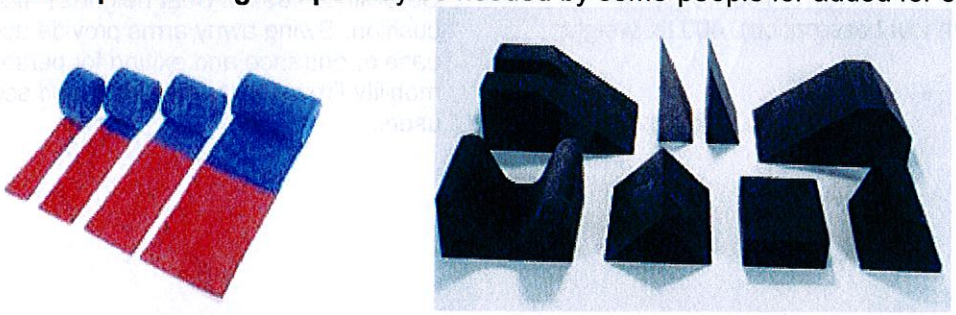


Figure 3. xiv. Positioning straps with velcro closures, and positioning wedges. For positioning devices sample site, see Ali Medical

- ✓ **Articulating knee crutches**. These provide added safety for both the patient and the provider by allowing increased stability and control for patients unable to hold their legs in place on their own or have spasticity.

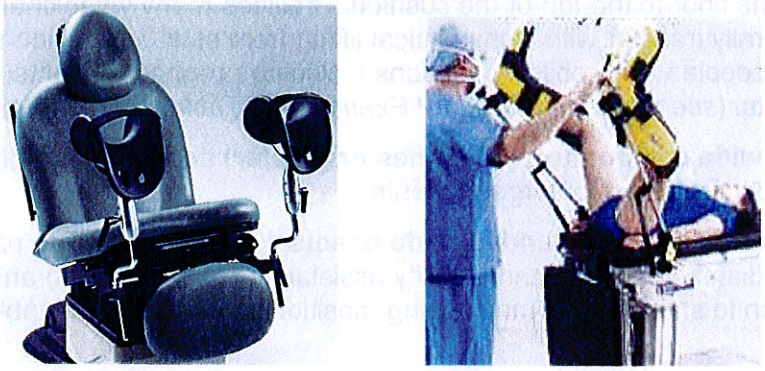


Figure 3. xiv. (Left) Midmark Corporation accessories offered for Barrier Free model 222/ 2223 Examination Table and 623/623 Procedural Table includes articulating knee crutches.

Figure 3. xv. (Above right) Yellofins, www.allenmedical.com

4. ACCESSIBLE WEIGHT SCALES

Accessible scales are useable by all people without and with disabilities including wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries.); and people who use mobility devices (e.g. canes, crutches, walkers.)

When patients cannot be weighed, they receive a lesser quality of health care. Without an accurate and current weight measurement, chances of missed diagnosis or incorrectly prescribed medication increase. It is well documented that weight gain and obesity can be linked to:

- Cardiovascular Disease,
- High Blood Pressure,
- Unhealthy Cholesterol Levels and Lipid Levels,
- Diabetes,
- Cancer,
- Negative impacts on muscles and bones,
- Reproductive and hormonal problems,
- Effects on the liver and lungs, and
- Many other conditions.[xxii]

For 18 years, John Lonberg, a man in his early 60's with quadriplegia from a spinal cord injury, urged his health care clinic to install an accessible exam table and wheelchair scale. The clinic refused. Often no one was available to lift him onto the standard-height table; his clinicians frequently performed cursory examinations, while John sat in his wheelchair. .[iii]

> "It took a while," he said, "but I gradually realized that I wasn't getting the same level of care I had received when I could walk, and get on the scale, and climb up on the examination table. Doctors were prescribing dosages based on what they guessed I weighed, so I began thinking maybe I should be weighed."
>
> "I remember asking my doctor when he was prescribing the amount and the dosage of a particular medication that was very critical for my care, 'what was he basing it on?' He said, 'well, this is based on the record of your size and weight.' And I said, 'are you aware the weight you're looking at in that chart is more than ten years since anyone has had me on a scale?'"
>
> ". . . Nobody had done anything other than... estimating how tight my pants were that morning when I put them on to determine whether I'd been gaining... or losing weight. And that wasn't really a very scientific way to determine dosage in medications either."[iv]
>
> **John Lonberg, Kaiser Permanente Member**

