Pacific ADA Center
Healthcare and the ADA Webinar
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>> LEWIS KRAUS: Welcome to the Healthcare and the ADA: Inclusion of Persons with Disabilities. I'm Lewis Kraus from the Pacific ADA center, your moderator for this series. This is brought to you by the ADA Center on behalf of the ADA National Network. The ADA National Network is made up of 10 regional centers that are federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act.

You can reach your regional ADA center by dialing 1-800-949-4232.

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Also, I want to remind you that this webinar is being recorded and can be accessed on the ADAPresentations.org website under the archive tab in the health section next week.

This webinar series is intended to share issues and promising practices in healthcare accessibility for people with disabilities. The series topics cover physical accessibility, effective

communication and reasonable modification of policy issues under the Americans with Disabilities Act of 1990, the ADA.

Upcoming sessions are available at ADAPresentations.org under the schedule tab and then follow to the healthcare section.

These monthly webinars occur on the fourth Thursday of the month at 2:30 Eastern, 1:30 Central, 12:30 Mountain, and 11:30 Pacific time. By being here you are on the list to receive notices for future webinars in this series. The notices go out two weeks before the next webinar and open that webinar to registration.

You can follow along on the webinar platform with the slides. If you are not using the webinar platform, you can download a copy of today's PowerPoint presentation at the healthcare schedule page of ADAPresentations.org.

At the conclusion of today's presentation, there will be an opportunity for everyone to ask questions. You may submit your questions using the Chat area within the webinar platform, and the speaker and I will address them at the end of the session. So feel free to submit them as they come to your mind during the presentation.

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You can also email us at adatech@ADAPacific.org or call us at 510-285-5600.

Today's ADA National Network learning session is titled "Implementing Disability Access in a Healthcare Setting."

The Americans with Disabilities Act and other disability access laws set out principles to follow, implementing these principles requires careful program design. This session will set our program strategies for implementing the disability access principles in both inpatient and outpatient settings, including operations, policies, accessible medical equipment, and physical access.

Today's speaker is Carol Bradley. Carol is the Disability Access /504 Officer for Sutter Health. Ms. Bradley has 25+ years of experience in disability, disability access and leadership. She developed a disability compliance program for Sutter Health, a California comprehensive not-for-profit healthcare system. Ms. Bradley served as a member of the Access Board's medical diagnostic equipment advisory committee, responsible for recommendations on national standards from medical equipment accessibility.

She also served as the ADA coordinator for the city of Sacramento and ran several Centers for Independent Living, peer-based organizations empowering people with disabilities.

She is also an appointee to the State Independent Living Councils in both Indiana and California. And she has trained on a variety of topics over her career, including all aspects of disability access. So, Carol, I will turn it over to you now...

>> CAROL BRADLEY: Hello! Can you hear me?
>> LEWIS KRAUS: Yeah, a little louder would be good.
>> CAROL BRADLEY: Okay. I will turn it up.

So, hello, everyone! And unfortunately for some reason my computer is not cooperating today, so we're going to have Lewis advance my slides. So hopefully we will do this smoothly.

So just a note about Sutter Health. Basically we're a large not-for-profit health system, and we have a variety of entities in our system. So, for example, we have 24 hospitals. We have five medical foundations, which actually are big groups of medical offices, doctors, all throughout Northern California. So one medical foundation may have hundreds of locations. So that gives you an idea. And they have to have a minimum of 50 different services. We also have some unique programs, well, home is one of the things we do disability access in, and we have a PACE program as part of our program, which is a program for all-inclusive health for the elderly. So hopefully some of you are familiar with those types of programs. So you can see that there is a wide variety.

Going to the next slide, our program structure, I thought that would be helpful. I was brought on in 2007 to put the program together. And it was exciting for me because at that point, it was a blank slate in many ways.

You know, so what this slide demonstrates is that we have put various expertises in place. I think over time what happens is that entities realize that disability access is a little bigger than they may originally think. And as I was brought on, we have now system-level positions. My position, we have an Accessibility Architect. We have an ADA Equipment Officer, and we have an Informational Services Online Team that deals with web accessibility.

