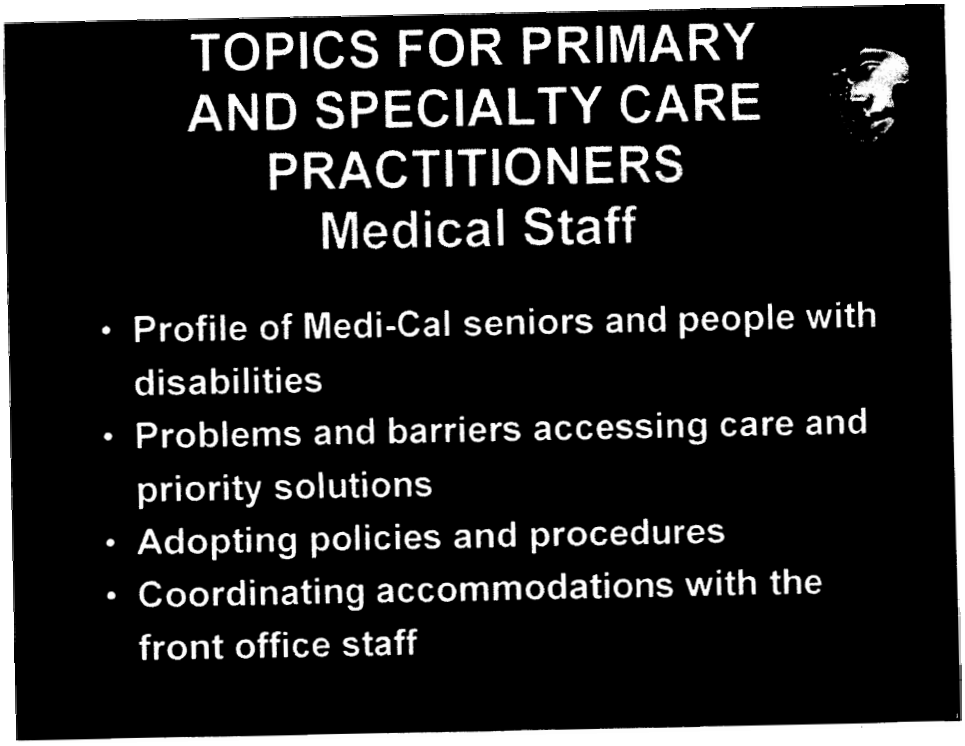

PRIMARY AND SPECIALTY
CARE PRACTITIONERS
Medical Staff
Serving People with Disabilities
And Seniors


TOPICS FOR PRIMARY
AND SPECIALTY CARE
PRACTITIONERS
Medical Staff
• Profile of Medi-Cal seniors and people with disabilities
• Problems and barriers accessing care and priority solutions
• Adopting policies and procedures
• Coordinating accommodations with the front office staff

What is Disability?

The interaction of physical, sensory, or cognitive impairment with environmental factors

Definition of Disability

Interaction of Impairment with Environmental Factors

Chronic conditions, diseases, disability

Functional Limitation

Accomm

Profile of Medi-Cal Beneficiaries Who Are Seniors

Disability, functional impairment and chronic conditions co-exist and cut across age among Medi-Cal beneficiaries

Profile of Medi-Cal Beneficiaries with Disabilities

- 70% who have disabilities live w/ two or more chronic conditions
- About 25% have four or more chronic conditions
- 30% of beneficiaries with disabilities receive treatment for mental health conditions annually

Profile of Medi-Cal Seniors

- Seniors represent about 14% of Medi-Cal beneficiaries who have no other insurance who will experience mandatory enrollment into managed care during 2011-2012

Profile of Medi-Cal Seniors: Activity Limitations

- About two-thirds of seniors in Med-Cal, and who have no other insurance, have disabilities
- Based on prevalence of disability among seniors, most seniors in Medi-Cal, who have no other insurance, are likely to have some type of activity limitation

Health Disparities & Medi-Cal Beneficiaries with Disabilities

- Among 70% with multiple chronic conditions -- 16% have diabetes compared with 7% of gen. pop.
- 30% are overweight or obese compared with 19% of gen. pop.
- 40% smoke compared with 22% of gen. pop

Health Care Disparities -- Medi-Cal Beneficiaries with Disabilities

- Women – fewer Pap tests and mammograms
- Overall -- Less participation in prevention programs

Problems and Barriers Accessing Care

- Physical (facility) barriers
- Communication barriers
- Equipment barriers
- Practitioner awareness barriers

Priorities for Physical Accessibility

- Access into the facility (for example, level entrance with no stairs)
- Access to areas where services are provided such as exam rooms or lab areas
- Access to restrooms
- Tax incentives available for modification of existing facilities

Priorities for Effective Communication

People Who Are Deaf, Hard-of-Hearing

- Qualified ASL interpreters
- Relay service
- Assistive listening device
- Text message
- Email
- Captioning

Priorities for Exam and Diagnostic Equipment

People with Ambulatory/balance Impairments

- Height adjustable exam tables
- Wheelchair accessible weight scales
- Adjustable mammography equipment
- Moveable optometry chairs

Priorities for Modification of Policies

People with Intellectual and Developmental disabilities

- Flexible appointment time
- Longer appointment time
  - Communication
  - Care coordination
- Providing assistance filling out forms

Misinformation Can Affect Treatment Decisions

Common Misconceptions and Stereotypes

- All deaf people can read lips
- Some women with disabilities are not sexually active
- People with developmental disabilities cannot contribute to their community

Other Priorities for Modification of Policies

People with Various Functional Limitations

- Providing assistance filling out forms
- Providing lifting assistance
- Providing print materials in alternative, accessible formats
- Allowing service animals

Sample Policies and Procedures

Accommodating Seniors and People with Disabilities–Model Policies and Procedures for Primary and Specialty Care Providers

- Americans with Disabilities Act Compliance
- Accommodations for Seniors and People with Specific Disabilities
- Standard Patient Information Materials Produced in Alternative Formats
- Disability Awareness Staff Training
- Accommodations Check Sheet
- Grievance Policy

How the Health Plan Can Help

- Assistance with arranging for Sign Language interpreters
- Methods for providing print materials in alternative formats
- Sources for equipment such as assistive listening devices, accessible weight scales, conversion of print material to Braille

Coordinating with Front Office Staff

- Communicate accommodation needs with front office staff
- Ask front office staff to arrange accommodations IN ADVANCE

  Sign Language interpreters
  Print materials in accessible formats (for example, consent forms, insurance documents, brochures, diabetes education material)
  Flexible exam time

Handouts/Resources

- Accommodation Check Sheets for Patients with Disabilities
- Accommodating Patients with Disabilities: Model Policies and Procedures
- Tax Incentives for Providers

Who Are People With Disabilities and Activity Limitations?

By June Isaacson Kailes, Disability Policy Consultant

People with disabilities and activity limitations include those who have:

- Limitations, which interfere with walking or using stairs (joint pain, mobility devise user - wheelchair, canes, crutches, walker),
- Reduced stamina, fatigue or tire easily (due to a variety of temporary or permanent conditions not limited to those on this list),
- Respiratory (heart conditions, asthma, emphysema, or other symptoms triggered by stress, exertion, or exposure to small amounts of dust or smoke etc.),
- Emotional, cognitive, thinking, or learning difficulties,
- Vision loss,
- Hearing loss,
- Temporary limitations resulting from, but not limited to:
    - Surgery
    - Accidents and injuries (sprains, broken bones)
    - Pregnancy

Disability should not be thought of as a condition that affects the "unfortunate few." Disability is a common characteristic and occurrence within the human experience. People with disabilities are a part of the world's diversity. It is important to think about disability broadly. Individuals with disabilities include those with one or more activity limitations such as reduced or no ability to see, walk, speak, hear, learn, manipulate or reach controls, and/or respond quickly. [1]

Some people who have these limitations identify as having a disability while others do not identify. Some disabilities are quite visible, while others may be hidden such as heart disease, emotional or psychiatric conditions, arthritis, significant allergies, asthma, multiple chemical sensitivities, respiratory conditions, and some visual, hearing and cognitive disabilities.[1]

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Disability-specific labels are not important, what is important is understanding that many people have limitations which can affect balance, coordination, endurance, manipulation, strength, bowel and bladder control, breathing, hearing, seeing, speaking, thinking, and walking. [1]

If you take the population of most communities a divide by five, the result approximates the number of people with disabilities in that community. 1996 data suggest that 19.7% of the general population, about 52.6 million people, live with some level of disability. [2] This represents 20 percent of the population. This number includes 29 million people between the ages of 16 and 64, or more than one in six people of working age. [1]

How does disability vary by age in the U.S.?

Prevalence of Disability Increases with Age	
Ages	**% Of People with Limitations**
Under 18	6.1.
18-24	6.9
25-54	14.1
55-64	28.4
Over 65	38.8
Over 85	56.6

The prevalence of disability increases with age, reaching its highest level among the very elderly, the majority of who are limited in activity. According to 1992 National Health Interview Survey data many Americans report limitations indicative of disability. Rates of activity limitation are incrementally lower among younger Americans. [3]

Likelihood of Experiencing Disability Increases with Age	
Ages	**Disability Rates**
Under 22	1.7
22-44	6.4
45 – 54	11.5
55 – 64	21.9
65 – 79	27.8
Over 80	53.5

A 1994 Survey of Income and Program Participation data also suggest that the likelihood of experiencing a disability increases with age. [4] [5]

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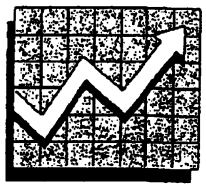
Americans Using Assistive Devices or Technologies	
Device	**Millions**
Canes	4.8
Hearing Aides	4.2
Walkers	1.8
Back Braces	1.7
Wheelchairs	1.6

1994 National Health Interview Data reports that an estimated 7.4 million Americans rely on devices to compensate for mobility impairments. [6]

U.S. Population Experiencing One or More Limitations in Physical Function	
Limitation	**Millions**
Trouble climbing stairs without resting	18.0
Difficulty walking 3 city blocks	18.4
Trouble hearing normal conversation	9.7
Difficulty seeing words and letters	8.3
Difficulty lifting or carrying a 10-pound object	6.0
Speech impairments	2.0

Functional Limitation provides a different dimension for measuring disability according to 1994-95 data from the Survey of Income and Program Participation. [5]

People with disabilities and people who are aging will constitute the majority of the population within the next 20 years. Most people, if they live long enough, will age into disability. As time alters our bodies, disability becomes a natural occurrence. There is an 80% chance that you will experience a temporary or permanent disability at some point in your life. [1]



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U.S. Department of Justice
Civil Rights Division
Disability Rights Section

U.S. Department of Health and Human Services
Office for Civil Rights

Americans with Disabilities Act

Access To Medical Care For Individuals With Mobility Disabilities

This publication may be viewed or downloaded
from the ADA Website (www.ada.gov).
Additional copies may be obtained
by calling the ADA Information Line

at

800-514-0301 (voice),
800-514-0383 (TTY).

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PART I: OVERVIEW AND GENERAL REQUIREMENTS

Accessibility of doctors' offices, clinics, and other health care providers is essential in providing medical care to people with disabilities. Due to barriers, individuals with disabilities are less likely to get routine preventative medical care than people without disabilities. Accessibility is not only legally required, it is important medically so that minor problems can be detected and treated before turning into major and possibly life-threatening problems.

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in every day activities, including medical services. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services. These statutes require medical care providers to make their services available in an accessible manner. This technical assistance publication provides guidance for medical care providers on the requirements of these statutes in medical settings with respect to people with mobility disabilities, which include, for example, those who use wheelchairs, scooters, walkers, crutches, or no mobility devices at all.

The ADA requires access to medical care services and the facilities where the services are provided. Private hospitals or medical offices are covered by Title III of the ADA as places of public accommodation. Public hospitals and clinics and medical offices operated by state and local governments are covered by Title II of the ADA as programs of the public entities. Section 504 covers any of these that receive federal financial assistance, which can include Medicare and Medicaid reimbursements. The standards adopted under the ADA to ensure equal access to individuals with disabilities are generally the same as those required under Section 504.

Services and Facilities

Titles II and III of the ADA and Section 504 require that medical care providers provide individuals with disabilities:

- full and equal access to their health care services and facilities; and
- reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e., alter the essential nature of the services).

The ADA sets requirements for new construction of and alterations to buildings and facilities, including health care facilities. These requirements are found in the regulations for the ADA, at 28 CFR 35.151, for Title II entities and at 28 CFR Part 36, Subpart D, for Title III entities. The regulations are available at *www.ada.gov/reg2.html* and *www.ada.gov/reg3a.html*.

In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility requirements for existing facilities. Under Title III, existing facilities are required to remove architectural barriers where such removal is readily achievable. Barrier removal is readily achievable when it is easily accomplishable and able to be carried out without much difficulty or expense. If barrier removal is not readily achievable, the entity must make its services available through alternative methods, if those methods are readily achievable. Under Title II, a public entity must ensure that its program as a whole is accessible; this may entail removing architectural barriers or adopting alternative measures, such as relocating activities to accessible locations. This same program accessiblity standard applies under Section 504.

PART 2: COMMONLY ASKED QUESTIONS

Q Is it OK to examine a patient who uses a wheelchair in the wheelchair, because the patient cannot get onto the exam table independently?

Generally no. Examining a patient in their wheelchair usually is less thorough than on the exam table, and does not provide the patient equal medical services. There are several ways to make the exam table accessible to a person using a wheelchair. A good option is to have a table that adjusts down to the level of a wheelchair, approximately 17-19 inches from the floor. (See Part 4 of this publication for a more in-depth discussion of accessible exam tables.) What is important is that a person with a disability receives equal medical services to those received by a person without a disability. If the examination does not require that a person lie down (for example, an examination of the face), then the exam table is not important to the medical care and the patient may remain seated.

Q Can I tell a patient that I cannot treat her because I don't have accessible medical equipment?

Generally no. You cannot deny service to a patient who you would otherwise serve because she has a disability. You must examine the patient as you would any patient. In order to do so, you may need to provide an accessible exam table, an accessible stretcher or gurney, or a patient lift, or have enough trained staff available who can assist the patient to transfer.

Q Is it OK to tell a patient who has a disability to bring along someone who can help at the exam?

No. If a patient chooses to bring along a friend or family member to the appointment, they may. However, a patient with a disability, just like other individuals, may come to an appointment alone, and the provider must provide reasonable assistance to enable the individual to receive the medical care. This assistance may include helping the patient to undress and dress, get on and off the exam table or other equipment, and lie back and be positioned on the examination table or other equipment. Once on the exam table, some patients may need a staff person to stay with them to help maintain balance and positioning. The provider should ask the patient if he or she needs any assistance and, if so, what is the best way to help.

Q If the patient does bring an assistant or a family member, do I talk to the patient or the companion? Should the companion remain in the room while I examine the patient and while discussing the medical problem or results?

You should always address the patient directly, not the companion, as you would with any other patient. Just because the patient has a disability does not mean that he or she cannot speak for him- or herself or understand the exam results. It is up to the patient to decide whether a companion remains in the room during your exam or discussion with the patient. The patient may have brought a companion to assist in getting to the exam, but would prefer to ask the

companion to leave the room before the doctor begins a substantive discussion. Before beginning your examination or discussion, you should ask the patient if he or she wishes the companion to remain in the room.

Q Can I decide not to treat a patient with a disability because it takes me longer to examine them, and insurance won't reimburse me for the additional time?

No, you cannot refuse to treat a patient who has a disability just because the exam might take more of your or your staff's time. Some examinations take longer than others, for all sorts of reasons, in the normal course of a medical practice.

Q I have an accessible exam table, but if it is in use when a patient with a disability comes in for an appointment, is it OK to make the patient wait for the room to open up, or else use an exam table that is not accessible?

Generally, patients with disabilities should not wait longer than other patients because they are waiting for a particular exam table. If the patient with a disability has made an appointment in advance, the staff should reserve the room with the accessible exam table for that patient's appointment. The receptionist should ask each individual who calls to make an appointment if the individual will need any assistance at the examination because of a disability. This way, the medical provider can be prepared to provide the assistance and staff needed. Accessibility needs should be noted in the patient's chart so the provider is prepared to accommodate the patient on future visits as well. If the medical provider finds that it cannot successfully reserve the room with the accessible exam table for individuals with disabilities, then the provider should consider acquiring additional accessible exam tables so that more exam rooms are available for individuals with disabilities.

Q In a doctor's office or clinic with multiple exam rooms, must every examination room have an accessible exam table and sufficient clear floor space next to the exam table?

Probably not. The medical care provider must be able to provide its services in an accessible manner to individuals with disabilities. In order to do so, accessible equipment is usually necessary. However, the number of accessible exam tables needed by the medical care provider depends on the size of the practice, the patient population, and other factors. One accessible exam table may be sufficient in a small doctor's practice, while more will likely be necessary in a large clinic. (See Part 4 for discussion of accessible exam tables and clear floor space.)

Q I don't want to discriminate against patients with disabilities, but I don't want my staff to injure their backs by lifting people who use wheelchairs onto exam tables. If my nurse has a bad back, then she doesn't have to help lift a patient, does she?

Staff should be protected from injury, but that doesn't justify refusing to provide equal medical services to individuals with disabilities. The medical provider can protect his or her staff from injury by providing accessible equipment, such as an adjustable exam

table and/or a ceiling or floor based patient lift, and training on proper patient handling techniques as necessary to provide equal medical services to a patient with a disability. (See Part 4 for more information on this equipment.)

Q What should I do if my staff do not know how to help a person with a disability transfer or know what the ADA requires my office to do? Also, I am unsure how to examine someone with spasticity or paralysis.

To provide medical services in an accessible manner, the medical provider and staff will likely need to receive training. This training will need to address how to operate the accessible equipment, how to assist with transfers and positioning of individuals with disabilities, and how not to discriminate against individuals with disabilities. Local or national disability organizations may be able to provide training for your staff. This document and other technical assistance materials found on the ADA Website (www.ada.gov) can be used in conjunction with live training to train medical staff. The U.S. Department of Justice ADA Information Line is another resource. Anyone can call the Information Line at 800-514-0301 (voice) or 800-514-0383 (TTY) to speak with an ADA Specialist to get answers to questions about the ADA. Additionally, when preparing to assist a patient with a disability, it is always best to ask the patient if assistance is needed and if so, what is the best way to help. If the provider is unsure of how to handle something, it is absolutely OK to ask the patient what works best.

Q If I lease my medical office space, am I responsible for making sure the examination room, waiting room, and toilet rooms are accessible?

Yes. Any private entity that owns, leases or leases to, or operates a place of public accommodation is responsible for complying with Title III of the ADA. Both tenants and landlords are equally responsible for complying with the ADA. However, your lease with the landlord may specify that, as between the parties, the landlord is responsible for some or all of the accessibility requirements of the space. Frequently, the tenant is made responsible for the space it uses and controls (e.g., the examination rooms and reception area), while the landlord is responsible for common space, such as toilet rooms used by more than one tenant.

Q Are there any tax breaks for making accessibility changes to my medical office?

Yes. Subject to IRS rules, federal tax credits and deductions are available to private businesses to offset expenses incurred to comply with the ADA. See Form 8836 at *www.irs.gov/pub/irs-pdf/f8826.pdf* for additional information about the Disabled Access Credit established under Section 44 of the Internal Revenue Code. See Publication 535 (Number 7: Barrier Removal) at *www.irs.gov/publications/p535/index.html* for more information about the tax deduction, established under Section 190 of the Internal Revenue Code. Both the tax credit and deduction may be taken annually.

PART 3: ACCESSIBLE EXAMINATION ROOMS

An accessible examination room has features that make it possible for patients with mobility disabilities, including those who use wheelchairs, to receive appropriate medical care. These features allow the patient to enter the examination room, move around in the room, and utilize the accessible equipment provided. The features that make this possible are:

- an accessible route to and through the room;
- an entry door with adequate clear width, maneuvering clearance, and accessible hardware;
- appropriate models and placement of accessible examination equipment (See Part 4 for detailed discussion of accessible examination equipment.); and
- adequate clear floor space inside the room for side transfers and use of lift equipment.

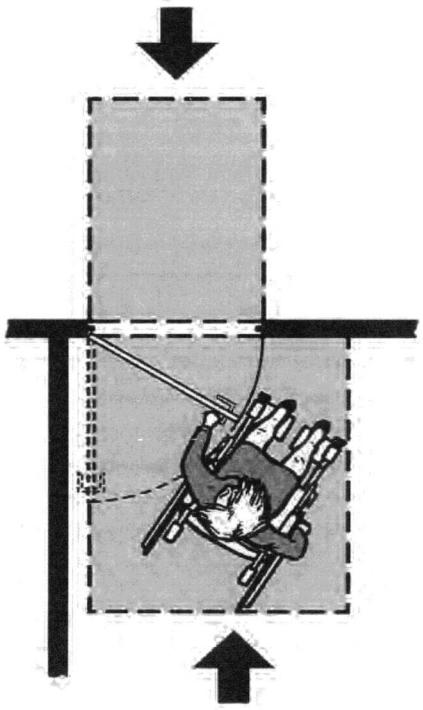
New and altered examination rooms must meet requirements of the ADA Standards for Accessible Design. Accessible examination rooms may need additional floor space to accommodate transfers and for certain equipment, such as a floor lift.