John's story exemplifies a common problem, failure to provide safe and accessible care. This failure produced disastrous consequences, for John and the health care system that now needed to expend a substantial amount of funds for the costs of surgery and lengthy postoperative care.[v]

In addition, cancer-related weight loss can negatively affect response to therapy, quality of life and survival. Weight loss of just 5 percent is associated with a decreased rate of survival.[xxiii]

Unintended weight loss can put older people and people with disabilities at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases.[xxiv]

By providing accessible weight scales you can improve the quality of care provided to people with disabilities and activity limitations.

> "Minimal effort is required to set up or operate these scales . . . for many Kaiser Permanente Members; the scales restore a vital but sometimes neglected component of a standard medical assessment." [xxv]
>
> **Linda Kent, Certified Radiology Technician**
> **Kaiser Permanente, Folsom**

Several types of accessible weight scales are available from a number of manufacturers including wheelchair, platform, bed, standing, and bariatric scales.

4.1. Wheelchair Scales

The most common types of accessible scales are wheelchair scales. Wheelchair scales can be used by ALL patients, are recommended for patients with limited stability, larger patients, and patients needing to sit on a chair while be weighed. Types of these scales include:

i. Folding Portable Wheelchair Scales (easily moved when needed)

ii. Stationary

iii. Platform (portable and in-ground)

1. Folding Portable Wheelchair Scales (easily moved when needed)

Portables scales range in the ease in which they can be moved. For example, some portable scales can be folded up and are light in weight, while others are heavier and take greater effort to move. When planning to purchase a wheelchair scale it is important to consider the safely features needed for the patient, and, that of staff, and whether portability of a scale is needed.

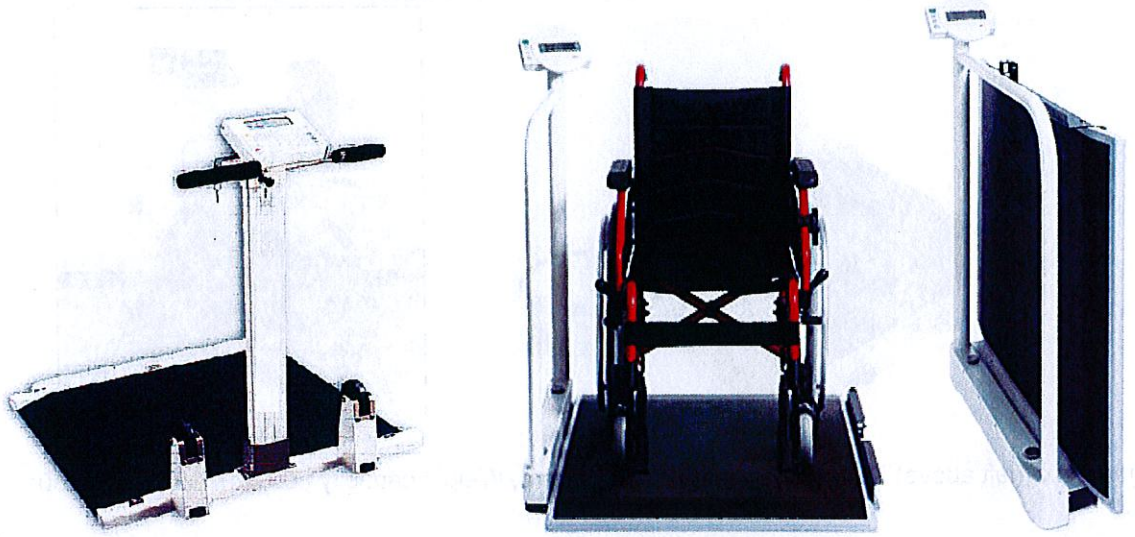


Figure 4. i. (left above) Detecto Portable Wheelchair Scale. Weight capacity 600 lb. Platform size 34 x 32.

Figure 4 ii. (middle and right above) Seca 676 Wheelchair Scale. Weight capacity 800 lb. Platform size 35 x 38.