And each entity -- so I mentioned that we have a number -- we're a little bit like a network that is coming together to become more centralized. And each of those entities that I mentioned, so, for example, each of the 24 hospitals have to designate a person identified as an ADA coordinator. And in most cases, you know, those folks are people who get the training from my office.

And, you know, I've given you a little description of sort of the way our program is resourced. So, for example, we create template policies at this level. Those get rolled out to each of the affiliates, what we call -- we call each entity an affiliate, and they have to adopt the policies as-is. Any changes, of course, would need to go through me.

We have training modules that get rolled out. So first of all, our program is a little bit like a train the trainer. So I would train many of the ADA coordinators, and they would then take the information back to their system.

So, expertise is the a really important part of that. You know, one of the things that gets communicated. And, of course, part of it is always having the expertise that someone can call. So, you know, in our system, as I said, we have right now, when I started we had 35 different ADA coordinators that went through the training. We have consolidated some of our entities, and we now have 28. So over time those folks have developed the expertise to advise at the local level, but wherever they don't have the ability to do that, or some really unusual situations come up, you know, they have systems input that they can contact.

And we also have surveys that are based on physical access, and we have different ways of helping people identify their accessible medical equipment. And I'm going to talk more about some of those aspects as we go through this.

So, talking about elements of a successful program. In each of the pieces in this, although some of them fight the regulations, each of these have to be incorporated into a successful program. You know, obviously the law tells us what we need to do, but, you know, any time you are putting -- you are teaching people, any time you are working -- and really disability access is all about changing the culture in an organization. And it's not going to happen overnight. It often happens through a variety of mechanisms. And so as we go through this, we'll talk more about this.

But one of the first ones that I think is really important is to depict people with disabilities for care professionals. And, you know, that is an important element. One of the challenges in disability -- or in healthcare is actually that, because each disability would have a diagnosis as well that goes along with it, often health providers think that they're the most knowledgeable. And so part of what we have to train around is how important each person brings expertise to the table.

So, for example, a healthcare provider will know more about the health conditions, but when you start to talk about a disability, you really are talking about how that impacts our daily lives, and as a person with a disability, I can tell you, people don't understand it oftentimes and we have to do a lot of education.

So the same thing happens in a program like this. You know, it's really important to help educate what providers bring to the table. Because I think each area that you work in, there are different challenges, and in healthcare, one of the challenges, as I described is that folks think that they already know it. But the other thing that is a positive in the healthcare setting is

generally care providers really do care about their patients, and it's really important to them to do a good job.

So, in the next slide, I've given you -- next couple slides, actually, I've given you some examples of ways that I have helped portray the disability aspects that people need to know about. So some of the things are disability facts. For example, the most frequently reported disabilities were in mobility and cognition, and that there's a higher number of people with disabilities in older groups. So those are the kinds of things that you can begin teaching folks about.

The other fact that I would like to make people aware of is the fact that we all picture people who are wheelchair riders and wheelchair users often when we speak about people with disabilities, and, statistically, when you go to look at the different facts, you realize that 93-95% of people have other types of disabilities.

So at least one in five persons, and that's often a big surprise, live with a disability. I'm expecting many of you are very familiar with that fact.

And disability-specific disparities in healthcare access were common, particularly among young, 18-44-year-olds, and middle-aged folks.

And I guess what I'm portraying here is that I try to use information from experts. The reason I do that, and the reason that that is so important is healthcare people and practitioners really do look at data. They're very persuaded by experts.

The next slide on care disparities, again, you know, I think it's important to cite some of the experts on care disparities, the barriers that people with disabilities find in accessing and navigating the healthcare system. The fact that people with disabilities are significantly less likely to receive preventive care. And, of course, the middle bullet point talks about cost and the fact that people with disabilities are less likely to get care due to cost than others.

So my next slide is another example of using the experts. And I often like to use this, the Department of Justice comment, and Health and human services both have put this out.

Due to barriers, individuals with disabilities are less likely to get to routine preventative medical care than people without disabilities. Accessibility is not only required, it is important medically so that minor problems don't become bigger problems, basically.

And you want to use this kind of information and put it in front of your care practitioners in order to help them understand why it's so important. And I guess -- I don't know about many of you, but in my experience, sometimes two people could say the exact same thing and it will be heard from one person versus the other.