The number of examination rooms with accessible equipment needed by the medical care provider depends on the size of the practice, the patient population, and other factors. One such exam room may be sufficient in a small doctor's practice, while more will likely be necessary in a large clinic.

Entry Doors

Under the ADA Standards for Accessible Design, an accessible doorway must have a minimum clear opening width of 32 inches when the door is opened to 90 degrees.

Maneuvering clearances on both sides of the door must also comply with the ADA Standards. In addition, the door hardware must not require tight grasping, tight pinching, or twisting of the wrist in order to use it. Keep in mind that the hallway outside of the door and the space inside the door should be kept free of boxes, chairs, or equipment, so that they do not interfere with the maneuvering clearance or accessible route.

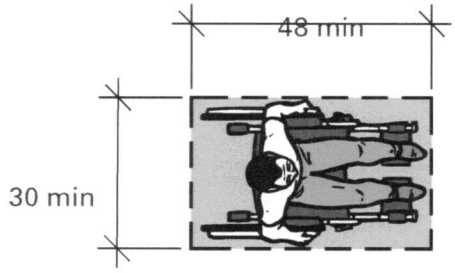


Plan view showing clear floor space on both sides of entry door to permit entry and exit

Clear Floor and Turning Space Inside Examination Rooms

In order for accessible equipment to be usable by an individual who uses a wheelchair or other mobility device, that individual must be able to approach the exam table and any other elements of the room to which patients have access. The exam table must have sufficient clear floor space next to it so that an individual using a wheelchair can approach the side of the table for transfer

onto it. The minimum amount of space required is 30 inches by 48 inches. Clear floor space is needed along at least one side of an adjustable height examination table.



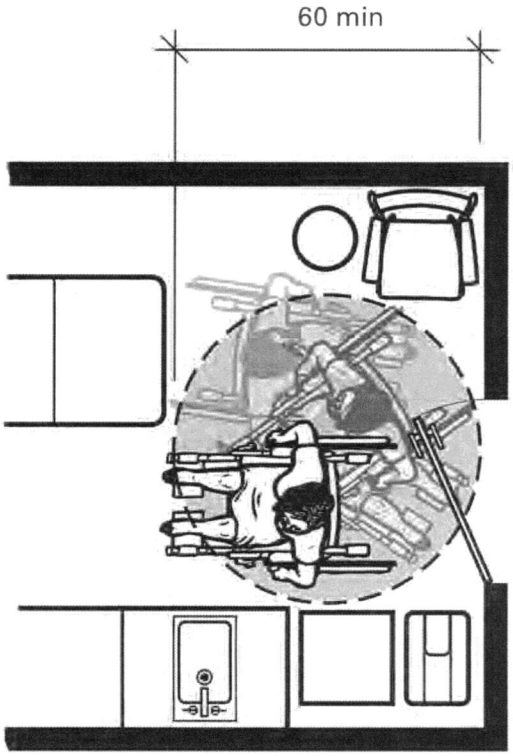
Plan view showing an outline of a clear floor space of 30 inches by 48 inches

Because some individuals can only transfer from the right or left side, providing clear floor space on both sides of the table allows one accessible table to serve both right and left side transfers. Another way to allow transfers to either side of exam tables, particularly when more than one accessible examination room is available, is to provide a reverse furniture layout in another accessible examination room.

Patient sitting on adjustable height exam table positioned with clear floor space on both sides

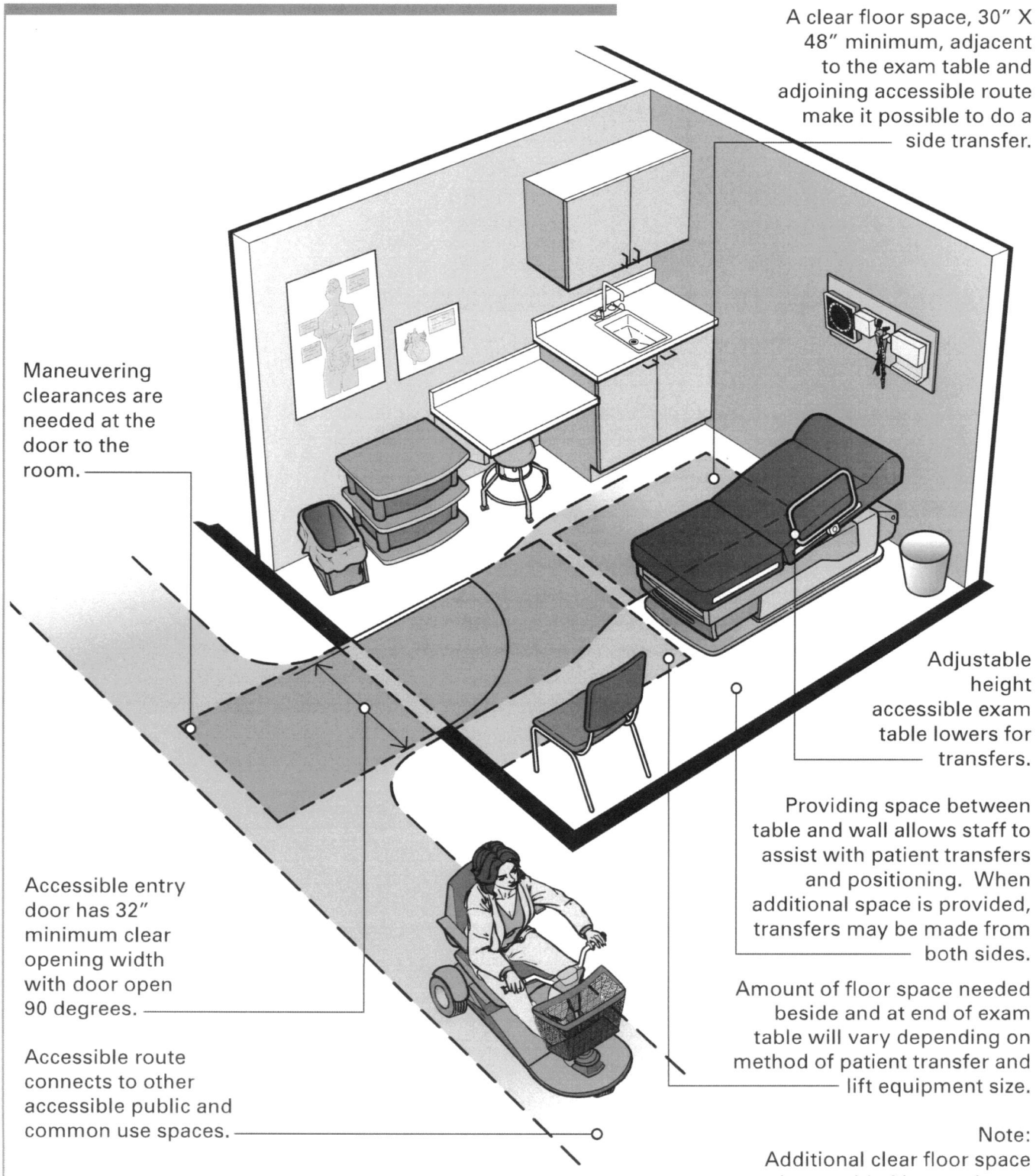
The room should also have enough turning space for an individual using a wheelchair to make a 180-degree turn, using a clear space of 60 inches in diameter or a 60 inch by 60 inch T-shaped space. Movable chairs and other objects, such as waste baskets, should be moved aside if necessary to provide sufficient clear floor space for maneuvering and turning.

When a portable patient lift or stretcher is to be used, additional clear floor space will be needed to maneuver the lift or stretcher. Ceiling-mounted lifts, on the other hand, do not require the additional maneuvering clear floor space because these lifts are mounted overhead. (See Part 4 of this publication for more information about lifts.)



Plan view of part of an examination room showing clear floor space for turning a wheelchair. This space can also make it possible for use of a portable patient lift.

Features of an Accessible Examination Room

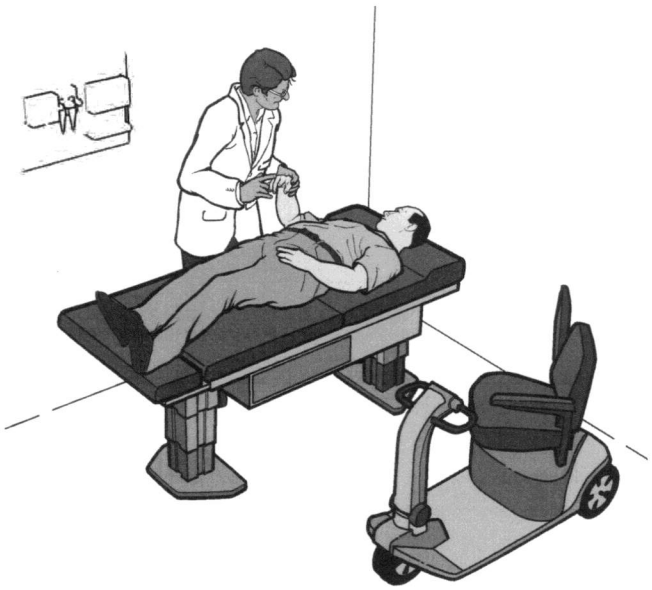


PART 4: ACCESSIBLE MEDICAL EQUIPMENT

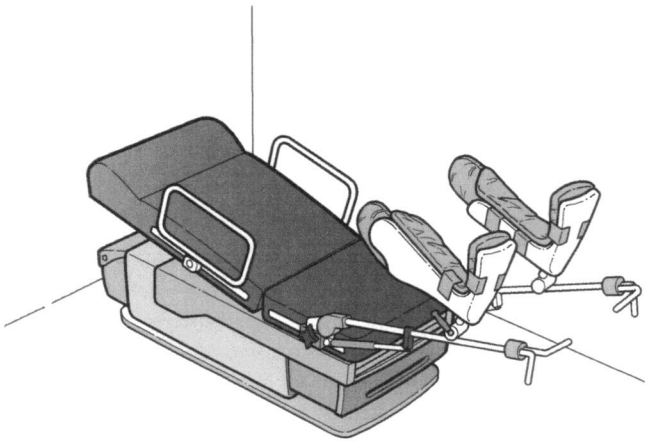
Availability of accessible medical equipment is an important part of providing accessible medical care, and doctors and other providers must ensure that medical equipment is not a barrier to individuals with disabilities. This section provides examples of accessible medical equipment and how it is used by people with mobility disabilities. Such equipment includes adjustable-height exam tables and chairs, wheelchair-accessible scales, adjustable-height radiologic equipment, portable floor and overhead track lifts, and gurneys and stretchers.

It is essential that a person with a disability receives medical services equal to those received by a person without a disability. For example, if a patient must be lying down to be thoroughly examined, then a person with a disability must also be examined lying down. Likewise, examinations which require specialized positioning, such as gynecological examinations, must be accessible to a person with a disability. To provide an accessible gynecological exam to women with paralysis or other conditions that make it difficult or impossible for them to move or support their legs, the provider may need an accessible height exam table with adjustable, padded leg supports, instead of typical stirrups. However, if the examination or procedure does not require that a person lie down (for example, an examination of the face or an x-ray of the hand), then using an exam table is not necessarily important to the quality of the medical care and the patient may remain seated.

Evaluating the existing equipment available, the space within the examination room, the size of the practice and staff, and the patient population is necessary to determine the equipment needed to provide accessible medical care.



A patient with a mobility disability is examined while lying down on an adjustable height exam table.



An adjustable height exam table equipped with adjustable, padded leg supports.

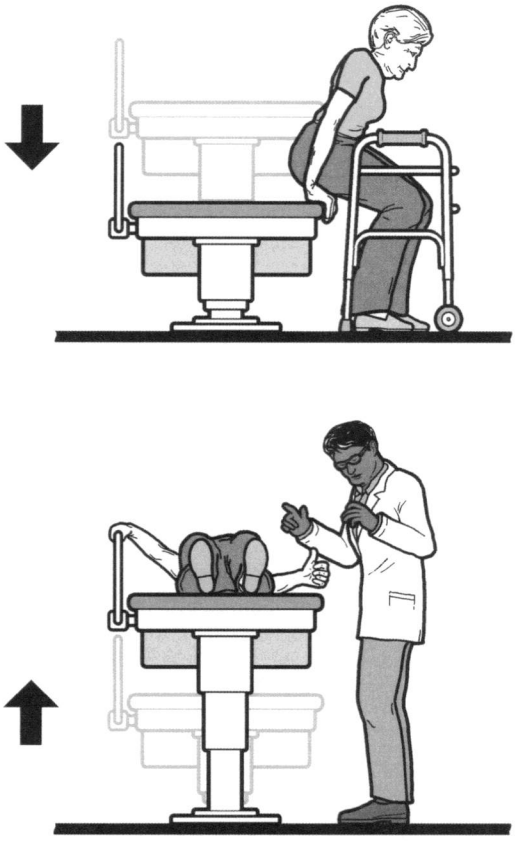
Exam Tables and Chairs

Traditional fixed-height exam tables and chairs (also called treatment tables or procedure tables) are too high for many people with a mobility disability to use. Individuals with mobility disabilities often need to use an adjustable-height table which, when positioned at a low height, allows them to transfer from a wheelchair. A handle or support rail is often needed along one side of the table for stability during a transfer and during the examination.

Individuals transfer to and from adjustable-height exam tables and chairs differently. Some will be able to transfer on their own by standing up from a mobility device, pivoting, and sitting down on the exam table. Those using walkers may simply walk to the exam table and sit down, while others with limited mobility may walk more slowly and need a steadying arm or hand to help with balance and sitting down. Some people using wheelchairs may be able to independently transfer to the table or chair, while others will need assistance from a staff member. Transfers may also require use of equipment, such as a transfer board or patient lift.

An accessible exam table or chair should have at least the following:

- ability to lower to the height of the wheelchair seat, 17-19 inches, or lower, from the floor; and
- elements to stabilize and support a person during transfer and while on the table, such as rails, straps, stabilization cushions, wedges, or rolled up towels.

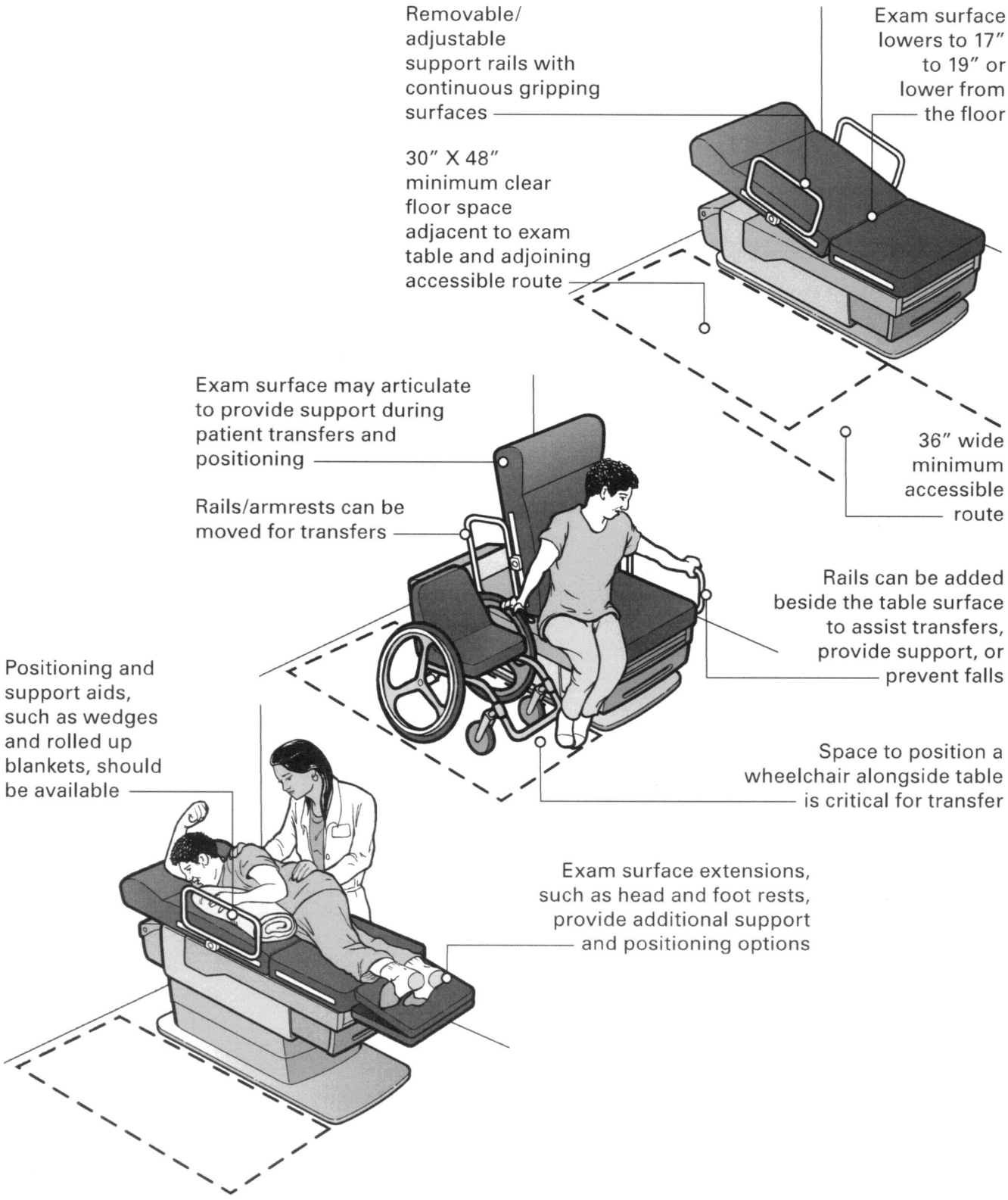


An adjustable height exam table shown in lowered and raised positions

Once a patient has transferred, staff should ask if assistance is needed -- some patients may need staff to stay and help undress or stabilize them on the table. Never leave the patient unattended unless the patient says they do not need assistance.

Different types of exam tables are used for different purposes. Some exam tables fold into a chair-like position; others remain flat. Either type can be used by people with disabilities with the right accessible features and table accessories. Pillows, rolled up towels, or foam wedges may be needed to stabilize and position the patient on the table. Tilt, adjustability, and headrests, footrests, and armrests may make the examination more accessible for the patient and also easier for the doctor.

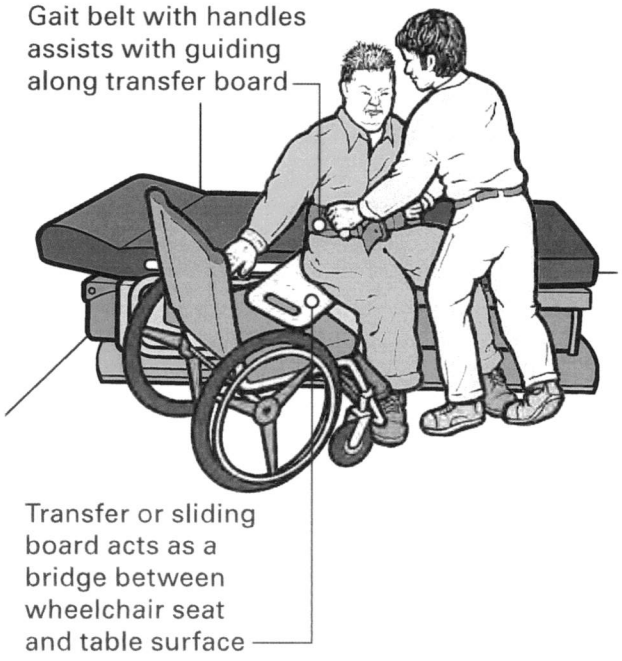
Features of Accessible Exam Tables



Typical Transfer Techniques: Staff Assistance and Patient Lifts

Some individuals will need additional assistance to get on and off an exam table, even if it lowers to 17-19 inches from the floor. The kind of assistance needed will depend on the patient's disability. The provider should ask the patient if he or she needs assistance, and if so, what is the best way to help and what extra equipment, if any, is needed.

Some individuals will need only a steady hand from a staff person in order to transfer safely to the exam table. Other individuals will need simple tools such as a transfer board (a product made of a smooth rigid material which acts as a supporting bridge between a wheelchair and another surface, along which the individual slides) or sheet. Individuals using a transfer board may need assistance from a staff person.



Assisted transfer using a transfer board and gait belt with handles

Patients who can complete an independent transfer may prefer to do so for reasons of safety and simplicity.

Using Patient Lifts

Medical providers may need a lift in order to transfer some patients safely onto an exam table. Patient lifts may move along the floor or be mounted on an overhead track attached to the ceiling or to a free-standing frame. A staff person operates the lift. To use the lift, a sling is positioned under the individual while sitting in the wheelchair. Then the sling is attached to the lift so the staff person can move the individual to the examination surface. Once over the surface, the individual is lowered onto the table, stabilized, and then the sling is detached from the lift. The sling may remain under the patient during the exam or may be removed, depending on the exam. A variety of slings are available to provide different kinds of support.