2. Stationary (wall-mounted and wall-hugging) Wheelchair Scales (with safety rails and non-slip surface)

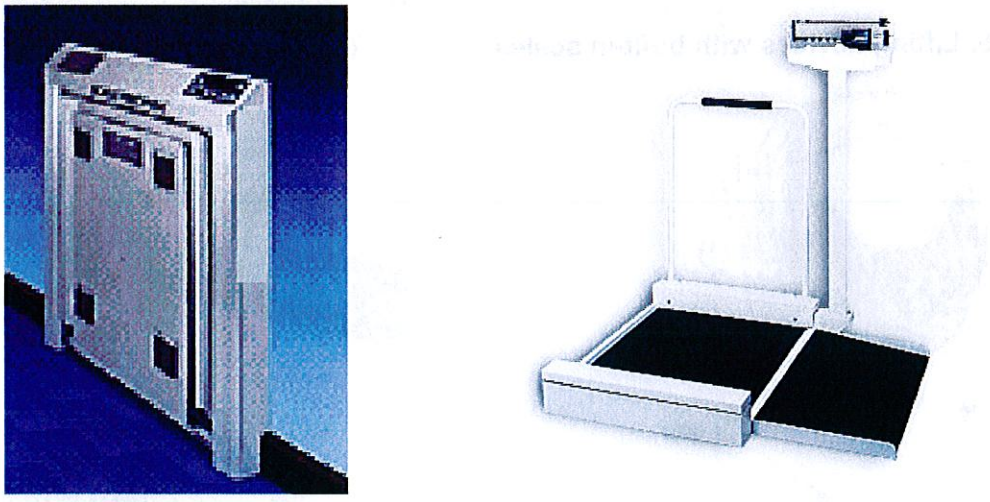
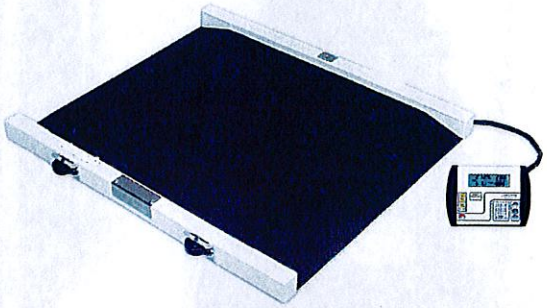


Figure 4. iii. (left above) Scaletronix Wall Mounted Wheelchair Scale. Weight capacity 660 lb. Platform size 34 x 32.

Figure 4 iv. (right above) Detecto 6496 Wall Hugger Wheelchair Scale. Weight capacity 800 lb. Platform size 30 x 26.

3. Platform (portable)



4. Platform (in-ground)

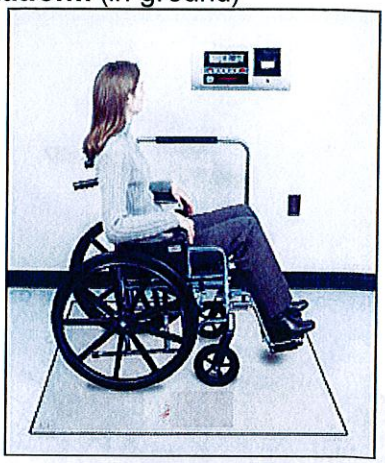
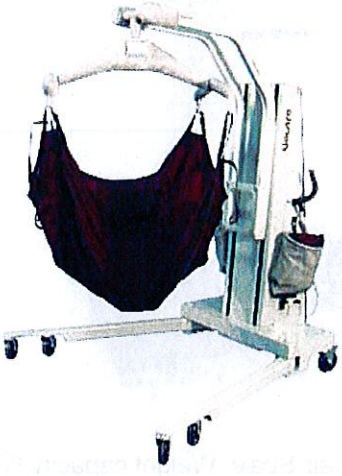


Figure 4. v. (left above) Detecto Bariatric Portable Scale. Weight capacity 800 lb. Platform size 30 x 32.

Figure 4 vi. (right above) In-Floor Medical Scales. Scales are recessed into the floor for multi-purpose weighing. Weight capacity 1,000 lb. Platform sizes available 36" x 36", 48" x 36", and 72" x 48". Extra-wide platform to accommodate large wheelchairs, extra-wide dialysis chairs, beds, and ambulatory stretchers.