So sometimes when you're an insider -- and I will say that I think it's really important to have inside expertise in disability access, which sometimes happens in healthcare systems, they will appoint a person who is inside already, and that may be fine if the person educates

themselves and consults with the community. But it is really important to have good access to ex per cease so that you can use that in analyzing various problems.

So my next slide about healthcare providers understanding cultural competent care, I think today that is a really important piece that is being discussed widely in care. So I think that's important in previous time periods. We might have talked about using training on disability etiquette. But I think you really want to use the parlance of today's cultural expectations, which is cultural care. And so culturally competent care. And the ability rests on attitudes, kills, policies and practices.

By the way, you really want to use and train on those particular pieces.

You know, I talked about -- my next slide talks about training on attitudinal barriers. Some examples of stereotyping, stigma, prejudice and discrimination. But, again, I think the more you can frame that in terms of what do you do. Let's give an example of how you approach things with disability, so that rather than a negative message you want to carry a positive message. So certainly portraying the barriers. But in talking about the attitudinal barriers, the views of beliefs that care practitioners have get in the way of care, so you want to help them understand that piece.

Again, you want to use positive, independent pictures of people with disabilities. And I really want to focus on this, because I know when I first started our program, I had a lot of difficulty finding good pictures, and I had to go to many of the community organizations to get permission to use their pictures. Because many of the traditional pictures in healthcare show a very passive approach. In other words, often the care provider is pushing someone who is a wheelchair user. So for me, what I felt was very important at the beginning was to go out and find pictures that helped portray my community in a much more positive way.

So we want to help people understand especially that you must work towards the same clinical outcomes. For example, providers must not avoid examining a person as a wheelchair user in a wheelchair. And that unfortunately has been a common practice in the past. So beginning to change the importance of that. And part of the way I approached it is you really need to look at whether or not positioning someone on the exam table is important to the care.

So if that position is important to a diagnosis, it's really important that that person get transferred and that you have effective ways to do that.

So my next two slides really talk about ADA program components.

The first is to develop policies that guide staff on providing accessible care. Assure a process for accommodating patients. And truthfully, that becomes a really big deal oftentimes in healthcare. It takes a lot to get the question asked and to gather that information.

Install accessible medical equipment.

And maintain accessible facilities and features in your facilities and programs.

The next slide is effective complaint process. You want to have a good way of problem-solving patient issues. And so, for example, some of -- these two certainly work together, the complaint process, you know, in our system, for example, we don't require that the ADA coordinators are the ones to resolve the complaint, but they need to be called into the process as needed. They also need to be the one who assures that the quality folks and the other folks who may be the frontlines of getting the complaints or getting the patient issues are actually trained and know where to go. Because sometimes it means calling in the ADA coordinator at the right point.

You want to remove barriers in existing facilities, and you want to build compliant facilities. And those two are both, obviously, physical access components, but I will tell you that they often -- you know, they aren't seen as two separate things. So it's really important to have new construction that is made compliant but removing barriers in an existing facility is also really important.

So, the next slide talks about how the law requires us to provide the same care to our patients. And this is a slide that I use in my system, and our policies guide us on how to do this.

I've given a set of policies to you that are our policies. So, for example, responsibility for accessible facilities and services is the top left policy. And I will tell you that that is a little bit of an overarching policy. So it contains references to all of the other policies, but the detail is in the other policies. So that's how ours is structured. We created an overarching policy that references the other more specific policies. And as you can see, we have a communication assistance, that is what our Effective Communication Policy is called, accessible inpatient, outpatient, medical facilities and equipment and I will point out those are two very different models of care, and what I have found -- we usually have a separate policy for inpatient and a separate policy for outpatient. Because the norms in each of those practices are very different than in the hospital.

Medical imaging and diagnostic/therapeutic procedures. Adaptations in mammography. Mobilizing, lifting and transferring inpatient/outpatient services. Again, we have separate policies.

Weight measurement. Service animals. And guidance for maintaining an accessible environment.

So now going into... I was just going to sort of quickly go through our specific policy elements, and many of our policies contain -- and you'll see the importance. So the one that I actually think is one of the most critical policies that is often overlooked is the Effective Communication Policy.