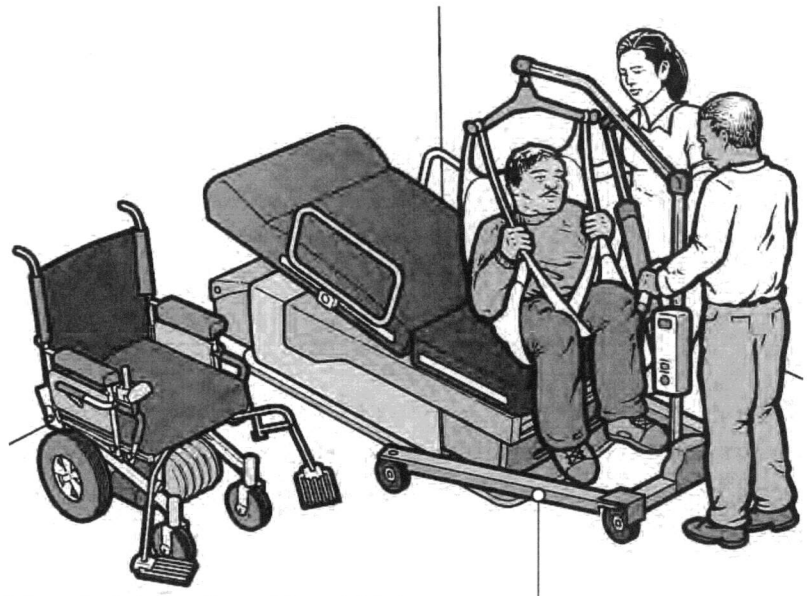
Using lifts provides better security for the patient than being lifted by medical staff because there is less likelihood that the individual will be dropped or hurt in the process. Patient lifts also protect health care providers from injuries caused by lifting patients.

Portable Floor Lifts

The most common types of lifts in medical settings are portable with a U-shaped base that moves along the floor on wheels. These bases must go under, or fit around, the exam table in order to accomplish the transfer. A lift's base may fit around the bottom end of an exam table, or fit fully or partially under the table at a perpendicular angle to the table. Some lifts are more easily operated by two or more people; others may be operated by one person. An advantage of a portable floor lift is that it can be moved from room to room and thus used with multiple exam

tables. If a lift is used with multiple exam tables, the medical provider, depending on its size, may need to establish a procedure governing how the lift is shared and where it is stored. The provider should ensure that it does not schedule for the same appointment time more than one patient needing the lift. While these lifts may be less expensive than overhead lifts, they require more maneuvering space in the room and space for storage.

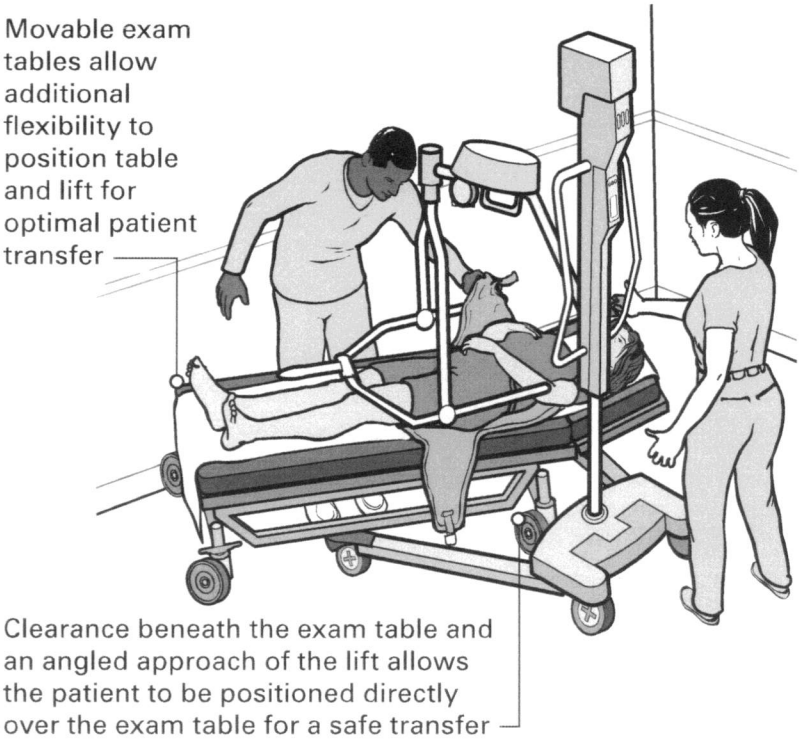
To properly and safely assist patients with transfers, medical staff will likely need training on how to operate the equipment and on safe patient handling techniques.



Assisted Transfer Utilizing a Portable Floor Lift

Notes for Portable Floor Lifts:

- The amount of clear floor space needed to maneuver will depend on the type of floor lift equipment used.
- Portable floor lifts must be able to position the patient over the table surface; select a model that is compatible with the exam table and room configuration.
- A low height, adjustable width base can move closer to the end of the exam table and can be narrowed for transit and storage.



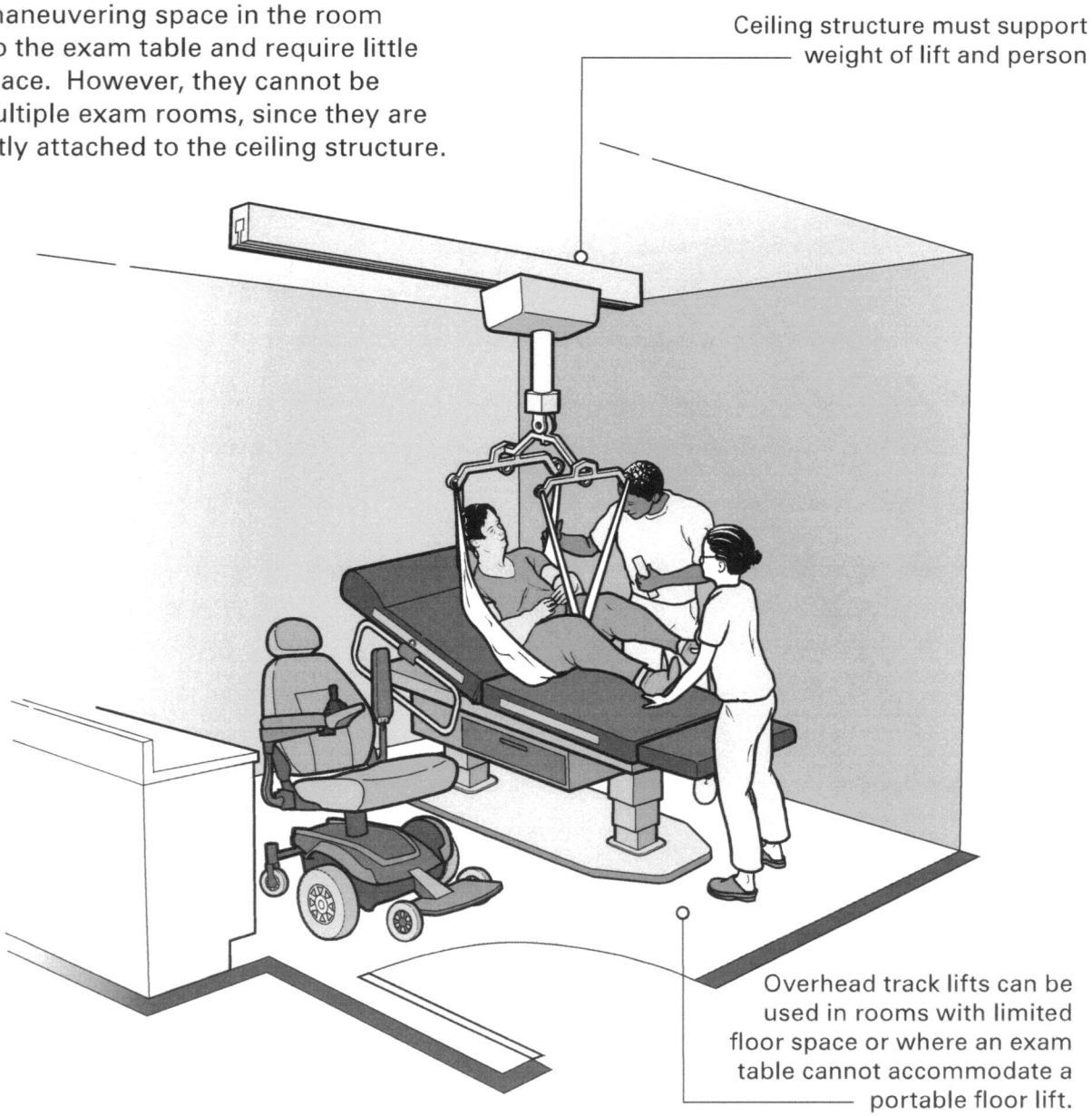
Assisted Transfer Utilizing Both a Portable Floor Lift and Movable Exam Table

Overhead Track Lifts

Overhead track lifts include ceiling-mounted lifts and lifts mounted on a frame supported from the floor.

Ceiling-Mounted Lifts

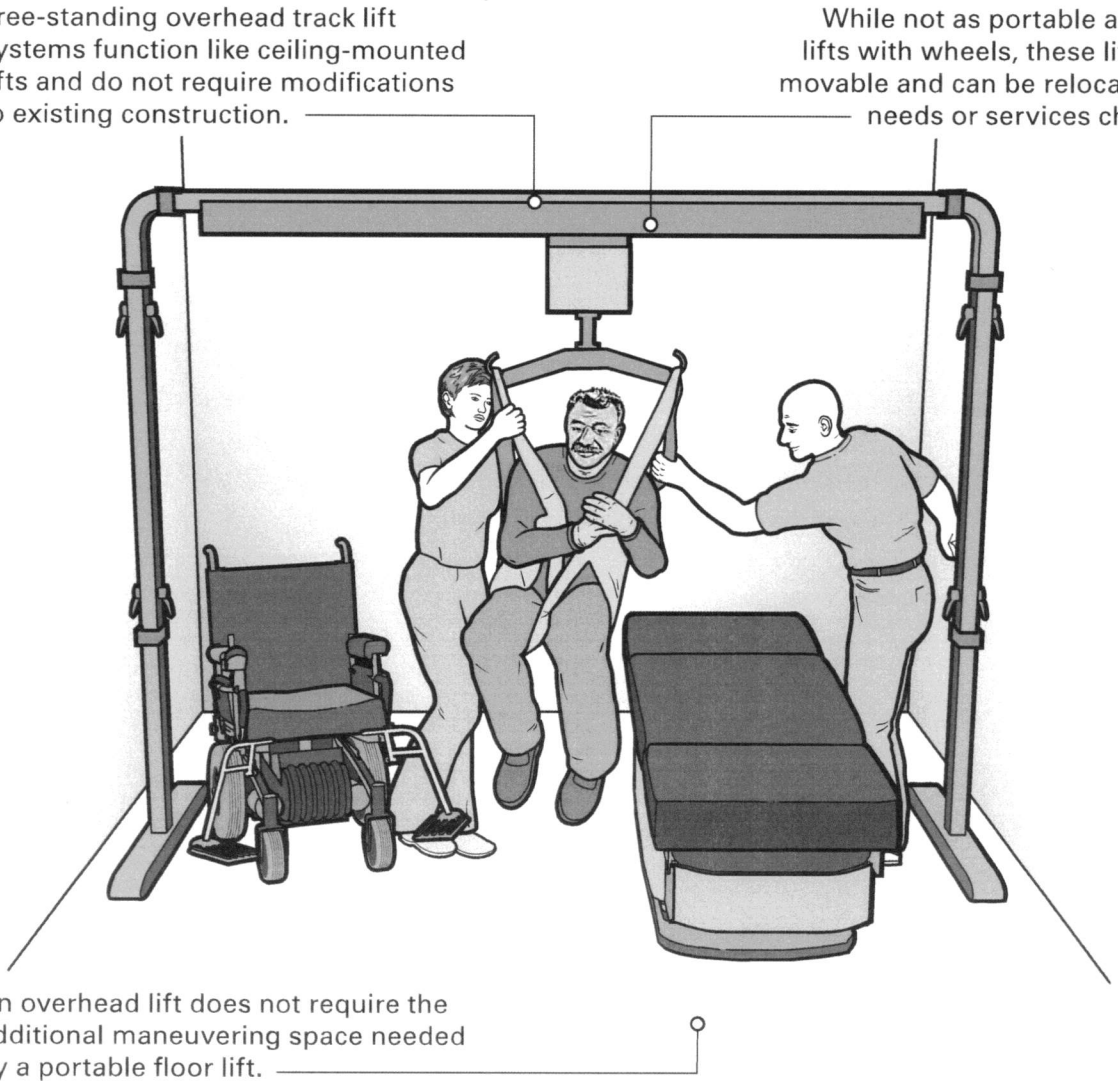
Ceiling mounted lifts are permanently mounted to the ceiling structure and run along one or more tracks. These lifts require no extra maneuvering space in the room adjacent to the exam table and require little storage space. However, they cannot be used in multiple exam rooms, since they are permanently attached to the ceiling structure.



Assisted Transfer with Ceiling Mounted Overhead Track Lift

Free-Standing Overhead Lifts

Another type of overhead lift is supported from a frame that rests on the floor. Free-standing, nonpermanent overhead track lifts are a good solution when the provider does not want the lift to be permanently installed or where the existing ceiling structure cannot support a ceiling-mounted overhead lift. The medical provider should choose the type of lift that will work best with the exam tables, the space, and the ceiling or floor structure of the medical facility.

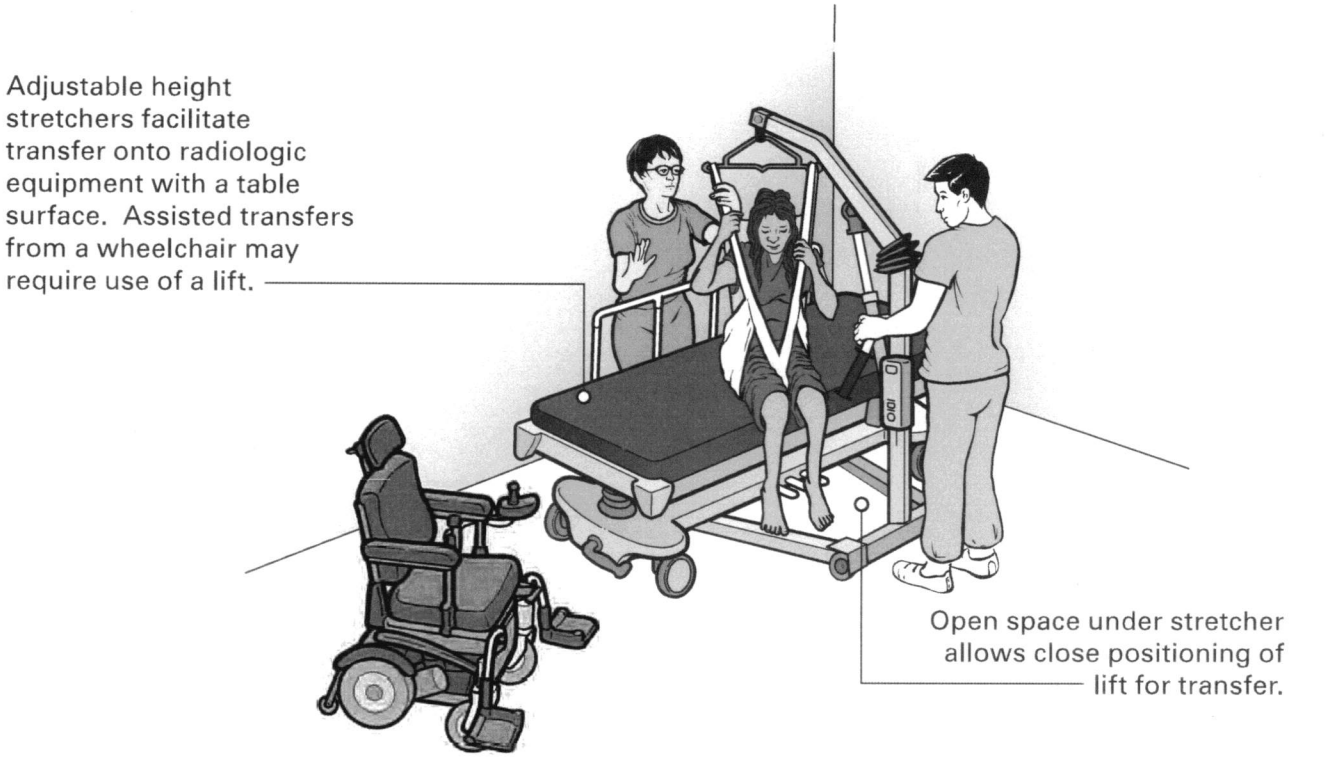


Assisted Transfer with Free Standing Overhead Track Lift

Additional Transfer Techniques: Use of Stretchers and Gurneys

Some equipment, including radiologic equipment, lacks space underneath necessary for a portable floor lift to be used. Other equipment may be located in spaces with no room at the end of the table making it impossible to position a portable floor lift. In such cases, an overhead track lift, either permanently mounted or free-standing, may provide access to the equipment. However, metal components of these overhead lifts may not be compatible with some radiologic technologies.

When it is not feasible or possible to use a lift, another option is an adjustable-height stretcher or gurney (a table that is on wheels) that can be raised or lowered to the height of the exam table or surface. This approach involves a two step process in which the patient must transfer from their wheelchair to the stretcher, usually in a different space or area away from the equipment, and then from the stretcher to the table or surface. As many stretchers do not lower to 17" to 19" above the floor, an assisted transfer with a lift may be required to get the patient onto the stretcher. Stretchers that can be lowered to this range of typical wheelchair seat heights allow individuals capable of independent transfers a choice to do so if they prefer. Once the stretcher is positioned next to the equipment and set at the right height, many people will require assisted transfers utilizing devices such as transfer boards or slip sheets to get onto the table or surface.

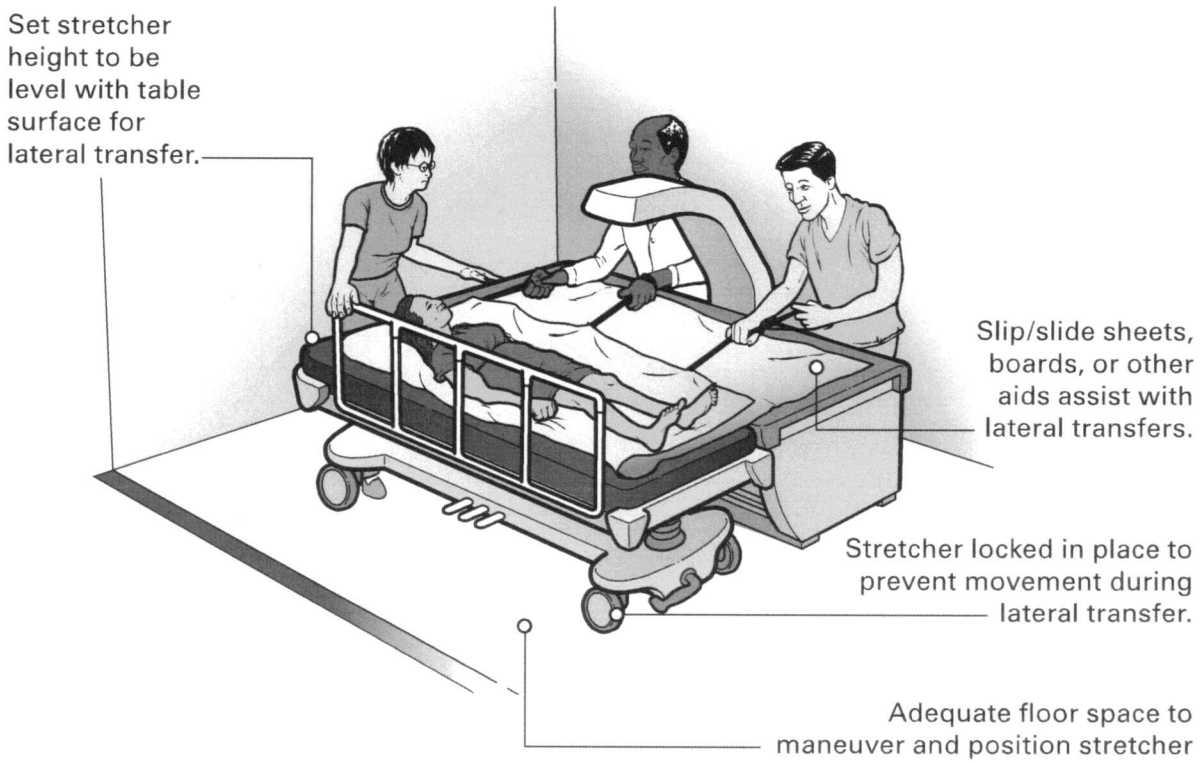


Assisted Transfer to Stretcher Utilizing a Portable Floor Lift

Radiologic Equipment

There are many types of radiologic technologies and equipment associated with them, including MRI, x-ray, CT scan, bone densitometry, mammography, and ultrasound. Most of these technologies require the patient to lie on a flat surface that is part of the equipment. The accessibility issues related to transfer to the surface are similar to those addressed previously under Examination Tables and Chairs. However, because the technology is often integrated into the table, the table may not be able to be lowered sufficiently. In these cases, use of a patient lift or another transfer and positioning technique is particularly important for access to this equipment.