While wheelchair scales are the most commonly, used type of scale used to weigh the largest variety of patients, particularly in a clinical setting. There are other types of "specialty" scales used more commonly in hospitals to ensure providers and patients are weighed safely and accurately. These include 5. lifting devices with built-in scales, 6. in-bed scales, and 7. hospital beds with built-in scales. Areas where such scales are commonly used include: intensive care, coronary care, geriatric care, surgical recovery, burn treatment, and rehabilitation. Below are samples of these three types.

5. Lifting devices with built-in scales



6. In-bed scale

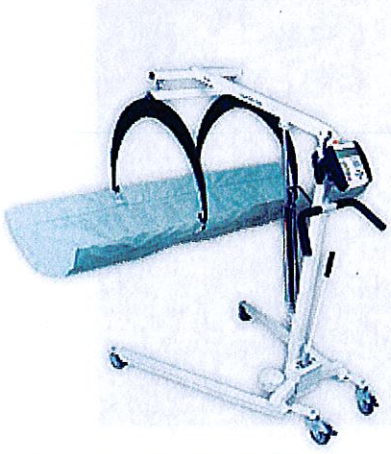


Figure 4. vii. (Left above) Volaro Series 4XB Full Body Patient Lift w/Scale. Weight capacity 1,000 lb.

Figure 4 viii. (Right above) IB400 Weigh mobile Electronic In-Bed Scale. Weight capacity 400 lb. Under bed clearance 4.8" (122mm) high.

7. Hospital beds with built-in scales

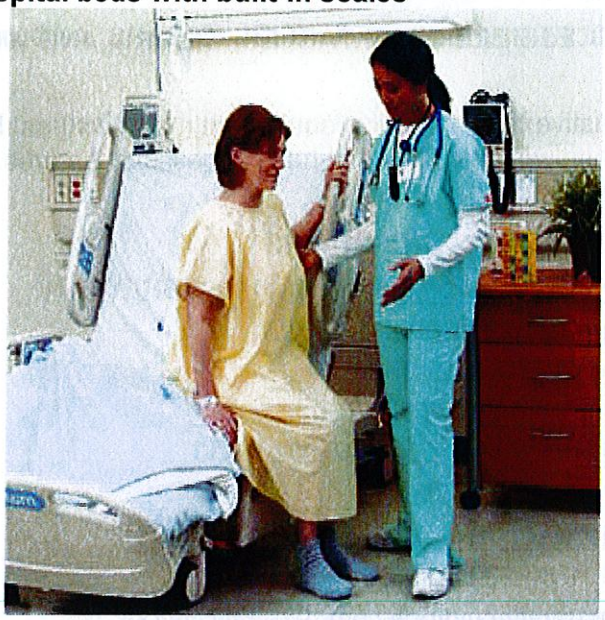
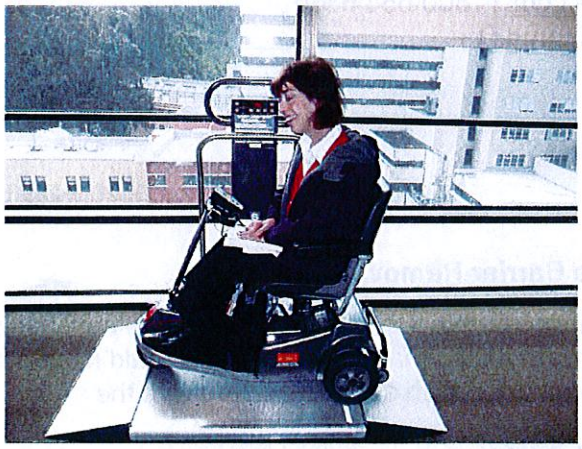


Figure 4. ix. (Left). Hill-Rom VersaCare® Bed. Built-in scale. Lowest height to 15.5 inches, floor to sleep surface (excluding mattress).