And it's really important to have all of your elements in there. That's actually our longest policy in our system. And, again, it gets overlooked. In general, sometimes healthcare folks are

aware of the need to do an interpreter to bring in an American Sign Language interpreter, but they aren't aware of many of the other aspects of effective communication in the care setting.

And so you can see you want to train people on the fact that this is necessary through auxiliary aids and services or other accommodations. And I like the picture just because it shows how important it is that care providers communicate effectively with people with disabilities, and I've listed a number of the types of disabilities that likely need some adaptation to the communication process.

So deaf, hard-of-hearing, blind, visually impaired, cognitive disability, speech disability. All require some adaptation.

And your policy should lay out each of those.

So the next slide, the communication policy is needed again. I've repeated the types of situations that would require adaptations. I think we have covered that.

And, again, these are things that are in many of the regulations.

In the next slide, communication must be effective for the person considering the complexity of the communication. So, this is a really important point, because sometimes care providers and others want to make their own decisions about how care should be provided, how communication should be done, and, you know, it's really important -- they may or may not know what they need to know. So it's always important to consider all aspects of the communication and what is needed.

So the next slide, again, effective communication, it's really important to include practical considerations and contact information. So in your policy, you will have a number of different aspects referenced. Each of those things may use a vendor or you may have an in-house way that those things get turned out. So, for example, we had recent -- some of the recent experiences that we had was finding out that the electronic health record system that we were using did not allow the practitioners to print out large print or to change the print size, and so we had to go to that. We had to come up with a specific process that would allow large print. So those are examples where each of the elements in the communication assistance policy need to be considered. And you may have a separate process, a separate contact person for each of those.

So you need to know how to engage vendors and how to spell out -- how to evaluate simple v. complex communications. There is times you can get by with writing notes. If a patient is looking for the bathroom, for example, you may be able to use simple communication. But if you're discussing care considerations you need to make sure that the most effective communication that works for that particular patient is what is used.

And I think I found auxiliary aids and services must be designed for the type of communication involved. And the reason I put this, and it may seem redundant, but I really, really found that

people didn't understand the difference, for example, between telephone communication and effective communication and in-person communication. So if you're not somebody who is familiar, just know that your folks may need to really understand the differences.

And obviously most of us know that, but when you are starting to think about how you communicate with someone with a disability, it's not something they're used to thinking about.

Next slide. Effective communication with family or companions. This can be a tough one. So there are so many situations where you have to independently analyze the situation. So making sure that the messaging around how you do that is very important, and this requires training. There are beliefs out there that you don't have to provide something for a family member, for example. And we've had a number of situations where the patient themselves did not need the accommodation but the family member did. So, for example, we have had situations where this question came up around children who were in a class in the normal way that this would get -- the normal way that the class was conducted is that children were in one room and all the parents would watch.

Well, when you had a situation where one of the parents had a disability and needed an interpreter, for example, you would need to bring the interpreter in despite the fact that in this case the patient themselves was not the person who needed the effective communication.

So, again, you've got to think about strategies to train people on these things. Because people aren't used to thinking about it in that setting. Or when people offer free classes or yoga... you know, some of these things take creativity. Or childcare classes, in terms of how you approach things. You know, it's really unusual for practitioners to think about the cost of including interpreter services in something like that, or coming up with a creative solution for ways in which they will communicate with those folks.

And I've described, and I'm going to go through it pretty quickly, the effective communication with family or companions is critical in the care setting, and obviously there are a number of reasons why, you know, that person may be the person's support, they may be the legally authorized person who is making decisions. There can be a lot of reasons why they need to be included in that process.

And I'm going to skip over -- I've given you a slide of -- because this isn't a basic information on auxiliary services, but I provided a list for you. Again, that would be something that we would have in our policy. So that gives you a sample.

And I've given you some examples -- sometimes you have to modify -- again, you've got to think about the model of care, what is going on in the particular setting. So, for example, here is an example of tools that can be easily used in a clinic for different types of communication. And the outpatient setting is a very fast-paced type of care. And, you know, there's a lot of pressures on care providers.