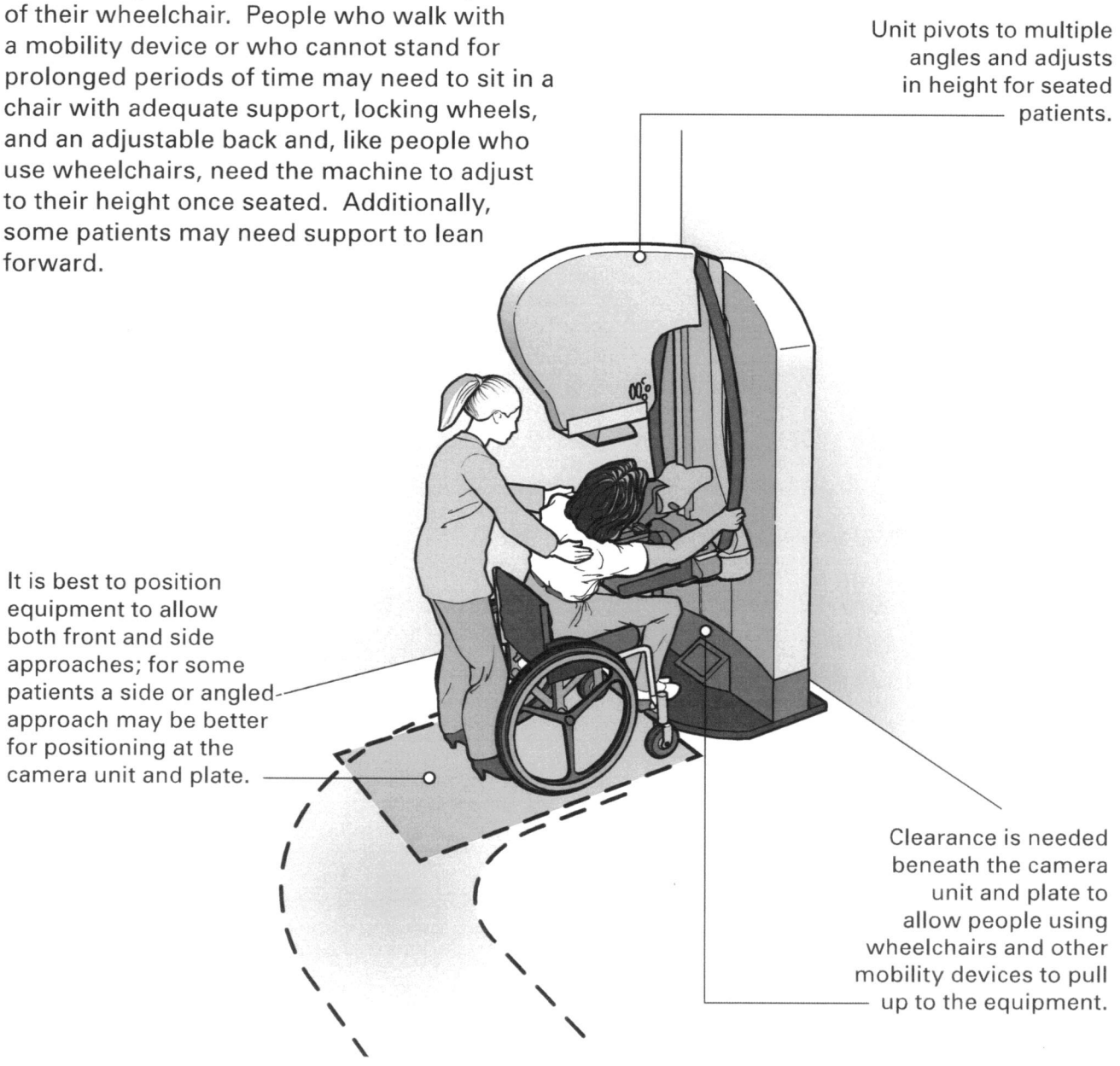
Many radiologic technologies also require the patient to keep still, which may be very difficult for some individuals with a mobility disability, including those with spasticity, tremor, or other condition. Patients may need a staff person to support them with pillows, rolled up towels, wedges, or by holding onto them.



Assisted Transfer to Densitometer Utilizing a Stretcher

Mammography Equipment

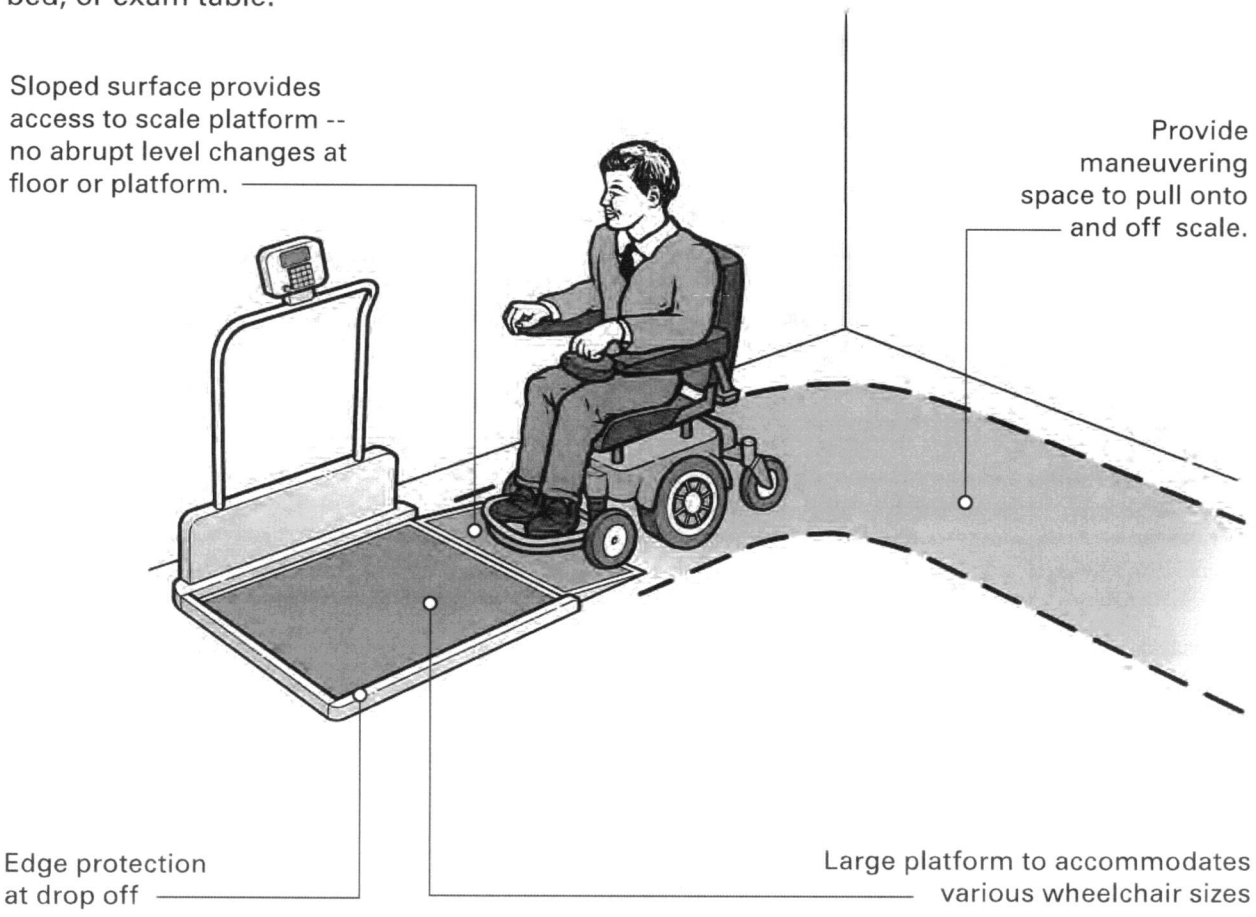
A mammography exam typically requires the patient to stand up. Individuals who use wheelchairs will need to have an exam while seated in their wheelchair. The mammography machine will need to adjust to their height and accommodate the space of their wheelchair. People who walk with a mobility device or who cannot stand for prolonged periods of time may need to sit in a chair with adequate support, locking wheels, and an adjustable back and, like people who use wheelchairs, need the machine to adjust to their height once seated. Additionally, some patients may need support to lean forward.



Accessible Mammography Machine

Scales

A patient's weight is essential medical information used for diagnostics and treatment. Too often, individuals who use wheelchairs are not weighed at the doctor's office or hospital, even though patients without disabilities are routinely weighed, because the provider does not have a scale that can accommodate a wheelchair. Medical providers should have an accessible scale with a platform large enough to fit a wheelchair, and with a high weight capacity for weighing an individual while seated in his or her wheelchair. Other options may include a scale integrated into a patient lift, hospital bed, or exam table.



Accessible Scale

The previous information provides guidance on the ADA's requirement to provide accessible health care to individuals with mobility disabilities as well as illustrated examples of accessible medical equipment, room and office configurations, and lifting and transfer equipment and techniques. This guidance, when applied and adapted to the specific needs and circumstances of individual health care providers, can help ensure that people with mobility disabilities have an equal opportunity to receive accessible health care services.

Staff Training

A critical, but often overlooked component to ensuring success is adequate and ongoing training of medical practitioners and staff. Purchasing accessible medical equipment will not provide access if no one knows how to operate it. Staff must also know which examination and procedure rooms are accessible and where portable accessible medical equipment is stored. Whenever new equipment to provide accessible care is received, staff should be immediately trained on its proper use and maintenance. New staff should receive training as soon as they come on the job and all staff should undergo periodic refresher training during each year.

Finally, training staff to properly assist with transfers and lifts, and to use positioning aids correctly will minimize the chance of injury for both patients and staff. Staff should be instructed to ask patients with disabilities if they need help before providing assistance and, if they do, how best they can help. People with mobility disabilities are not all the same - they use mobility devices of different types, sizes and weight, transfer in different ways, and have varying levels of physical ability. Make sure that staff know, especially if they are unsure, that it is not only permissible, but encouraged, to ask questions. Understanding what assistance, if any, is needed and how to provide it, will go a long way toward providing safe and accessible health care for people with mobility disabilities.

For more information about the ADA, please visit The Department of Justice's ADA Website or call our toll-free number:

ADA Website -- *www.ADA.gov*

ADA Information Line
800-514-0301 (voice)
800-514-0383 (TTY)
24 hours a day to order publications by mail

M-W, F 9:30 a.m. – 5:30 p.m.,
Th 12:30 p.m. – 5:30 p.m.
(eastern time)
to speak with an ADA Specialist.

All calls are confidential.

For more information about Section 504, visit the Department of Health and Human Services Office for Civil Rights website at: *www.hhs.gov/ocr.*

A list of HHS OCR regional offices near you can be found at: *www.hhs.gov/ocr/office/about/rgn-hqaddresses.html.*

Section 504's requirements for new construction and alterations to buildings and facilities are found at 45 C.F.R. Part 84, Subpart C for receipients of federal financial assistance. The regulations are available at: *www.hhs.gov/ocr/civilrights/resources/laws/index.html.*

For persons with disabilities, this publication is available in large print, Braille, audio tape, and computer disk.
July 2010

IMPORTANCE OF ACCESSIBLE EXAMINATION TABLES, CHAIRS and WEIGHT SCALES

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- Health Care Facilities Access
- Improving Accessibility with Limited Resources
- Choosing and Negotiating an Accessible Facility Location
- Review of Legal Research on Accessible Medical Equipment
- Importance of Accessible Mammography Equipment
- Providing Information in Alternative Formats
- Accessible Web-sites
- Tax Incentives for Improving Accessibility
- ADA Resources

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INTRODUCTION

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

1. Improves quality of care for people with disabilities and activity limitations;
2. Complies with legal obligations under Title II or Title III of the Americans with Disabilities Act;
3. Serves Individuals with disabilities and activity limitations who represent a sizable portion of the population;
4. Reduces health care professionals' workplace injuries; and
5. Takes 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.[viii]

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."[ix]

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

According to the U.S. 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**.[x]

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.[xi]

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

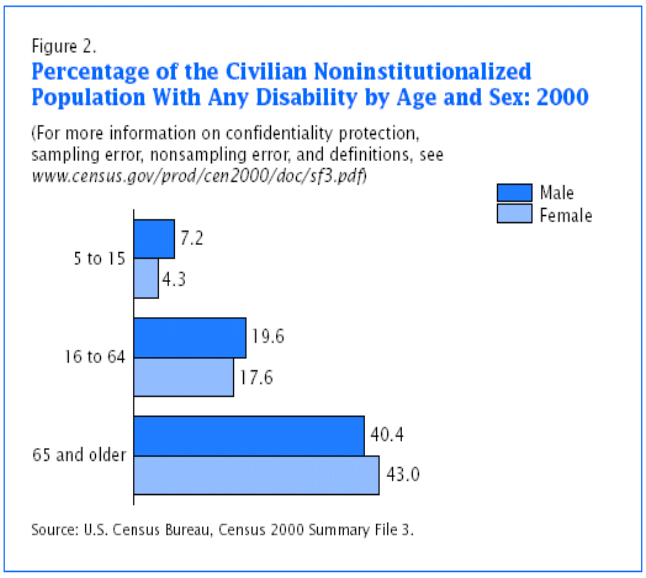

Figure 2. (Above left) Percentage of Civilian Non-institutionalized Population with any Disability by Age and Sex: 2000

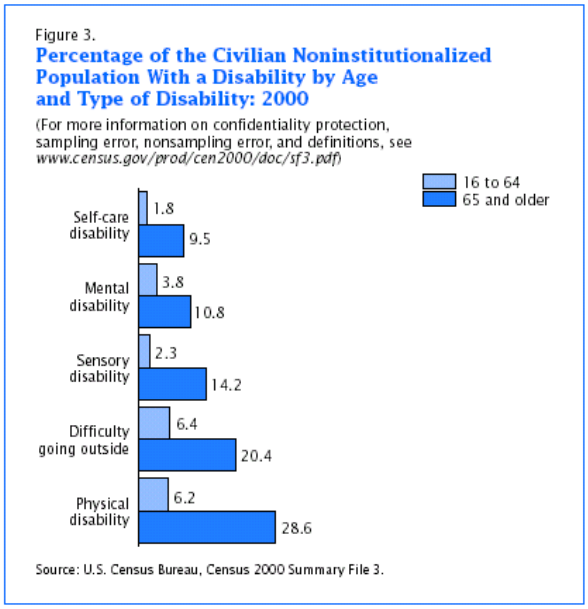

Figure 3. (Above right) Percentage of Civilian Non-institutionalized Population with a Disability by Age and Type of Disability: 2000

Tables and chairs that can be lowered to 17”-19” from the floor make 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 this 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.[xii]

> "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."[xiii]

Nursing is one of the riskiest occupations 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.[xiv]

One of the responsibilities of many nurses is getting patients onto (and often, off) 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.[xv]

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

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

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: **HFCDHP Brief: Disability Access Tax Incentives**)

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2. c. MEDICAL CARE DISABILITY DISCRIMINATION CASES

Since the '90s, a growing number of private and public disability discrimination cases have been successfully filed. 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.[xvii]

- 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.[xviii]

- 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.[xix]

- 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.[xx]

- In November 2005, a settlement was reached with the largest private hospital in the nation's capital, *Washington Hospital Center (WHC).* 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:
  - 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.[xxi]

- In October 2009, a settlement was reached with the *Beth Israel Deaconess Medical Center (BIDMC)* in Brookline, Mass. BIDMC, a teaching hospital affiliated with Harvard University, encompassing more than 30 buildings, three community health clinics, and operates as a quaternary acute care facility and level one trauma center. The agreement requires, among other things:
  - Taking steps to ensurie that a minimum of 10 percent of its existing patient rooms are accessible, including accessible toilet facilities, and are dispersed through its clinical services;
  - Ensuring each department and clinical practice provides at least one accessible examination table that lowers to 17-to-19 inches from the floor;
  - Surveing existing hospital and patient care facilities and equipment, including patient beds, exam tables, lifts, and radiologic and diagnostic equipment, for compliance with ADA standards; and implementing a system to ensure that BIDMC purchases accessible equipment where they are commercially available;
  - Develop and implementing a barrier removal plan;
  - Reviewing hospital policies and train staff to address the needs of individuals with disabilities; and
  - Appointing an ADA officer to oversee implementation of the agreement.[xxii]

STRUCTURED NEGOTIATIONS

In April 2008, *the Boston Center for Independent Living (BCIL)* entered into a landmark agreement with Partners HealthCare and its two flagship hospitals, *Brigham and Women's Hospital (BWH)* and *Massachusetts General Hospital (MGH).* The comprehensive plan will be implemented over six years. Gary Gottlieb said *"*This initiative is intended to go well beyond providing ramps and eliminating architectural barriers. It is designed to build a stronger partnership between health care providers and patients with disabilities, and help to fundamentally change the culture of access and care for people with disabilities.*"* Greater Boston Legal Service*'*s Dan Manning called the initiative a *"*model for hospitals in Massachusetts and nationwide.*"*

The agreement includes:

- A detailed survey of both hospitals and their level of compliance with the ADA as well as ongoing collaboration with BCIL on all issues related to people with disabilities;
- Removing architectural barriers in hospitals, off hospital campus physicians*'* offices and health centers (including exam rooms, patient rooms, treatment rooms, waiting areas, gift shops and parking areas);
- Purchasing additional medical equipment and devices that are accessible for people with disabilities (including wheelchair scales, power adjustable exam tables, power door openers, mammography);
- Modifying hospital policies and procedures that address issues related to the care of people with disabilities; and
- Developing a training program for all staff including physicians, nurses and support staff that interact with patients and visitors.[xxiii]

In November 2008, the *University of California Medical Center (UCSF)* signed a comprehensive settlement agreement to evaluate Medical Center programs, policies, services and facilities and improve accessibility for persons with disabilities where necessary. Among other things, UCSF agreed to:

- Modify in-patient bathrooms to make them accessible to patients who use wheelchairs;
- Conduct extensive review of policies and procedures affecting people with disabilities, making enhancements where needed;
- Evaluate the availability of accessible medical equipment in UCSF patient care facilities, and purchasing and installing accessible medical equipment where necessary; and
- Update its patient registration systems, and policies for effectively communicating with patients and visitors with disabilities.[xxiv]

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.[xxv] Terms 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; and
- Development of a complaint handling system to meet the needs of 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.[xxvi]

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.[xxvii]

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.[xxviii]

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 24 inches (ground to top-of-cushion)

3. b. SAMPLES OF EXAMINATION TABLES AND CHAIRS

Below are examples of examination / treatment tables and chairs with some access features that include: lowering to a minimum of 17 to 19 inches from ground to top-of-cushion, swing away arms, and higher weight capacity.

1. Standard Examination Tables
2. Bariatric Examination Tables
3. Procedural Tables
4. Podiatry Chairs
5. Treatment Tables
6. Infusion Recliners
7. Phlebotomy / ENT Chair
8. Ophthalmology Chairs & Equipment Tables
9. Dental Chairs

---

1. Standard Examination Tables

Figure 3. i. Midmark Barrier-Free Examination Table 222/223. 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.

2. Bariatric Examination Tables

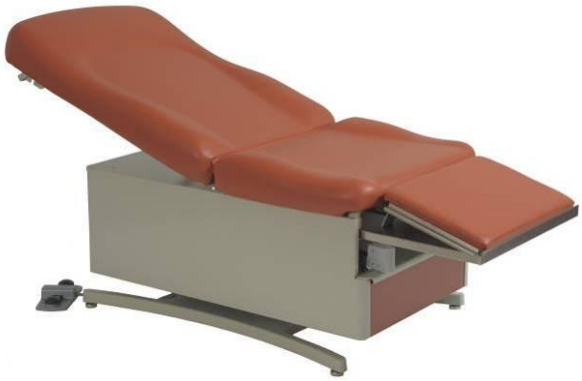


Figure 3. 3. UMF 4070 Power Exam Table. Lowers to 19″ floor to top-of-cushion. 600 lb. weight capacity.

Figure 3. 4. Midmark 625 Barrier-Free Exam Table. Lowers to 18″ floor to top-of-cushion. 650 lb. weight capacity.

Figure 3. 5. Midmark Bariatric Treatment Table. Height lowers to 18″ floor to top-of-cushion, 54″ wide, 800 lb. weight capacity.

Figure 3. 6. The Welner Enabled Legacy Examination Table. Lowers to 18″ floor to top-of-cushion, 54″ wide, 650 lb. weight capacity.

Figure 3. 7. UMF – Bariatric Exam Table. Height lowers to 18″ floor to top-of-cushion, 30″ wide, 800 lb. weight capacity.