4. a. CHOOSING AN ACCESSIBLE WEIGHT SCALE:

Desirable features of an accessible weight scale include:

- ✓ Sturdy hand rails,
- ✓ High weight capacity (500-800lbs+),
- ✓ Large and easy-to-read display (digital),
- ✓ Slip resistant platform, and
- ✓ Wide platform, large enough to accommodate large power-wheelchairs



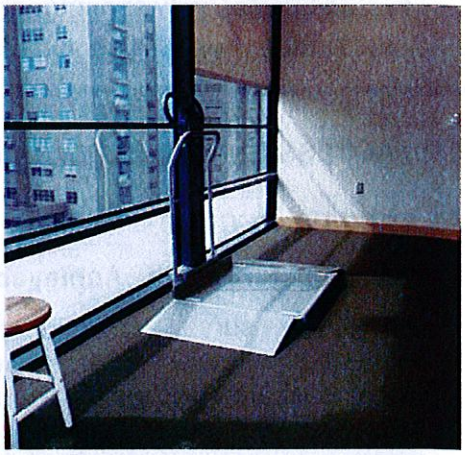


Figure 4. x. Above is a sample picture of a Scaletronix Oversized Wheelchair Scale, 6702W with a scooter user. This wheelchair scale is large enough to accommodate a scooter user. For more information on wheelchair scale platform sizes, refer to page 19, *Resources*.

5. RESOURCES

5. a. MANUFACTURERS OF ACCESSIBLE EXAM TABLES, CHAIRS, AND WEIGHT SCALES

The following is a sample (non-exhaustive) list of medical equipment manufactures that produce examination tables, chairs, and weight scales that have accessible features. For more information, contact the manufactures.

A. ACCESSIBLE EXAMINATION TABLES AND CHAIRS

- The Brewer Company, www.brewercompany.com, 1-888-BREWER-1
- Chattanooga, www.chattgroup.com 1-800-494-3395
- Earthlite, www.earthlite.com 1-800-872-0560
- Hausmann, www.hausmann.com 201-767-0255
- Hill Laboratories, www.hilllabs.com, 1-877-445-5020
- Hill-Rom, www.hill-rom.com, 1-800.445.3730
- Jameson Medical, www.jamesonmedical.com, 1-877-585-4041
- Keitzer, www.keitzer.com, 1-800-321-3146
- Martin Innovations, www.martininnovations.com, 919.647.4218
- Ritter/ Midmark, www.midmark.com, 1-800-MIDMARK
- Sonesta, www.stille-sonesta.com 1-800.665.1614
- United Metal Fabricators, www.umf-exam.com 1-800-638-5322
- Welner Enabled, www.welnerenabled.com, 1-800-430-9810
- Winco, www.wincomfg.com, 1-800-237-3377

B. ACCESSIBLE WEIGHT SCALES

- Detecto, www.detectoscale.com 1-800-641-2008
- Health-o-meter, www.healthometer.com,
- Scaletronix, www.scaletronix.com, 1-800-873-2001
- SECA, www.itinscale.com
- SR Scales, www.srinstruments.com 1- 800-654.6360
- Tantia, www.tanita.com, 847-640-9241

5. b. ACCESS GUIDANCE DOCUMENTS

A. FACILITY ACCESS

- **Checklist for Readily Achievable Barrier Removal**

  Easy-to-use survey tool for identifying barriers in facilities. The complete checklists and worksheets are the kind of documentation that organizations should keep on file to demonstrate that they are making a good faith effort to comply with the requirements of the ADA.
  www.usdoj.gov/crt/ada/checkweb.htm

- Kailes, J., **Americans with Disabilities Act Compliance Guide for Organizations,**1995, (Hardcover)

  Informal presentation on ADA compliance with chapters on: program access and nondiscrimination; physical access; communication access; and employment practices. Gives steps for completing an ADA compliance plan, contains checklists, planning sheets, samples of ADA compliance plans and lists many resources available for additional information and assistance. (Compliance with the transportation provisions of ADA is not covered).
  www.jik.com/adacg.html

  Contact June Isaacson Kailes, Disability Policy Consultant
  Email: jik@pacbell.net, www.jik.com

- **Removing Barriers to Health Care: A Guide for Health Professionals, 1998.**

  This booklet provides guidelines and recommendations to help health care professionals ensure equal use of the facility and services by all their patients. This guide gives health care providers a better understanding of how to improve both the physical environment and personal interactions with patients with disabilities
  www.fpg.unc.edu/~ncodh/rbar/

  PDF (335KB): www.fpg.unc.edu/~ncodh/pdfs/rbhealthcare.pdf

B. COMMUNICATION and CUSTOMER SERVICE ACCESS

- Kailes, J., **Language is More Than a Trivial Concern!** November 1990, Revised 1999.