So, one of things you want to make sure you're able to do is to make things very seamless for the care providers. So, if these tools are available and people know where to get them, they will be used.

If they have to pull out a policy and read and try to figure it out, you need to make things as simple as possible for the frontline staff. There's a lot of pressure to be quick in today's healthcare environment for a lot of reasons. You know, there's a lot of pressure on affordability. There's a lot of emphasis on the healthcare practitioners, as well as everyone else. And we all know as patients, it's disturbing to be in a situation where you're not understood.

So as a person setting up the program -- and that's the position -- that's the approach I'm taking today, you want to make sure these things are made easy for the healthcare practitioners.

So, going into the service animal policies, I think there are some really important things. First of all, it is actually really important for staff to understand what questions they can and can't ask. And I have to tell you that even today, with all the training we have done, you know, there is still folks who believe that service animals needs to have the designation on them.

[coughing]

Excuse me.

Despite the fact that for a long time that has not been the case, and knowing what questions to ask is very important. But I have to tell you that in my approach, what I try to really do is to make sure that folks have an understanding of how they can -- what they need to do if an animal is not appropriately behaved. That's the really important thing. Because, you know, staff members -- and I have had this in other positions as well, other jobs. People get really tweaked out by service animals and animals in general. And they want to prove that it is or isn't a service animal.

And I just steer people away from that. Yes, you need to know what to ask. But even more importantly, you need to know when an animal can be asked to be removed. Because if a service animal is not appropriately behaved -- and some of the examples that I think of and that I have talked about in here are the kinds of things -- we've had situations where the animal is growling at the care provider, and I can tell you that is going to be -- get in the way of care.

So, you know, it is important to help your practitioners understand how to screen the service animals and where an issue may get brought up. You know, it's really important that service animals accompany their person, but you also have to understand and help people understand that, you know, there does need to be access to care. And so I guess, you know, that's one of the things that we often struggle with, because obviously we want the animal to be with the person. But in their job, it means they're protective and they will get in the way of the care provider, you don't want that to get in the way of your care. So, that's one of the places where

I often try to educate people about what is really important is to know what you can and can't do if there's a problem.

So I'm going to move on beyond the service animals. There are two slides on that and I think I covered most of the points. But I'm going into... and one of the policies that we more recently have developed is a policy called Maintaining an Accessible Environment. And, you know, I don't know how many of you, if you've been involved in this physical access process, what you often find is that things get turned over to architects and to people who are used to thinking in terms of construction.

But I can tell you that in most cases our actual -- many of the barriers are what we call movable barriers, or we actually in our system termed the coin "low-hanging fruit," in other words, barriers that can be easily removed. But in our case, in our experience, sometimes it tends to meander back.

So, for example, if someone has a trash can that is under the elevator button, you know, that would have been removed, and we would have made sure that was removed. But the next step is making sure you have a policy and you train people on the policy about how important it is for everyone to be able to reach those elevator buttons. And when there's a blockage, obviously someone who has a smaller or has a low reach range is not going to be able to reach the elevator button.

So this policy is about creating a procedure and designating people responsible for periodic review and maintenance of spaces. We want to make sure that they're free. And, again, I use the term "low-hanging fruit," and other non-construction barriers. Your policy should include specific requirements for pow the entity will maintain the barriers. In our situation we asked each of our affiliates to come up with different ideas, things that will work at each of their entities.

And you have to have a procedure.

So that people know who is designated to deal with these situations. And I've given examples on the next slide of movable barriers. You know, those clearances are all really important. And I portrayed a picture there of a lack of the clear space on the pool side of the door, that 18 inches is very important. And you can see we have a trash can in the way of that. So that would have been one of our early pictures that portrays some of the barriers we had.

So next I'm going to talk about policies that adapt care procedures. And this was an important part of the process as well. Because there are situations when you have to actually change how you approach the care, adapt how you approach the care in order for the patient to get the same care. And the examples of this... so weight measurement. We have to have a method where the care practitioners understand how to capture weight if they're using an accessible scale or a wheelchair accessible scale with the flat -- having a flat platform that someone who is a wheelchair user can go up on.