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

Figure 3. 8. UMF 4010 Power Procedure Table. Height lowers to 19″ floor to top-of-cushion width 27,″ 600 lb. weight capacity.

Figure 3. 9. Midmark 622/623 Procedural Table. Height lowers to 18″ floor to top-of-cushion. 54″ wide, 450 lb. weight capacity.

4. a. Podiatry

Figure 3. 10. UMF 5016 Power Podiatry Chair. Lowers to 19″ floor to top-of-cushion. 550 lb. weight capacity.

Figure 3. 11. Midmark 647 Barrier-Free® Power Podiatry Chair Lowers to 19″ floor to top-of-cushion. 450 lb. weight capacity.

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

Figure 3. 12. Huasmann Model 4756 Powermatic Table**.** Height lowers to 19 in. floor to top-of-cushion, 27″ wide, 400 lb. weight capacity.

Figure 3. 13. Chattanooga Group Adapta® 340 Treatment Table - Three Section. Height lowers to 18″ floor to top-of-cushion, 32″ wide.

- **Orthopedics/Casting**

Figure 3. 14 Oakworks PT300-31 in width Height lowers to 17″ floor to 35″ top-of-cushion. Width – 31″,″ 550 lb. weight capacity.

- **Ortho. / Phys. Med. / Rehab. Storable Mat**

Figure 3. 15 Oakworks – Storable Mat. Height lowers to 16″ floor to 25″ top-of-cushion. Width – 33″, 35″ and 40″ 550 lb. weight capacity.

- **Massage / Chiropractic**

Figure 3. 16. Earthlite - Ellora Massage Table. Height lowers to 17″ floor to 36″ top-of-cushion. Widths 25″, 27″, and 30,″ 650 lb. weight capacity.

Figure 3. 17. ProLuxe Valencia. Height lowers to 18″ floor to 34″ top-of-cushion. Width – 31″, 550 lb. weight capacity.

6. Infusion Recliners

Figure 3. 18. 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.

Note: while access features include swing-away side arms, the seat height of 21″ exceeds the recommended maximum of 19.″

7. Phlebotomy / ENT Chair

Figure 3. 19. UMF 8678 Power Phlebotomy / ENT Chair. Lowers to height of 19″ and maximum height of 35″ floor-to-seat, 375 lb. weight capacity.

Figure 3. 20. Winco 2587 - Power Designer Blood Drawing Chair . Lowers to 15.5″ and maximum height of 27″ floor-to-seat, 300 lb. weight capacity.

8. Ophthalmology Chairs, Chair Glides, & Equipment Tables

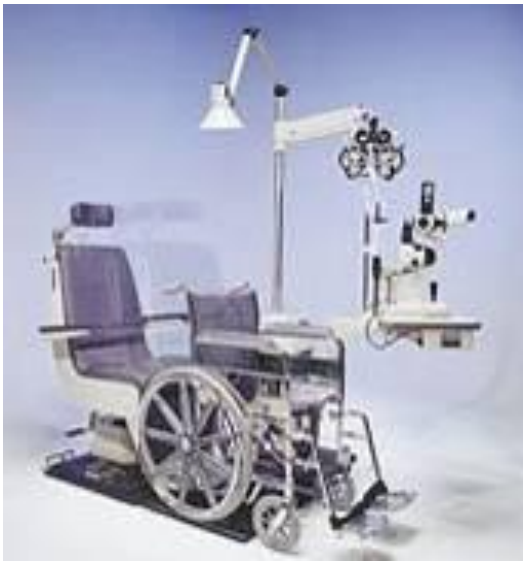


Figure 3. 21. Chair Glides. Above, examples of an Optometry chair on glider (below) sliding back approximately 30 inches, allowing for some wheelchair positioning.

Note: When considering Ophthalmic chairs, access feature may include a 19″ seat height (above right); Reliance 980 - lowers to 19″ floor to top-of-cushion (with low base option only). Note: many wheelchair users may not be able to transfer due to large base and non-removable footrests.

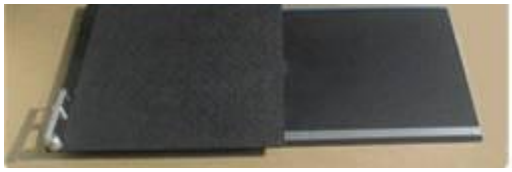


Figure 3. 22. Chair Glides. Above left: Cal Coast Ophthalmic Instruments Inc., right Reliance Medical.

Figure 3. 23. Above: Chair Mover RPK SALES, INC.

- **Ophthalmology Equipment Tables**

Figure 3. 24. Accessible motorized ophthalmic tables may increase access to testing by mounting potable diagnostic equipment. Above left - Topcon AIT-350W Wheelchair Accessible Instrument Table.

9. Dental Chairs

For those unable to transfer into a standard dental chair, there are options to increase access. For example, a dental chair should be purchased with the option of **double articulating headrest**. This type of head rest can be flipped around to provide neck support behind the wheelchair, given that the office space has allotted for needed wheelchair floor spacing.

Figure 3. 25: Standard dental chair with a double articulating replacement head rest.

- **Reclining Platform Dental Chairs**

When designing space for an accessible dental room, an option to consider is the installation or use of a permanent or portable *"*bucket*"* or *"*platform*"* dental chair. Adequate space is required. Check model for maximum width of platform to allow for larger / wider power wheelchairs.

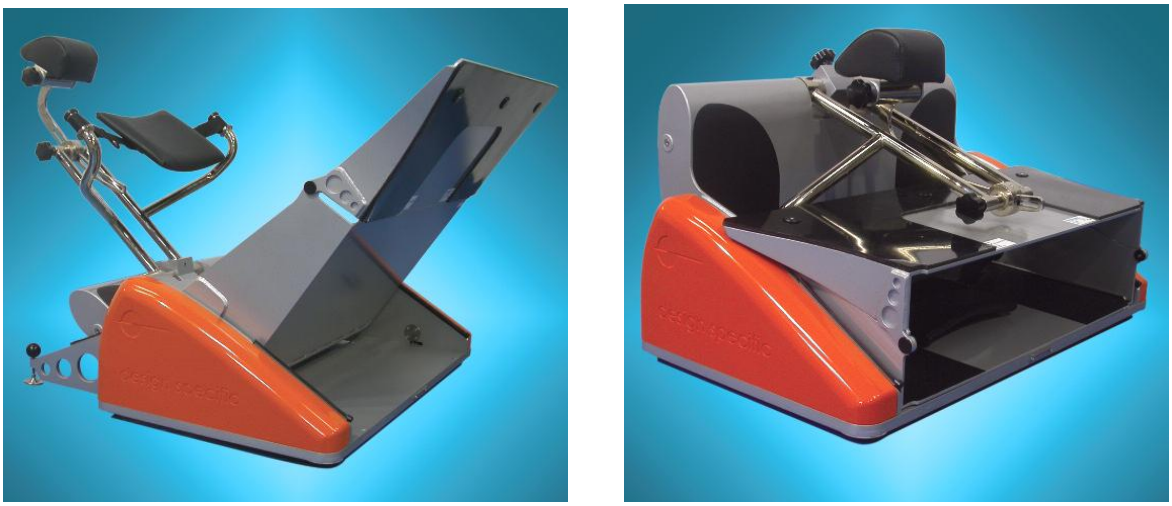


Figure 3. 26: Design Specific LTD., Compact Wheelchair Reclining Platform. Refer to specification sheet for more information including video, unit dimensions and room layout required at: www.designspecific.co.uk.

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 17 inches, from floor-to-top of cushion (versus top of table/chair frame).** 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.
- ✓ **Extra-wide cushion top (≥ 24 inches).**
- ✓ **Higher weight capacities (≥ 400 lbs) 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 on the table.

Rotating Arms Rails **Side Panels**

Figure 3. 27. UMF Patient Assist Armrest rotates 360 degrees and can be locked into place. Above right: Midmark accessories offered for Examination and Procedural Table includes side panels.

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

Figure 3. 28. (Left) Midmark Corporation accessories offered for Barrier Free model 222/ 2223 Examination Table and 623/623 Procedural Table includes articulating knee crutches.

Figure 3. 29. (Above center) Yellofins, www.allenmedical.com.

Figure 3. 30. (Above right) Harvey Stirrups™ https://harveystirrups.com.

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. 31. Positioning straps with Velcro closures, and positioning wedges. For positioning devices sample site, see Ali Medical.

- ✓ **Grab bars** on walls for tables positioned next to wall provide assistance with getting on and off the tables, as well as turning while patient is lying on table.

Figure 3. 31. Positioning grab bars on the wall adjacent to a table.

Refer to ***Tips for Exam Room Selection, Accessible Tables / Chairs & Lifting Assistance*** page 34, for a guide on accessible exam table placement and tips on patient transferring assistance and devices.

4. ACCESSIBLE WEIGHT SCALES

Accessible scales are useable by all people with and without 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.[xxix]

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.[xxx]

> "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."[xxxi]
>
> **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.[xxxii]

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.[xxxiii]

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.[xxxiv]

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.*"*
>
> **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, and 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:

1. Folding Portable Wheelchair Scales (easily moved when needed)
2. Stationary
3. 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. 1. (left above) Detecto Portable Wheelchair Scale. Weight capacity 600 lb. Platform size 34 x 32.

Figure 4 2. (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. 3. (left above) Scaletronix Wall Mounted Wheelchair Scale. Weight capacity 660 lb. Platform size 34 x 32.

Figure 4. 4. (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. 5. (left above) Detecto Bariatric Portable Scale. Weight capacity 800 lb. Platform size 30 x 32.

Figure 4 6. (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.

Wheelchair scales are the most common 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

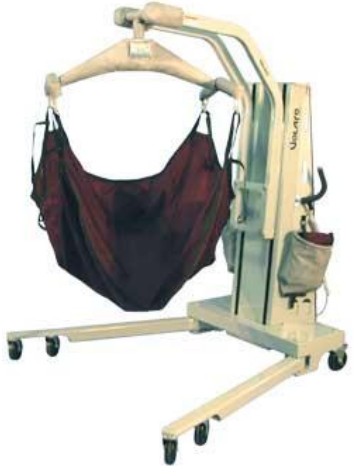


Figure 4. 7. (Left above) Volaro Series 4XB Full Body Patient Lift w/Scale. Weight capacity 1,000 lb. Figure 4. 8. (Right above) IB400 Weigh mobile Electronic In-Bed Scale. Weight capacity 400 lb. Under bed clearance 4.8*"* (122mm) high.

7. Hospital beds with built-in scales

Figure 4. 9. (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 attached to unit, if unavailable (Figure 4. 10 below right), install grab bars on wall.

Figure 4. 11. (above left) standard stationary wheelchair scale with fixed arm rails, Figure 4. 12. (above right) wall mounted wheelchair scale without hand rails. Figure 4. 13. standard grab bars.

- ✓ 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.

STANDARD VS. LARGER STATIONARY WHEELCHAIR SCALES


Figure 4. 14. (above left) standard stationary scale that may not accommodate a larger power wheelchair user (24″ w x 30″l). Figure 4. 15. (above right) large-size (28″ w 32″ l).

4. b. PLACEMENT CONSIDERATIONS

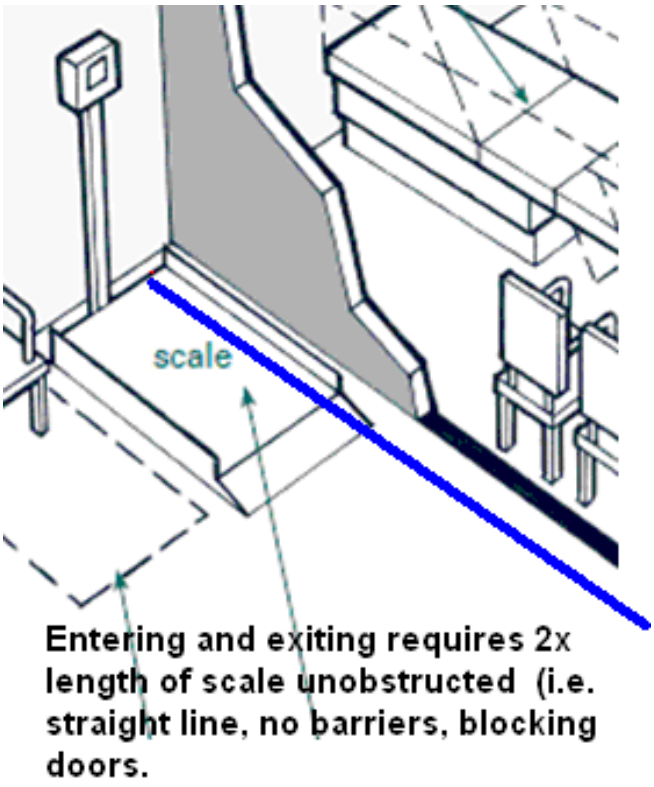


Figure 4. 16. – All wheelchair scales require 2x the (straight-route) length of the scale for a wheelchair or scooter user to enter and exit. The scale entering route should not be blocked by obstructions, protruding objects, firer exits, or in the path of high used area or blocking frequently used room entrances.

ADDITIONAL CONSIDERATIONS:

- One accessible scale for all departments that weigh patients as part of vitals' process.
- For departments / clinics that may not weigh patients regularly, consider sharing scale with adjoining departments.
- Train staff on proper use.
- Create, distribute and post accessible wheelchair location/s. Include platform size (standard or oversized).

STANDARD SCALE (NON-ACCESSIBLE)

- In addition to accessible wheelchair scales, consider placing grab bars or walker type devices to aid in getting on and off a step-up scale as well as providing increased stability and safety.

Figure 4. 17. – a walker place around a standard step-up scale

Refer to ***Tips for Weighing Patients Using an Accessible Scale*** page 31, for placement and use of an accessible wheelchair scale.

4. C. (SAMPLE) LOCATOR GUIDE: ACCESSIBLE (WHEELCHAIR) WEIGHT SCALES

#	Campus	Department	Bldg./ Floor	Qty.	Model	Platform Size	Weight Capacity	Hand Rails	Will accommodate all wheelchairs and scooters
1				2	Scaletronix 6702W	28”w X 32”d	880 lb.	YES	**YES**
2				1	Scaletronix 6202	24”w X 30”d	800 lb.	YES	**NO**

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 with 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
- Design Specifics LTD. www.designspecific.co.uk 1-866 305 6462
- 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
- Oakworks, www.oakworks.com 717.235.6807
- 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

Sample of standard and over-sized wheelchair as of the date of this guidance document

- ***Standard Platform***
  - A. Scale-Tronix 6202 (Stow-A-Weigh) Wheelchair Scale (standard platform)
  - B. Health-O-Meter Pro-Plus Wheelchair Scale 2500KL (standard platform)
- ***Large Platform***
  - C. Detecto Wheelchair Scale model 6550 (portable, folding) (large platform)
  - D. Scale-Tronix In-Floor Medical Scale (large platform)
  - E. Health-O-Meter Pro-Plus Wheelchair Scale 2600KL (large platform)
  - F. Seca 676 (large platform)
  - G. Detecto Wall Hugger Wheelchair Scale 6496 (large platform)

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

- **Access To Medical Care For Individuals With Mobility Disabilities,** July 2010. U.S. Department of Justice Civil Rights Division *Disability Rights Section*
  http://www.ada.gov/medcare_mobility_ta/medcare_ta.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

Edition 1 of this brief was funded, in-part, by the National Institute on Disability and Rehabilitation Research, U.S. Department of Education, under grant #H133E020729. The Rehabilitation Engineering Research Center (RERC) on Accessible Medical Instrumentation was a five-year project that evaluates methods and technologies to increase the accessibility and usability of diagnostic, therapeutic, and procedural healthcare equipment, and associated assistive technologies, for people with disabilities.

Department of Health Care Services

Harris Family cdhp Center for Disability and Health Policy

Tips for Weighing Patients Using an Accessible Scale

10.4.10

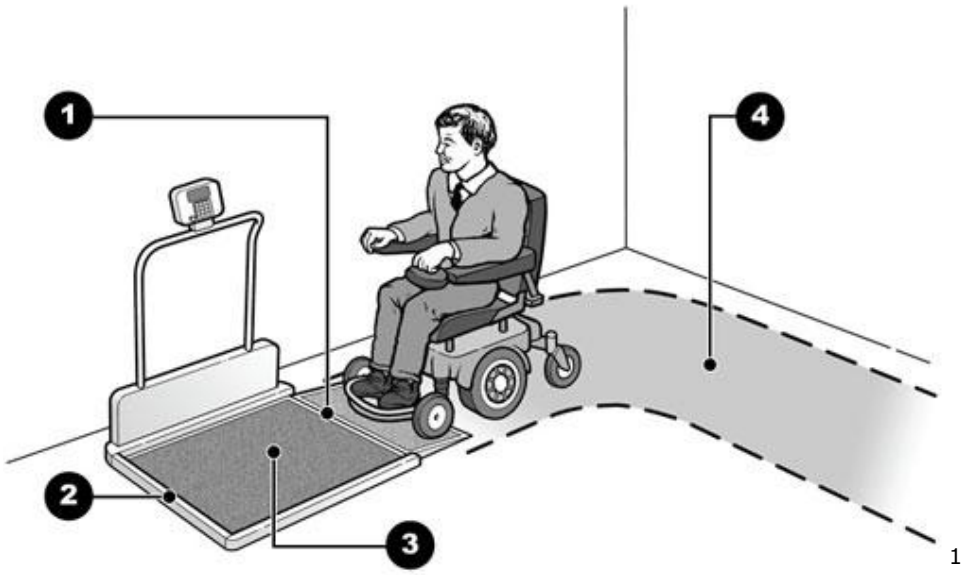
Who should use an accessible weight scale?

Patients who…

- Have difficulty standing or maintaining balance on a standard scale platform.
- Have difficulty or are unable to step onto a standard scale.
- Weight is higher than the standard scale's limit.

How to weigh wheelchair users:

All wheelchair scales require 2x the (straight-route) length of the scale for a wheelchair or scooter user to enter and exit. The scale entrance route should not be blocked by obstructions, protruding objects, or fire exits. The route should also be away from high foot traffic areas and should not block frequently used room entrances.



[1]

1. **Sloped surface provides access to scale platform -- no abrupt level changes at floor or platform.**
2. **Edge protection at drop off.**
3. **Large platform to accommodate various wheelchair sizes.**
4. **Provide maneuvering space to pull onto and off scale**.

[1] *Access to Medical Care for Individuals with Mobility Disabilities*, U.S. Department of Justice, Civil Rights Division, May 2010

1. Remove excess weight from the wheelchair, such as book bags, backpacks, etc.
2. Have the patient roll their wheelchair onto the scale and lock the brakes for safety.
3. Weigh patient and wheelchair together.
4. Have the patient roll off the scale and then help the patient transfer to a safe location, e.g., chair, hospital bed or exam table.
    a. Use lifting equipment and/or a one or two-person team, depending on need, to transfer the patient from their wheelchair to a safe location.
    b. During transfer, carefully monitor the patient and provide for balance and support as needed.
    c. If the safe location is in a separate room from the scale, do not leave the patient alone.
5. Roll the empty wheelchair back onto the scale and weigh. Then, document weight in the patient's chart for future use. (NOTE: <u>There is no standard weight for a wheelchair)</u>
6. Subtract the weight of the empty wheelchair from the combined weight of the patient and wheelchair to obtain the patient's weight.
7. Document the patient's weight in their chart.
8. After the exam, assist the patient in transferring back into their wheelchair.

**On every visit, ask the patient if they have the same wheelchair – that way you do not need to weigh it every time. However, you will still need to weigh the patient in their wheelchair at every visit, as you would for all patients.*

Weighing patients with limited mobility and / or who have difficulty maintaining their balance on a standard scale:

1. Place a chair (preferably an armchair) on the scale and document its weight.
2. Have the patient sit on the chair.
3. Weigh the patient and chair together.
4. Provide assistance to patient throughout weight measurement procedure. Carefully monitor the patient and watch for any balance support that may be Subtract the chair's weight from the combined weight of the chair and patient to get the patient's weight.

Remember, <u>*anyone*</u> and <u>*everyone*</u> can use an accessible scale!
It is accessible to <u>*all*</u> your patients!

Harris Family Center for Disability and Health Policy
Voice (909) 469-5380 ● TTY (909) 469-5520 ● FAX (909)-469-5503
Information V/TTY (800) 832-0524 ● www.hfcdhp.org, hfchdp@westernu.edu

Department of Health Care Services

Harris Family cdhp Center for Disability and Health Policy

Tips for Exam Room Selection,
Accessible Tables / Chairs & Lifting Assistance
10.4.10

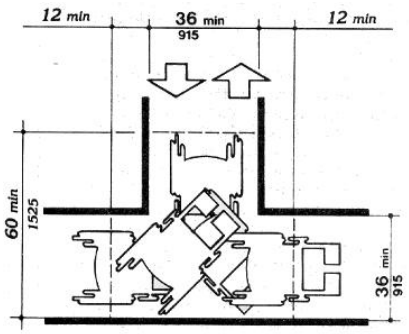
A. Number of Accessible Exam Rooms with Exam Tables / Chairs

- All clinics and / or departments should have a minimum of one accessible exam, procedural and/or treatment room that contain one "accessible" exam table/ chairs lowering to at least 19 inches or less from floor to top of the cushion.
- In departments with more than one examination room, accessible tables or treatment chairs should be placed in no less than 10% of rooms, and up to 50%. Higher percentage equipment standards should be applied in those clinics / departments serving patients that have mobility limitations due to arthritis, stroke, orthopedic conditions, late term pregnancy, neurological conditions and general weakness.