  Sensitizes people to appropriate terminology to use when speaking with, writing about or referring to people with disabilities. Challenges readers to be aware of the importance of using disability-neutral terms. Details preferred language and gives reasons for the disability community's preferences. Serves as an excellent reference tool for the public, media, marketers, providers and for board members, staff and volunteers of disability-related organizations. Includes a language quiz and many examples. A best seller!
  www.jik.com

- Kailes, J., **Preferred Practices to Keep in Mind as You Encounter People Who Have Disabilities,** Revised October 2000.

  Describes practical approaches to use when serving or waiting on customers with physical, visual, hearing, cognitive, intellectual, and psychiatric disabilities, as well as people with significant allergies, asthma, multiple chemical sensitivities, and respiratory-related disabilities. Excellent training tool for people working with the public, includes a quiz as well as language and communication tips.

  jik@pacbell.net,
  www.jik.com/gpam.html

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ENDNOTES

[i] *Accessible Examination Tables in Physicians' Offices,* wwww.members.aol.com/criptrip/accessible-exam-tables.htm (last updated August, 2002)

[ii] Ibid.

[iii] Glionna, J. M., *California and the West; Suit Faults Kaiser's Care for Disabled; Courts: Advocates Say Provider Fails to Give Equal and Adequate Treatment to the handicapped. Chain Says it Complies with Disabilities Act,* Los Angeles Times (Record edition), 27 July 2000, p. 3.

[iv] Ibid.

[v.] Ibid.

[vi.] U.S. Bureau of Labor Statistics. www.bls.gov/news.release/osh.t02.htm (16 Sept. 2002).

[vii.] Ibid.

[viii] Hedge, A. Spine Universe: *Back Care for Nurses* www.spineuniverse.com/displayarticle.php/article1509.html

[ix] Ibid.

[x] Ibid.

[xi] Wells, J., *Achieving the Highest Level of Efficiency and Comfort in the Examination Room for both Physician and Patient.* Midmark Corporation (August 2002).

[xii] 29 U.S.C. § 794 (1994).

[xiii] U.S. Department of Justice, *Enforcing the ADA: A Status Report from the Department of Justice,* Washington, D. C., Apr-Jun 2002.

[xiv] Ibid.

[xv] *Settlement agreement between the United States of American and Georgetown University*, under the Americans with Disabilities Act, Department of Justice complaint number 204-16-92; L. Einstein, Department of Justice staff attorney. Telephone conversation with author. 28 Jul 2003. www.usdoj.gov/crt/ada/gtownhos.htm#anchor262953

[xvi] *Settlement agreement between the Unites States of American and Dr. Robila Ashfaq,* under the Americans with Disabilities Act, Department of Justice complaint number DJ# 202-12C-264, OCR# 04-].

[xvii] *Settlement agreement between the United States of American and WASHINGTON HOSPITAL CENTER* under the Americans with Disabilities Act, Department of Justice complaint number 202-16-120. www.ada.gov/whc.htm

[xviii] 15674 Metzler v. Kaiser Foundation Health Plan, Inc., No. 829265-2 (Calif. Super. Ct., Ala. Cnty) (Dismissal Based on Settlement Agreement March 2001) [full settlement available at www.resna.org/taproject/policy/health/kaiser-s.doc

[xix] Title II applies to all public entities, defined as "any state or local government. 42 U.S.C. §12131 (2002). Section 504 applies to any entity that receives federal funding. 29 U.S.C. § 794. Federal financial assistance can be direct or indirect. *Jacobson v. Delta Airlines, Inc.*, 742 F.2d 1202, 1211 (9th Cir. 1984).

[xx] Ibid.

[xxi] Ibid.

[xxii] Weight Control and Diet, December 2001, Reuters Health (RH) http://www.reutershealth.com/wellconnected/doc53.html

[xxiii] Frequently Asked Questions. Cancer Care. www.cancercare.org.

[xxiv] Huffman, B., M.D., *Evaluating and Treating Unintentional Weight Loss in the Elderly*. Am Fam Physician 2002;65: 640-50. Feb.15, 02. www.aafp.org/afp/20020215/640.html.

[xxv] Glionna, J. M.