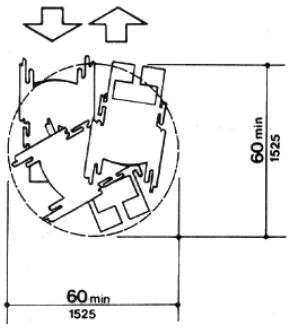
B. Choosing Exam Rooms for Placement of Accessible Equipment

Closest to:

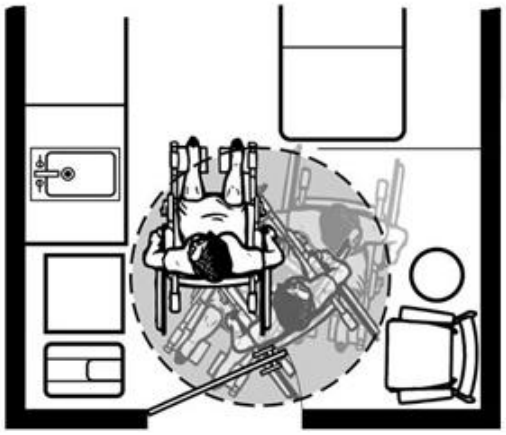
- Wheelchair accessible weight scale,
- Wheelchair accessible restroom,
- Clinical administrative area,
- Shared physicians' room (not dedicated to 1 physician / clinician), and
- Adequate wheelchair or scooter "turning radius" (below).



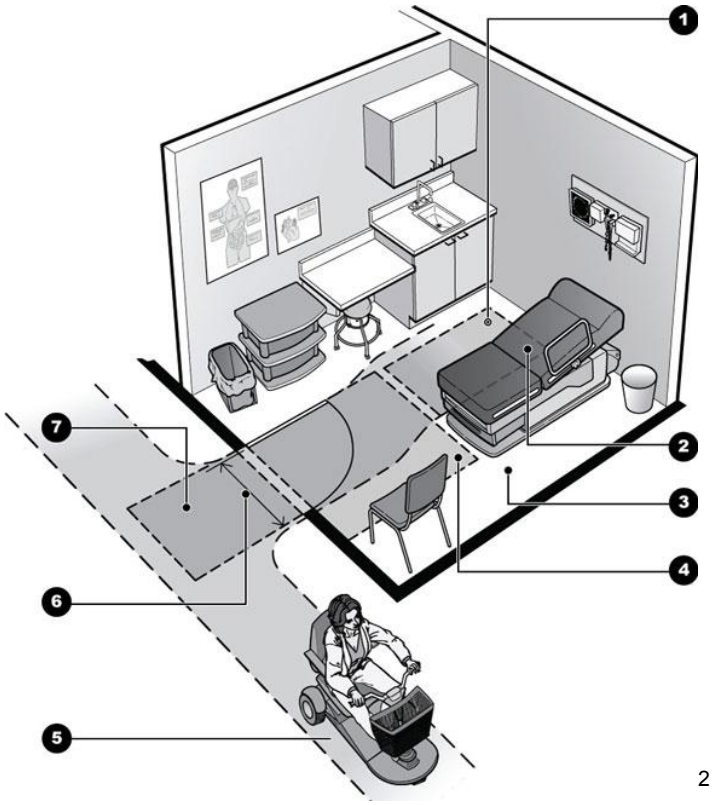
T-Shaped Space for 180 Degree Turns



Space 60 in. Diameter



Exam room showing clear floor space for turning a wheelchair. Space also can accommodate a portable patient lift.[1]



2

C. <u>Other Considerations</u> (Figure above)

1. Clear floor space, 30” X 48” min., next to exam table to make it possible to do a side transfer.
2. Adjustable height accessible exam table lowers for transfers.
3. Providing space between table and wall allows staff to assist with patient transfers and positioning. When additional space is provided, transfers may be made from both sides.

4. Amount of floor space needed beside and at end of exam table varies depending on method of patient transfer and lift equipment size.
5. Accessible route connects to other accessible public and common use spaces.
6. Accessible entry door has 32” minimum clear opening width. Door swings open at least 90 degrees.
7. Maneuvering clearances are needed at the door to the room.

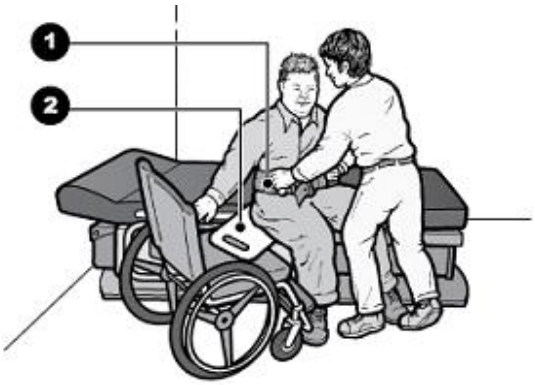
Note: Additional clear floor space can be provided by relocating chairs, trash cans, and other items.

D. Lift and transfer Assistance

Some people will need additional assistance to get on and off an exam table, even if it lowers to 17-19 inches from the floor. The kind of assistance needed will depend on the patient’s disability.

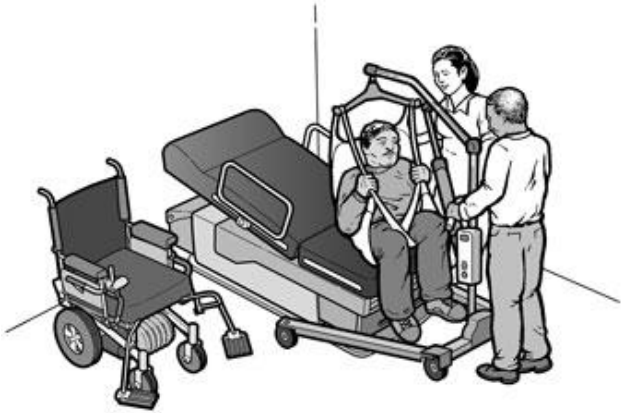
Some people will need only a steady hand from a staff person. Other people will need items such as a transfer board (a product made of a smooth rigid material which acts as a supporting bridge between a wheelchair and another surface, along which individual slides) or sheet; (Figure below)[3] Still others will need assistance through use of a lifting device.

Assisted transfer using a transfer board and gait belt with handles



1. **Gait belt with handles assists with guiding along transfer board**
2. **Transfer or sliding board acts as a bridge between wheelchair seat and table surface**

Assisted Transfer Utilizing a Portable Floor Lift



Low height, adjustable width base permits the lift to be positioned at the end of the examination table

✓ **Always** ask person the type of assistance needed. May include, but not limited to:

- Complete lifting
- Providing extra balance & stability
- Help with stabilizing medical equipment e.g. wheelchair, cane and walkers
- **Never …** leave person un-attended, after transfer has been complete.

E. <u>GOOD PRACTICES:</u> All staff should know which rooms have accessible medical equipment and should be trained on theuse of the equipment. When scheduling or assigning an exam room, inquire if the patient would benefit from the use of an accessible exam table / chair, lifting assistance, and exam room. If yes,

- Document in patient record
- When setting appointments allow more time for the patient's visit
- Schedule appointments when there is sufficient staff assistance available for lifting and/or transferring assistance.

[i] *Access to Medical Care for Individuals with Mobility Disabilities*, May 2010, US Department of Justice, Civil Rights Division, Disability Rights Section
[2] Ibid. [3] Ibid.

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ENDNOTES

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

[ix] Ibid.

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

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

[xii] Ibid.

[xiii] Ibid.

[xiv] Ibid.

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

[xvi] 29 U.S.C. § 794 (1994).

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

[xviii] Ibid.

[xix] *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.

[xx] *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-].

[xxi] *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.

[xxii] *Settlement agreement between the United States of American and The Beth Israel Deaconess Medical Center* under the Americans with Disabilities Act, Department of Justice complaint number # 202-36-19 www.ada.gov/bidmsa.htm.

[xxiii] *Structured negotiation for Partners HealthCare, 2008*

[xxiv] Structured negotiations on behalf of San Francisco disability rights activist *August Longo and University of California Medical Center (UCSF) 2008.* http://lflegal.com/2008/09/ucsf-settlement-agreement.

[xxv] *15674 Metzler v. Kaiser Foundation Health Plan, Inc., No. 829265-*2 (Calif. Super. Ct., Ala. Cnty) (Dismissal Based on Settlement Agreement March 2001)

[xxvi] 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).

[xxvii] Ibid.

[xxviii] Ibid.

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

[xxx] *15674 Metzler v. Kaiser Foundation Health Plan, Inc., No. 829265-*2 (Calif. Super. Ct., Ala. Cnty) (Dismissal Based on Settlement Agreement March 2001)

[xxxi] Ibid.

[xxxii] Ibid.

[xxxiii] Frequently Asked Questions**.** Cancer Care. www.cancercare.org.

[xxxiv] 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.

Center for Disability Issues and the Health Professions

IMPROVING ACCESSIBILITY WITH LIMITED RESOURCES

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This brief is part of the *Accessible Health Care Series* available at
www.cdihp.org/products.html#access_briefs

- Importance of Accessible Examination Tables, Chairs, and Weight Scales
- Review of Legal Research on Accessible Medical Equipment
- Health Care (Clinic / Out-patient) Facilities Access
- Choosing and Negotiating an Accessible Facility Location
- Providing Information in Alternative Formats
- Accessible Web-sites
- Improving Accessibility with Limited Resources
- Tax Incentives for Improving Accessibility
- ADA Resources

TABLE OF CONTENTS

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1. INTRODUCTION

1. a. 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.[i]

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.[ii]

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. [iii]

1. b. Barrier Removal: A Continuing Obligation

The ADA requires companies providing goods and services to the public to take certain limited steps to improve access to existing places of business. This mandate includes the obligation to "**remove barriers from existing buildings when it is readily achievable to do so**." Readily achievable means, "easily accomplishable and able to be carried out without much difficulty or expense."[iv]

The ADA establishes different requirements for existing facilities and new construction. However, while it is not possible for many existing small businesses to make their facilities fully accessible, much can be done without difficulty or expense to improve accessibility.[v]

Readily achievable barrier removal is a continuing obligation. Barrier removal that was not readily achievable initially may later be required because more resources available. Therefore, you must continually monitor your facilities accessibility as well as your financial and other resources and engage in barrier removal as new measures become readily achievable. It is also important to remember that when you move to new facilities accessibility features of the new location need to be a very high priority.[vi]

Determining if a barrier removal is "**readily achievable**" is, determined on a case-by-case basis. The "readily achievable" requirement is based on the size and resources of the business. Barrier removal is an ongoing obligation -- you are expected to remove barriers in the future as resources become available.[vii]

---

2. ACCESSIBILITY GUIDELINES

The Americans with Disabilities Act Accessibility Guidelines (ADAAG) issued by the Access Board can serve as a guide for identifying the various kinds of measures that can be taken to remove barriers and as a guide for how best to remove them.[viii]

2. a. Priorities for Barrier Removal

When funds are not available to remove all existing barriers, the Department of Justice (DOJ) recommends an order of priorities for barrier removal:

1. Provide access from public transportation, parking areas, sidewalks, and entrances to the public accommodation so a person with a disability can "get through the door," (e.g., installing an entrance ramp, widening entrances, and providing accessible parking spaces).
2. Provide access to those areas where goods and services are provided (e.g., adjusting the layout of display racks, clearing routes to exam rooms, rearranging tables, providing Braille and raised character signage, widening doors, providing visual alarms, and installing ramps).
3. Provide access to rest room facilities when they are open to the public (e.g., removal of obstructing furniture or vending machines, widening of doors, installing of ramps, providing accessible signage, widening of toilet stalls, and installation of grab bars).
4. Take other measures to provide access to goods, services, or facilities.[ix]

3. CONDUCTING AN ON-SITE SURVEY

It is helpful to conduct physical access surveys with people with disabilities who have a user's perspective and who are knowledgeable about cross-disability access issues. Surveying demands strict attention to detail. Items that may seem minor to a person without a disability can really be major. A perceived minor detail can make a person's ability to use a facility inconvenient or impossible. (**See page 13 for a listing of survey tool resources)**

Examples of low-cost barrier removal and/or modifications includes, but not limited to:[x]

a. <u>Entrance and exit</u> (see pages 5-7)

- Installing:
  - Portables ramps for access into/out of the building,
  - Low-energy door operators,
  - Off-set door hinges, and
  - Lever door handles.

b. <u>Path-of-travel</u> (see pages 8-10)

- Ensuring:
  - 32" wide clear route (e.g. rearranging furniture, re-locating tables, chairs, trash receptacles, and potted plants),
  - Wheelchair turning radius,
  - Protruding objects, and
  - Patient reception desks too high and/ or access is blocked to lowered area of reception desk.

c. <u>Restroom Access</u> (see pages 11-12)

- Insulating lavatory pipes under sinks,
- Repositioning a soap and/or paper towel dispenser to be in reach range,
- Installing a full-length mirror and grab bars, and
- Re-arranging toilet partitions to increase maneuvering space.

d. <u>Effective Communication signage</u> (page 13)

- Pictorial symbol sign, braille and raised lettering

e. <u>General Access</u> (see pages 13-14)

- Reachable placement of:
  - Pamphlets and brochures, and
  - Disposable water cups.

3. a. Entering and Exiting the Building

- **Portables ramps**

If there are steps up to the entrance, ramping one step or even several steps may be readily achievable.

If a public accommodation cannot meet the ADAAG's technical requirements for ramps because of space or other limitations, it can deviate slightly from these specifications as long as the ramp is still safe. If a permanent ramp cannot be installed, you can provide a portable ramp if readily achievable. Portable, i.e. moveable ramps must also be safe. Most portable ramps are inexpensive to purchase or construct.[xi]

Figure 1: Temporary threshold ramp Temporary ramp to provides rolling surface over door threshold openings

Figure 2: Temporary ramp provides rolling surface over two small steps

If you use a portable ramp you should install a doorbell (with an appropriate sign) to call for an employee to bring the ramp to the door, if readily achievable.[xii] If the accessible entrance is one other than the main entrance, a sign at the main entrance should indicate where the accessible entrance is located.

Figure 3: Direction signage indicating accessible entrance pointing to the right side of the building.

- **Low-energy door operators**

Low-energy door operators can provide a cost-effective solution that meets the intent of barrier-free code requirements. Installation of a low-energy operator on a restroom door can reduce the need for expanded approach and clear space dimensions.[xiii]

Figure 4: Automatic door opener, with large push button.

Figure 5: Automatic door opener, with large push button affixed to left of sliding doors.

- **Hardware: off-set (continuous) door hinges**

Off-set door hinges can add 2" to any doorway. Replacing existing hinges on doors with swing-clear hinges can often provide the necessary width (32 inches) for a wheelchair user to pass through.

Figure 6: Off-set door hinges.

Hardware: Door Knobs

Inaccessible door hardware can prevent access to the medical offices. For example, the handle shown **(Figure 7 & 8)** requires the user to tightly grasp the handle to open the door. People with limitations in grasping, such as arthritis, find this type of handle difficult or impossible to use.

- **Non-accessible door hardware** such as a thumb latch or a round door knob requires tight grasping, pinching and twisting to operate.

Tip: Close-fist test, try opening the door or operating the control using only one hand, held in a fist; if you can, than the door is usable by a broad range of people. The same is true for faucets, handles, drawer pulls, and vending machine controls.

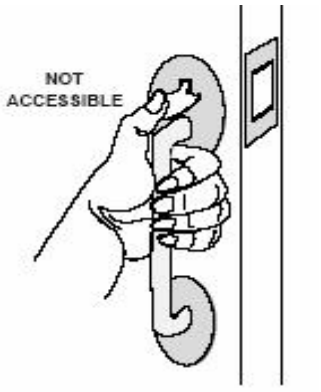

Figure 7: A thumb latch

Figure 8: A round door knob

- **Accessible door handles such** as lever (**Figure 9**) or loop hardware (**Figure 10**) can be used without grasping can be used without grasping, pinching or twisting.

Figure 9: Lever handle

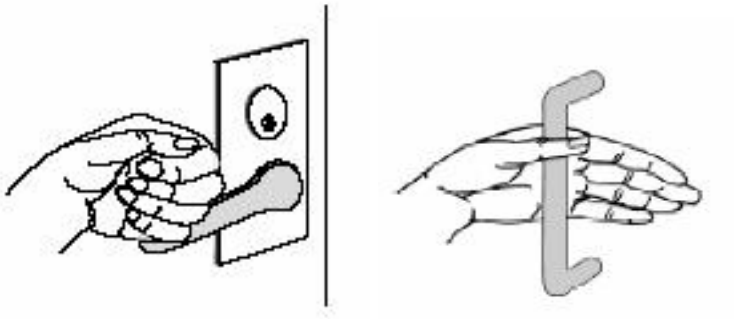

Figure 10: Loop-type handle

3. b. Path-of-Travel

Clear (path-of-travel) floor space: In addition to an accessible entrance, evaluate how people with disabilities will get into and around lobby, reception areas, and exam rooms.

- **Wheelchair Turning Radius (turning space needed)** For more information, See *Access Board, ADAAG Standards, www.access-board.gov/adaag/html/figures (Turning Radius)*

Turning radius: The T-shape space is 36 inches (915 mm) wide at the top and stem within a 60 inch by 60 inch (1525 mm by 1525 mm) square.

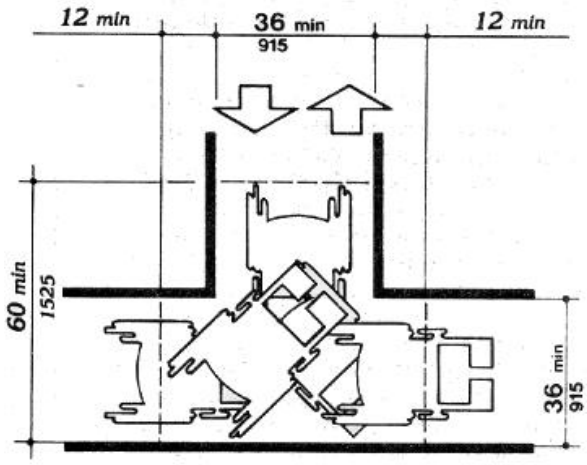

Figure 11: T-Shaped Space for 180 Degree Turns

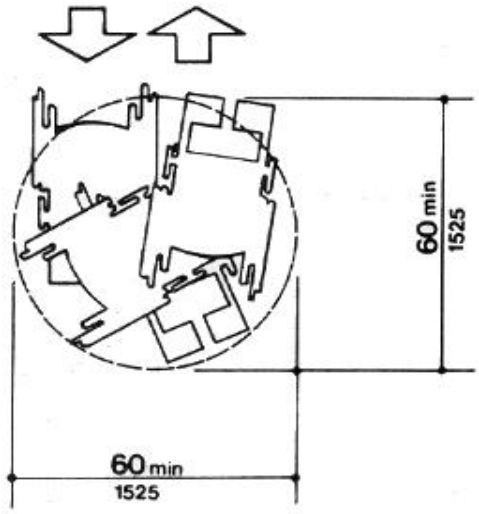

Figure 12: **Space 60 in. Diameter**

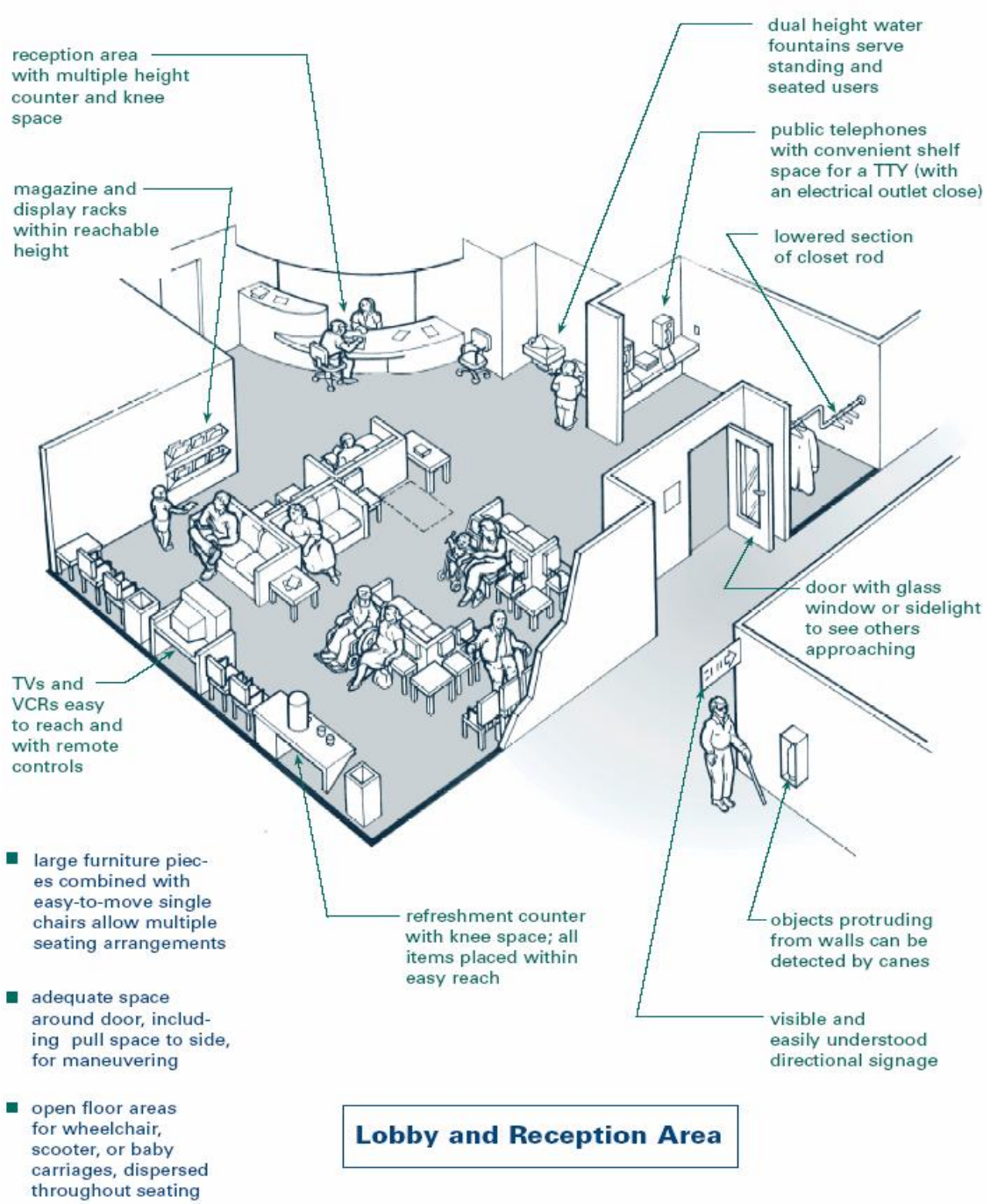

Figure 13: Detailed diagram of an accessible reception and lobby area, which includes lower reception areas, reachable magazine racks, dual height water sources, open areas for wheelchair users and scooters.[xiv]

- **Protruding objects**

  Patients with low or no vision may not be able to detect protruding objects on walls i.e. the chart boxed and shelves, which protrude over the 4" inch limit, and wheelchair users may hit their head.

  Objects projecting from walls (for example, telephones) with their leading edges between 27 in and 80 in (685 mm and 2030 mm) above the finished floor shall protrude no more than 4 in (100 mm) into walks, halls, corridors, passageways, or aisles.[xv]

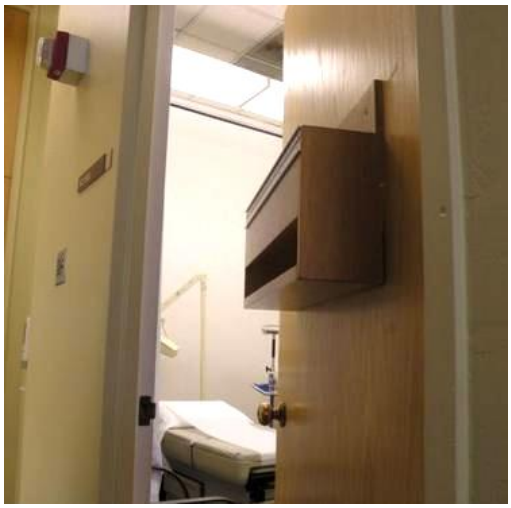

Figure 14: Chart box affixed to an examination entrance door, which protrudes over 4 inches.

Figure 15: Chart box affixed to an examination entrance door, shown as eye level to a wheelchair or scooter user.

- **Patient reception desks too high and / or access is blocked to lower reception desk**

  Patient service counters may be too high for many users **(see Figure 16 below),** including people of short stature and wheelchairs users.

  If service counters are too high, step around counters to speak directly to individual and provide service, and keep a clipboard or other portable writing surface handy for people unable to reach or use the counter when signing documents.

Figure 16: Reception desks too high for scooter user.

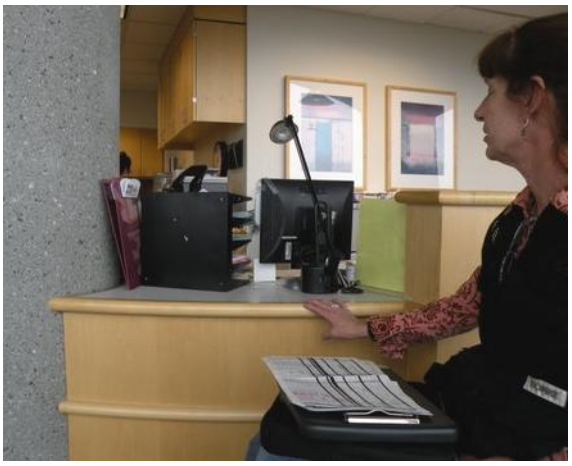

Figure 17: Computers and miscellaneous items block access to lower reception desk.

Access may be also blocked by computer monitors and miscellaneous items at lower sections of reception desks where scooter, wheelchair users, and people of short stature could easily communicate with staff.

- ✓ Educate staff on importance of keeping lower sections of reception desks clear and usable. **(see Figure 18 below)**

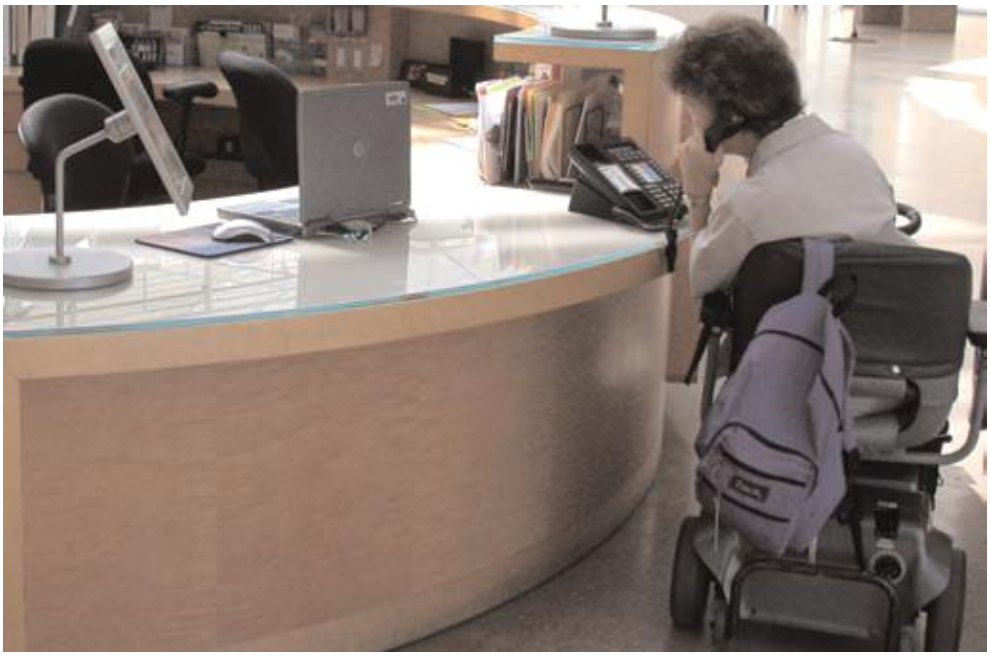

Figure 18: Patient using a scooter accessing a telephone located on a lower reception desk.

3. c. Restroom Access[xvi]

Most of the requirements for accessible restrooms address making the interior of the restroom usable:

- ✓ One stall must be accessible,
- ✓ It must have sufficient room for a person in a wheelchair to enter, close the door, and
- ✓ Maneuver from wheelchair to toilet seat.

Possible solutions include:

- Reconfigure rest room, and/or
- Combine rest rooms to create one unisex accessible rest room.

Readily achievable elements in an accessible restroom include installing usable door hardware, grab bars in toilet stalls, re-arranging toilet partitions to create maneuvering space, insulating lavatory pipes under sinks to prevent burns, installing a full-length bathroom mirror, and repositioning the paper towel dispenser.

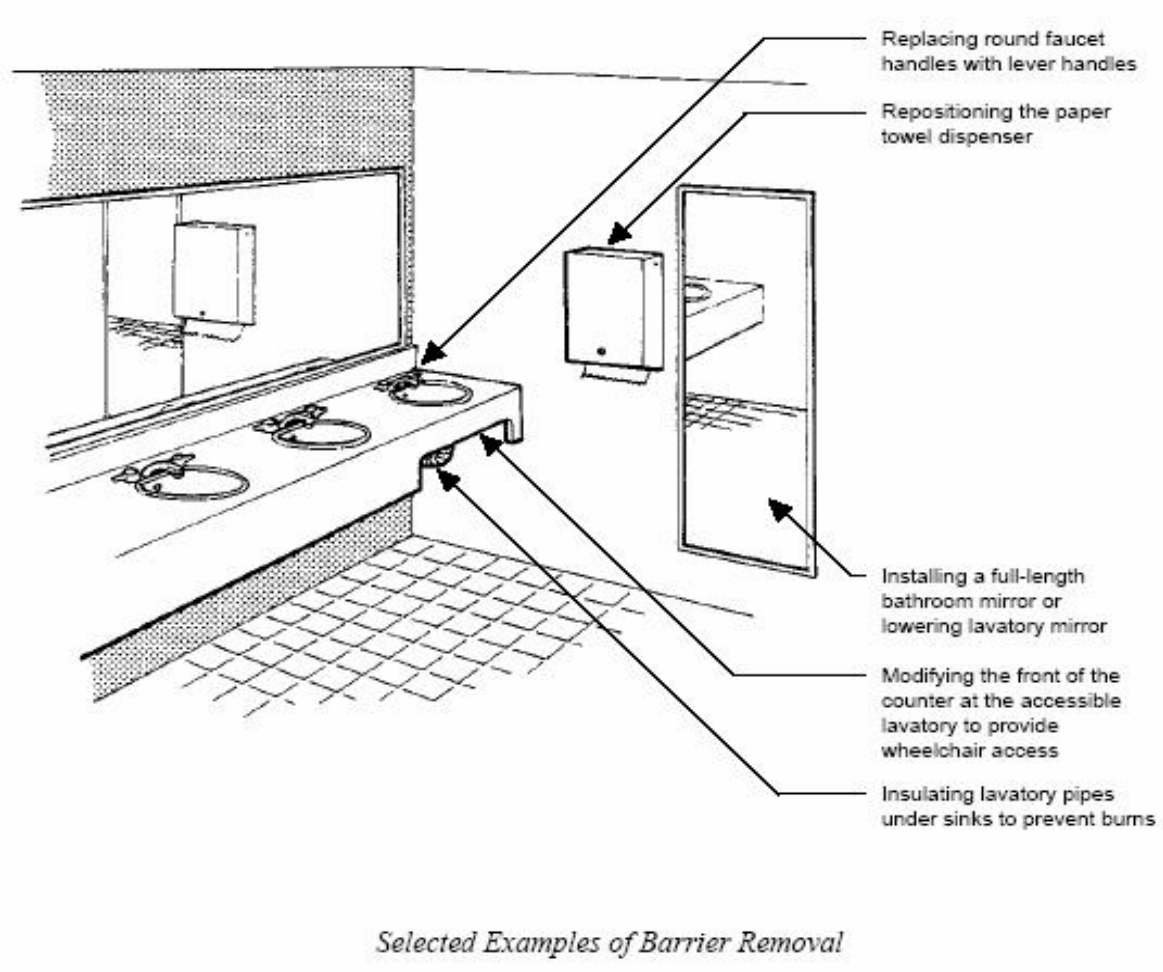

Figure 19: Detailed diagram of a restroom, which includes, leaver water handles, repositioning paper towel racks, installing full-length mirrors, and insulating lavatory pipes to prevent burns.[xvii]

3. d. Effective Communication Signage

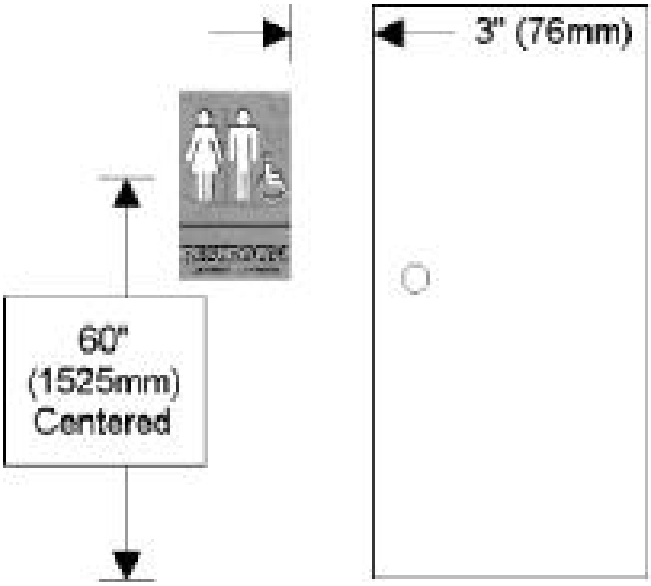

Figure 20: (left) Diagram detailing required height of accessible signage. Accessible signs should contain tactile lettering and Braille and be located 60 inches from ground and 3 inches from edge of a door. [xviii]

3. e. General Access

Other hardware and miscellaneous items can prevent access to the medical offices. The following are examples of low-cost solutions to improve access to brochures, and disposable water cups.

- **Reachable pamphlets and brochures:** A low-cost solution to inaccessible display racks is the use of desktop display holders. (**Figure 22 below right**)

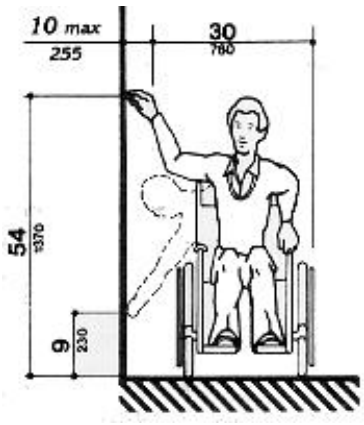

Figure 21: Diagram of accessible reach ranges for wheelchair and scooter users.[xix]

- **Disposable water cups:** If your facility does not have an accessible water fountain, consider placing disposable cups next to the water fountain.

Figure 22: Disposable water cups can be placed within a reachable range near water fountains and coolers.

4. RESOURCES

4. a. ACCESS GUIDANCE DOCUMENTS

- **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 they are making good faith efforts 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

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4. b. GOVERNMENT ADA PUBLICATIONS and INFORMATION

- **ADA BUSINESS CONNECTION**
  - **U.S. Small Business Administration Office of Entrepreneurial Development, U.S. Department of Justice Civil Rights Division**

    Americans with Disabilities Act (ADA) Guide for Small Businesses, October 15, 2002
    www.sbaonline.sba.gov/ada/smbusgd.html

    PDF (835 KB) **www.sbaonline.sba.gov/ada/smbusgd.pdf**

    This 15-page illustrated guide presents an overview of some basic ADA requirements for small businesses that provide goods and services to the public. It provides guidance on how to make their services accessible and how tax credits and deductions may be used to offset specific costs.

- **Reaching Out to Customers with Disabilities An online ADA course for businesses**

  A 10-lesson course divided it into individual lesson modules. Modules allow you and your staff to learn at their own pace. Topics include:

  1. Policies & Procedures
  2. Customer Communications
  3. Accessible Design
  4. Removing Barriers
  5. Alternative Access
  6. Maintaining Accessibility
  7. Transporting Customer
  8. Cost Issues
  9. ADA Enforcement
  10. Information Sources

- **Ten Small Business Mistakes (video)**

  is thirteen-minute video identifies common mistakes that small businesses make when trying to comply with the ADA and addresses the importance and value of doing business with 50 million people with disabilities. **www.ada.gov/videogallery.htm#anchor10mistakes990**

  Available modes:

  - Dial Up (Modem & ISDN) and High Speed Internet (DSL/Cable)
  - Quick Time | RealPlayer
  - Open Captions | Audio Description

- **THE ACCESS BOARD**

  1331 F Street, NW, Suite 1000
  Washington, DC 20004-1111
  Phone: 202.272.5434 (Voice) 202.272.5449 (TTY) 202.272.5447 (Fax)
  Email: **info@access-board.gov**., **www.access-board.gov**

  The following Access Board sites provide information about the Americans with Disabilities Act Accessibility Guidelines (ADAAG):

  - **ADAAG (Americans with Disabilities Act Accessibility Guidelines)**
    www.access-board.gov/ada-aba
  - **ADAAG Facility Access Surveys**
    www.access-board.gov/adaag/checklist/a16.html
  - **ADAAG Technical Assistance**
    Email: **ta@access-board.gov**
    Phone: (800) 872-2253 (v)
    (800) 993-2822 (TTY)
    Fax: (202) 272-0081

- **ADA Information Line (DOJ)**
  800.514.0301 Voice/800.514.0383 TTY **www.usdoj.gov/crt/ada/infoline.htm**

  Toll-free ADA Information Line provides information and free publications about the requirements of the ADA including the ADA Standards for Accessible Design.

  Title II (State and Local Governments)
  Title III (Public Accommodations)
  Public Access Section, Civil Rights Division, U.S. Department of Justice
  P.O. Box 66738 Washington, DC 20035-9998
  1 (800) 514-0301; 1 (800) 514-0383 TTY

- **Disability and Business Technical Assistance Centers (DBTACs)**
  Phone: 800.949.4232 (V/TTY) **www.adata.org/dbtac.html**

  Regional centers to providing information, training, and technical assistance to employers, people with disabilities, and other entities with responsibilities under the ADA.

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4. c. 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.

  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

ENDNOTES

[i] 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).

[ii] Ibid.

[iii] Ibid.

[iV] Checklist for Existing Facilities version 2.1(revised August 1995), Adaptive Environments Center, Inc. for the National Institute on Disability and Rehabilitation Research. For technical assistance, call 1-800-949-4ADA (voice/TDD). www.usdoj.gov/crt/ada/racheck.pdf

[V] Americans with Disabilities Act ADA Guide for Small Businesses (last revised - October 15, 2002). U.S. Small Business Administration Office of Entrepreneurial Development, U.S. Department of Justice Civil Rights Division. www.usdoj.gov/crt/ada/smbusgd.pdf

[VI] Ibid.

[VII] Ibid.

[VIII] Kailes, J. (1994). Americans With Disabilities Act Compliance Guide For Non-Profit Organizations, Kailes-Publications, 6201 Ocean Front Walk, Suite 2, Playa del Rey, California 90293-7556, www.jik.com/resource.html, jik@pacbell.net.

[IX] Check-list for Existing Facilities version 2.1

[X] Kailes, J. (1994).

[viii] Common Questions: Readily Achievable Barrier Removal. U.S. Department of Justice, Civil Rights Division, Disability Rights Section. ADA-TA, a series of technical assistance (TA) updates from the Disability Rights Section of the Civil Rights Division of the Department of Justice. www.usdoj.gov/crt/ada/adata1.pdf

[ix] The Access Board, ADAAG Standards, www.access-board.gov/adaag/html/adaag.htm#4.8 (Section 4 Ramps)

[x] Kailes, J. (1994).

[xi] Americans with Disabilities Act ADA Guide for Small Businesses (last revised - October 15, 2002). U.S. Small Business Administration Office of Entrepreneurial Development, U.S. Department of Justice Civil Rights Division. www.usdoj.gov/crt/ada/smbusgd.pdf

[xii] ibid.

[xiii] ibid.

[xiv] Mace, FAIA, Ronald L., (1998), Center for Universal Design and The North Carolina Office on Disability and Health, *Removing Barriers to Health Care: A Guide for Health Professionals.*

[xv] The Access Board, ADAAG Standards: www.access-board.gov

[xvi] The Access Board, ADAAG Standards, restroom access: www.access-board.gov

[xvii] Mace, FAIA, Ronald L.,

[xviii] Common Questions: Readily Achievable Barrier Removal. U.S. Department of Justice, Civil Rights Division, Disability Rights Section. ADA-TA, a series of technical assistance (TA) updates from the Disability Rights Section of the Civil Rights Division of the Department of Justice. www.usdoj.gov/crt/ada/adata1.pdf

[xix] The Access Board, ADAAG Standards: www.access-board.gov

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Tax Incentives Packet

on the Americans with Disabilities Act

Office of the Attorney General
Washington, D. C. 20530

July 6, 2001

Dear Sir or Madam:

Under President Bush's New Freedom Initiative, this Administration is committed to full and fair enforcement of the Americans with Disabilities Act (ADA), which provides people with disabilities an equal opportunity to work and to participate in the mainstream of American life. As part of the President's initiative, the Department of Justice is providing information to small businesses about the ADA and tax benefits to help them comply with the law. I am pleased to send you this ADA Tax Incentives Packet.

This packet contains information about the disabled access credit that is available for small businesses and the tax deduction that is available for businesses of any size to help offset some of the costs of improving accessibility for customers or employees with disabilities. It also includes the Internal Revenue Service (IRS) form and instructions for claiming the disabled access credit, a list of ADA publications available free from the Department of Justice, and a list of telephone numbers and Internet sites to which you can turn for answers to your ADA questions.

If you have questions about the ADA or want to order ADA publications, please call the ADA Information Line at 800-514-0301 (voice) or 800-514-0383 (TTY). Specialists are available to answer questions from 10:00am until 6:00pm Eastern time and automated service is available 24 hours a day to order publications. The ADA Home Page also provides information and publications at any time, day or night. Please visit us at www.usdoj.gov/crt/ada.

I hope you find this packet useful, and I encourage you to let others know about it.

Sincerely,

John Ashcroft
Attorney General

FACT SHEET 4

Tax Incentives for Improving Accessibility

The Americans with Disabilities Act Fact Sheet Series

September 4, 1998

Fact Sheets in this series:

Fact Sheet 1. Who Has Obligations Under Title III?

Fact Sheet 2. Providing Effective Communication

Fact Sheet 3. Communicating with People with Disabilities

Fact Sheet 4. Tax Incentives for Improving Accessibility

Fact Sheet 5. Alternatives to Barrier Removal

Fact Sheet 6. Resources for More Information

To obtain additional copies of any fact sheet in this series, contact your Disability and Business Technical Assistance Center. To be automatically connected to your regional center, call 1-800-949-4ADA. This fact sheet may be copied as many times as desired by the Disability and Business Technical Assistance Centers for distribution to small businesses but may not be reproduced in whole or in part and sold by any other entity without written permission from the authors.

Developed under a grant from the National Institute on Disability and Rehabilitation Research (grant #H133D10122).

Adaptive Environments Center, Inc. and Barrier Free Environments, Inc. are authorized by the National Institute on Disability and Rehabilitation Research (NIDRR) to develop information and materials on the Americans with Disabilities Act (ADA). However, you should be aware that NIDRR is not responsible for enforcement of the ADA. The information presented here is intended solely as informal guidance, and is neither a determination of

your legal rights or responsibilities under the ADA, nor binding on any agency with enforcement responsibility under the ADA.

(new page)

Fact Sheet 4

Tax Incentives for Improving Accessibility

Two tax incentives are available to businesses to help cover the cost of making access improvements. The first is a tax credit that can be used for architectural adaptations, equipment acquisitions, and services such as sign language interpreters. The second is a tax deduction that can be used for architectural or transportation adaptations.

(NOTE: A tax credit is subtracted from your tax liability after you calculate your taxes, while a tax deduction is subtracted from your total income before taxes, to establish your taxable income.)

Tax Credit

The taxcredit, established under Section 44 of the Internal Revenue Code, was created in 1990 specifically to help small businesses cover ADA-related eligible access expenditures. A business that for the previous tax year had either revenues of $1,000,000 or less or 30 or fewer full-time workers may take advantage of this credit. The credit can be used to cover a variety of expenditures, including:

- provision of readers for customers or employees with visual disabilities
- provision of sign language interpreters
- purchase of adaptive equipment
- production of accessible formats of printed materials (i.e., Braille, large print, audio tape, computer diskette)
- removal of architectural barriers in facilities or vehicles (alterations must comply with applicable accessibility standards)
- fees for consulting services (under certain circumstances)

Note that the credit cannot be used for the costs of new construction. It can be used only for adaptations to existing facilities that are required to comply with the ADA.

The amount of the tax credit is equal to 50% of the eligible access expenditures in a year, up to a maximum expenditure of $10,250. There is no credit for the first $250 of expenditures. The maximum tax credit, therefore, is $5,000.

Tax Deduction

The tax deduction, established under Section 190 of the Internal Revenue Code, is now a maximum of $15,000 per year a reduction from the $35,000 that was available through December 31, 1990. A business (including active ownership of an apartment building) of any size may use this deduction for the removal of architectural or transportation barriers. The renovations under Section 190 must comply with applicable accessibility standards.

Small businesses can use these incentives in combination if the expenditures incurred qualify under both Section 44 and Section 190. For example, a small business that spends $20,000 for access adaptations may take a tax credit of $5000 (based on $10,250 of expenditures), and a deduction of $15,000. The deduction is equal to the difference between the total expenditures and the amount of the credit claimed.

Example: A small business' use of both tax credit and tax deduction

$20,000 cost of access improvements (rest room, ramp, 3 doors widened)

- $5,000 maximum credit

$15,000 remaining for deduction

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Fact Sheet 4

Tax Incentives for Improving Accessibility

Annual Incentives

The tax credit and deduction can be used annually. You may not carry over expenses from one year to the next and claim a credit or deduction for the portion that exceeded the expenditure limit the previous year. However, if the amount of credit you are entitled to exceeds the amount of taxes you owe, you may carry forward the unused portion of the credit to the following year.

For further details and information, review these incentives with an accountant or contact your local IRS office or the national address below.

For More Information...

Request IRS Publications 535 and 334 for further information on tax incentives, or Form 8826 to claim your tax credit.

IRS Publications and Forms

(800) 829-3676 Voice

(800) 829-4059 TDD

IRS Questions

(800) 829-1040 Voice

(800) 829-4059 TDD

Legal Questions

Internal Revenue Service

Office of the Chief Counsel

attn: Jolene Shiraishi

CC:PSI: 7

1111 Constitution Avenue, NW, Room 5115

Washington, D.C. 20224

(202) 622-3120 Voice/Relay

www.irs.gov

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Free Environments, NIDRR grant #H133D10122

ADA Regulations and Technical Assistance Materials

ADA MATERIALS AVAILABLE FREE FROM THE DEPARTMENT OF JUSTICE

The U.S. Department of Justice provides free ADA materials. Printed materials may be ordered by calling the ADA Information Line (1-800-514-0301 (Voice) or 1-800-514-0383 (TDD)). Automated service is available 24-hours a day for recorded information and to order publications.

Publications are available in standard print as well as large print, audiotape, Braille, and computer disk for people with disabilities.

Many of these materials are available from an automated fax system that is available 24-hours a day. To order a publication by fax, call the ADA Information Line and follow the directions for placing a fax order. When prompted to enter the document number, enter the specific number from the following publication list.

ADA LEGAL DOCUMENTS

Public Law 101-336. Text of the Americans with Disabilities Act, Public Law 336 of the 101st Congress, enacted July 26, 1990. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

ADA Regulation for Title II, as printed in the Federal Register (7/26/91). The Department of Justice's regulation implementing title II, subtitle A, of the ADA which prohibits discrimination on the basis of disability in all services, programs, and activities provided to the public by State and local governments, except public transportation services.

ADA Regulation for Title III, as printed in the Code of Federal Regulations (7/1/94). The Department of Justice's regulation implementing title III of the ADA, which prohibits discrimination on the

basis of disability in "places of public accommodation" (businesses and non-profit agencies that serve the public) and "commercial facilities" (other businesses). The regulation includes Appendix A to Part 36 - Standards for Accessible Design establishing minimum standards for ensuring accessibility when designing and constructing a new facility or altering an existing facility.

Title II & III Regulation Amendment Regarding Detectable Warnings, as printed in the Federal Register (11/23/98). This amendment suspends the requirements for detectable warnings at curb ramps, hazardous vehicle areas, and reflecting pools until July 26, 2001. **FAX # 3001**

GENERAL ADA PUBLICATIONS AND INFORMATION

ADA Questions and Answers. (Spanish, Chinese, Korean, Tagalog and Vietnamese editions available from the ADA Information Line.) A 32-page booklet giving an overview of the ADA's requirements for ensuring equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation, and requiring the establishment of TDD/telephone relay services. **FAX # 3106**

ADA Information Services. A 2-page list with the telephone numbers and Internet addresses of Federal agencies and other organizations that provide information and technical assistance to the public about the ADA. **FAX # 3101**

Enforcing the ADA: *A Status Report from the Department of Justice*. A brief report issued by the Justice Department each quarter providing timely information about ADA cases and settlements, building codes that meet ADA accessibility standards, and ADA technical assistance activities. **FAX # 3102** (for the most current issue)

Enforcing the ADA: Looking Back on a Decade of Progress. A 41-page special edition of the Department of Justice's quarterly status reports highlighting accomplishments and activities from 1990 through 2000.

Enforcing the ADA: Looking Back on a Decade of Progress (HTML format) Acrobat PDF format

A Guide to Disability Rights Laws. A 21-page booklet that provides a brief over view of eleven Federal laws that protect the rights of people with disabilities and provides information about the federal

agencies to contact for more information. (Spanish, Cambodian, Chinese, Hmong, Japanese, Korean, Laotian, Tagalog, Vietnamese editions available from the ADA Information Line.) **FAX # 3103**

A Guide to Disability Rights Laws (HTML format)
Acrobat PDF format

A Guide for People with Disabilities Seeking Employment. A 2-page pamphlet for people with disabilities providing a general explanation of the employment provisions of the ADA and how to file a complaint with the Equal Employment Opportunity Commission. (Spanish edition available from the ADA Information Line.) **FAX # 3108**

A Guide for People with Disabilities Seeking Employment (HTML format) Acrobat PDF format

Learn About the ADA in Your Local Library. An 10-page annotated list of 95 ADA publications and one videotape that are available to the public in 15,000 public libraries throughout the country. **FAX # 3104**

Myths and Facts. A 3-page fact sheet dispelling some common misconceptions about the ADA's requirements and implementation. This publication contains basic information for businesses and State and local governments. **FAX # 3105** (Spanish edition available from the ADA Information Line.)

ADA Mediation Program. A 6-page publication that provides an overview of the Department's Mediation Program and examples of successfully mediated cases. **FAX # 3107**

BUSINESSES AND NON-PROFIT SERVICE PROVIDERS -- TECHNICAL ASSISTANCE MANUALS AND PUBLICATIONS

Title III Technical Assistance Manual (1993) and **Yearly Supplements**. An 83-page manual that explains in lay terms what businesses and non-profit agencies must do to ensure access to their goods, services, and facilities. Many examples are provided for practical guidance. (Spanish edition available from the ADA Information Line.)

Title III Highlights. A 12-page outline of the key requirements of the ADA for businesses and non-profit agencies. This publication provides detailed information in bullet format for quick reference. **FAX # 3200** (Spanish edition available from the ADA Information Line.)

Accessible Stadiums. A 4-page publication highlighting features that

must be accessible in new stadiums and providing guidance on line of sight for wheelchair seating locations. **FAX # 3201**

Accessible Stadiums (TEXT) • Acrobat PDF format

ADA Guide for Small Businesses. This 15-page illustrated guide presents an overview of some basic ADA requirements for small businesses that provide goods and services to the public. It provides guidance on how to make their services accessible and how tax credits and deductions may be used to offset specific costs. **FAX # 3202** (Spanish edition available from the ADA Information Line.)

ADA Guide for Small Businesses (HTML) • Acrobat PDF format

ADA-TA: A Technical Assistance Update from the Department of Justice. A serial publication that addresses two topics in each issue: "Common Questions" answers questions about ADA requirements; "Design / Details" provides information and illustrations of particular design requirements.

Volume 1: **Readily Achievable Barrier Removal and Van-Accessible Parking Spaces FAX # 3250**

Readily Achievable Barrier Removal and Van-Accessible Parking (HTML) • Acrobat PDF format

ADA Tax Incentive Packet for Businesses A packet of information to help businesses understand and take advantage of the tax credit and deduction available for complying with the ADA. **FAX # 3203**

Common ADA Errors and Omissions in New Construction and Alterations. This 13-page document lists a sampling of common accessibility errors or omissions that have been identified through the Department of Justice's ongoing enforcement efforts. The significance of the errors is discussed and references are provided to the requirements of the ADA Standards for Accessible Design. **FAX # 3207**

Common ADA Errors and Omissions in New Construction and Alterations (HTML) • Acrobat PDF format

ADA Design Guide 1 - Restriping Parking Lots. A 2-page illustrated design guide explaining the number of accessible parking spaces that are required and the restriping requirements for

accessible parking spaces for cars and van-accessible parking spaces. **FAX # 3208**

Restriping Parking Lots (HTML) • Acrobat PDF format

Commonly Asked Questions About Service Animals. A 4-page publication explaining the requirements of the ADA regarding animals that accompany and provide services for a person with a disability. **FAX # 3204** (Spanish edition available from the ADA Information Line.)

How to File a Title III Complaint. This publication details the procedure for filing a complaint under title III of the ADA, which prohibits discrimination based on disability by businesses and non-profit agencies. **FAX # 3206**

Commonly Asked Questions About Child Care Centers and the Americans with Disabilities Act A 13-page publication explaining how the requirements of the ADA apply to Child Care Centers. The document also describes some of the Department of Justice's ongoing enforcement efforts in the child care area and it provides a resource list on sources of information on the ADA. **FAX # 3209**

Assistance at Self-Serve Gas Stations. A 1-page document providing guidance on the ADA and refueling assistance at self-serve gas stations. **FAX # 3210**

Assistance at Self-Serve Gas Stations (HTML) • Acrobat PDF format

Common ADA Problems at Newly Constructed Lodging Facilities. An 11-page document lists a sampling of common accessibility problems at newly constructed lodging facilities that have been identified through the Department of Justice's ongoing enforcement efforts. **FAX # 3211**

Common ADA Problems at Newly Constructed Lodging Facilities (HTML) • Acrobat PDF format

Five Steps To Make New Lodging Facilities Comply With The ADA. A 3-page document highlighting five steps that owners, operators, and franchisors can take to make sure that new lodging facilities comply with the ADA. **FAX # 3212**

Five Steps To Make New Lodging Facilities Comply With The ADA (HTML) • Acrobat PDF format

Americans with Disabilities Act Checklist for New Lodging Facilities. This 34-page checklist is a self-help survey that owners, franchisors, and managers of lodging facilities can use to identify ADA mistakes at their facilities.

Americans with Disabilities Act Guide for Places of Lodging: Serving Guests Who Are Blind or Who Have Low Vision. A 12-page publication explaining what hotels, motels, and other places of transient lodging can do to accommodate guests who ae blind or have low vision. **FAX # 3214**

Americans with Disabilities Act Guide for Places of Lodging: Serving Guests Who Are Blind or Who Have Low Vision (HTML) Acrobat PDF format

Guide for Passengers: Accessible Bus Service Under the Greyhound Agreement. A 3-page document explaining how passengers can get accessible bus service from Greyhound under the Department of Justice settlement agreement until October 1, 2001 when Department of Transportation regulations will require accessible, lift-equipped service on demand with 48 hours' notice. **FAX # 3400**

Guide for Passengers: Accessible Bus Service Under the Greyhound Agreement (HTML) Acrobat PDF format

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STATE AND LOCAL GOVERNMENTS --
TECHNICAL ASSISTANCE MANUALS AND PUBLICATIONS

Title II Technical Assistance Manual (1993) and **Yearly Supplements**. A 30-page manual that explains in lay terms what State and local governments must do to ensure that their services, programs, and activities are provided to the public in a nondiscriminatory manner. Many examples are provided for practical guidance. (Spanish edition available from the ADA Information Line.)

Title II Highlights. An 8-page outline of the key requirements of the ADA for State and local governments. This publication provides detailed information in bullet format for quick reference. **FAX # 3300** (Spanish edition available from the ADA Information Line.)

ADA Guide for Small Towns. A 21-page guide that presents an informal overview of some basic ADA requirements and provides cost-effective tips on how small towns can comply with the ADA. **FAX # 3307**

ADA Guide for Small Towns (HTML) Acrobat PDF format

The ADA and City Governments: Common Problems. A 9-page document that contains a sampling of common problems shared by city governments of all sizes, provides examples of common

deficiencies and explains how these problems affect persons with disabilities. **FAX # 3308**

The ADA and City Government: Common Problems (HTML) • Acrobat PDF format

Accessible Stadiums. A 4-page publication highlighting features that must be accessible in new stadiums and providing guidance on line of sight for wheelchair seating locations. **FAX # 3201**

Accessible Stadiums (TEXT) • Acrobat PDF format

ADA-TA: A Technical Assistance Update from the Department of Justice. A serial publication that addresses two topics in each issue: "Common Questions" answers questions about ADA requirements; "Design Details" provides information and illustrations of particular design requirements.

Volume 1: **Readily Achievable Barrier Removal and Van-Accessible Parking Spaces FAX # 3250**

Readily Achievable Barrier Removal and Van-Accessible Parking (HTML) • Acrobat PDF format

Commonly Asked Questions About the ADA and Law Enforcement. A 13-page publication providing information for law enforcement agencies in a simple question and answer format. **FAX # 3301**

Questions and Answers: The ADA and Hiring Police Officers. A 5-page publication providing information on ADA requirements for interviewing and hiring police officers. **FAX # 3302**

Commonly Asked Questions About Title II of the ADA. A 6-page fact sheet explaining the requirements of the ADA for State and local governments. **FAX # 3303** (Spanish edition available from the ADA Information Line.)

Access for 9-1-1 and Telephone Emergency Services Under the American with Disabilities Act. A 10-page publication explaining the requirements for direct, equal access to 9-1-1 for persons who use teletypewriters (TTYs). **FAX # 3304**

Access for 9-1-1 and Telephone Emergency Services (HTML) • Acrobat PDF format

Questions and Answers: the ADA and Persons with HIV/AIDS. A 16-page publication explaining the requirements of the ADA for

employers, businesses and non-profit agencies that serve the public, and State and local governments to avoid discriminating against persons with HIV/AIDS. **FAX # 3206** (Spanish edition available from the ADA Information Line.)

Common ADA Errors and Omissions in New Construction and Alterations. This 13-page document lists a sampling of common accessibility errors or omissions that have been identified through the Department of Justice's ongoing enforcement efforts. The significance of the errors is discussed and references are provided to the requirements of the ADA Standards for Accessible Design. **FAX # 3207**

Common ADA Errors and Omissions in New Construction and Alterations (HTML) • Acrobat PDF format

ADA Design Guide 1 - Restriping Parking Lots. A 2-page illustrated design guide explaining the number of accessible parking spaces that are required and the restriping requirements for accessible parking spaces for cars and van-accessible parking spaces. **FAX # 3208**

Restriping Parking Lots (HTML) • Acrobat PDF format

Commonly Asked Questions About Child Care Centers and the Americans with Disabilities Act A 13-page publication explaining how the requirements of the ADA apply to Child Care Centers. The document also describes some of the Department of Justice's ongoing enforcement efforts in the child care area and it provides a resource list on sources of information on the ADA. **FAX # 3209**

Title II Complaint Form. Standard form for filing a complaint under title II of the ADA or section 504 of the Rehabilitation Act of 1973, which prohibit discrimination on the basis of disability by State and local governments and by recipients of federal financial assistance. **FAX # 3306**

U.S. Department of Justice
Civil Rights Division
Disability Rights Section

AMERICANS WITH DISABILITIES ACT AND TAX INFORMATION SERVICES

For information on the ADA and how it applies to your business or facility, or to obtain copies of ADA regulations, Standards for Accessible Design, the Guide for Small Businesses, or other publications, contact the U.S. Department of Justice

ADA Information Line for publications, questions, and referrals

800-514-0301 (voice)
800-514-0383 (TTY)

Internet address (ADA Home Page)

www.ada.gov

For information on ADA provisions applying to employers and employees, contact the Equal Employment Opportunity Commission

Employment - questions

800-669-4000 (voice)
800-669-6820 (TTY)

Employment - publications

800-669-3362 (voice)
800-800-3302 (TTY)

Internet address

www.eeoc.gov

For information about tax code provisions that can assist businesses in complying with the ADA, contact Internal Revenue Service

Tax code - information

800-829-1040 (voice)
800-829-4059 (TTY)

Legal questions about ADA tax incenties

202-622-3120 (voice)
TTY: use relay service

Internet address

www.irs.gov

For information on how to accommodate an employee with a disability, contact the Job Accommodation Network (JAN) funded by the U.S. Department of Labor

Job Accommodation Network

800-526-7234 (voice/TTY)

Internet address

www.jan.wvu.edu

For information on the ADA Accessibility Guidelines, contact the U.S. Access Board

ADA Accessibility Guidelines

800-526-7234 (voice and TTY)

Internet address

www.access-board.gov

For information on making transportation accessible, contact Project ACTION funded by the Department of Transportation

Project ACTION

800-659-6428 (voice)
TTY: use relay service

Internet address

www.projectaction.org

For information on complying with the ADA and to obtain assistance in your area of the country, contact the regional Disability and Business Technical Assistance Centers funded by the Department of Education

Disability & Business Technical Assistance Centers

800-949-4232 (voice and TTY)

Internet address

www.adata.org

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Return to Businesses and Service Providers

last update October 15, 2002