What we find is that it easily gets overlooked, that it's always important to transfer someone so that you weigh the wheelchair, if you don't already have an understanding of the weight of the wheelchair. And in a few cases, people do know the weights of their wheelchairs. We're starting to develop a process where people will actually capture that information in the chart. But you always have to -- even if you do that -- and I'm dating myself by using the word "chart" -- in the patient record, but it is important that staff knows how to approach this.

So, the next one that we came up with was how you mobilize patients. And in the hospital setting, the big differences that you -- you know, hospitals really are used to moving people around. That's what they do. When somebody is very sick, whether they have a disability or not, a lot of times moving the patient is important. So, you know, a lot of acute care sites have extensive processes, may have a lot of lift equipment that they are able to use to approach the -- approach how a patient is moved. It's a bit harder in the outpatient setting. And I know when we first required that each outpatient care setting have access to mechanical means, we started out with a transfer board, because that is a simple way of transferring people.

But there's a lot of work that has to be done. And, again, inpatient is very different from outpatient in this realm. So we, again, have different policies on this.

And it's also important for care providers here. So one of the key -- and I've had discussions with our people around this, our workers comp folks, wanting to understand what the difference between our perceptions of how you move patients and what ultimately happens, is that one of the important pieces is that people with disabilities know how to transfer themselves.

I've given an example of mammography adaptations and medical imaging and diagnostic therapeutic procedures. And we have developed processes for each of those things.

And I've given some examples on the next slide.

So, the functional limitations that may require specific adaptations that we have in our policy is given in a chart on the next page. These are processes and the things that need to be considered when imaging a patient.

Accessible medical equipment in spaces. Again, we have policies that are different for inpatient and outpatient. We have developed -- you know, we asked that people lay out the specific space requirements that are needed in the patient care rooms, and obviously a patient bedroom is very different than an examination treatment procedure room. We also have asked that each entity identify the accessible medical equipment and other ancillary equipment that is needed.

And you have to maintain that equipment in a working order. So keep in mind maintenance is always an important piece of that.

So I'm going to talk a little bit about you need to install and use accessible medical equipment. And there are a lot of -- there's a lot of discussions happening about this. We actually put our program in place before the Access Board developed its standards, so it was exciting to be able to participate in the medical diagnostic equipment discussions.

You know, we expect that -- and, you know, I've always presented, so there are some folks who say, well, it's not required yet, even though there are some standards out there. And it's been my experience that you really, really do need to use the best practices. Because otherwise -- and I talked about the fact that DOJ has specifically stated that equipment cannot be a barrier to care. What is going to happen, whether it's talked about or not, if you don't have accessible medical equipment in place, care providers are less likely to transfer a patient on to the equipment. And you really, really want to make sure that they're able to do that.

So while there are federal standards that have been at least issued by the Access Board, they haven't gone into the Department of Justice process yet. Right now there are no mandated scoping standards, but you do need to -- I would recommend as a system that you sit down and maybe engage some of the care providers in how you could do that. Because I think once they become advocates for this, you will have -- you may get pushback at the beginning. And I talked to other ADA coordinators who say how do you approach this, and one of the things that I will say that we did at Sutter was we created a standards committee, so it's called the Accessible Medical Equipment Standards Committee, a subcommittee of our executive group that oversees the accessibility program, and that group helped develop the standards for -- so we have scoping standards for each type of equipment in our system.

And I think it's important. We actually considered what is most needed and what kinds of -- we looked at it service-by-service and we brought in care practitioners to talk to us about it.

So next slide...

Your system will need to look at the differences in the model of care to consider this. So, again, I think I said we use -- we had to marry the knowledge of disability access with care professionals and what they know.

And I have to say, over time, what you really will find is that staff really like the accessible medical equipment. They may have a pushback at the beginning, but they actually really like it once it is in place. And we actually have had some folks who say we think there should be a higher percentage for your amount. So we started out -- you always have to have a minimum of one in every practice, clinic, and it depends on how they use the space.

So it can get quite complex. If scheduling is done where all practitioners use the same space, you can then probably look at your numbers different, but if each practitioner -- has their own individual offices, you have to count accessible medical equipment differently, because you have to have accessible medical equipment in each location in order to be effective.

And we require that our standards be used in all new and existing spaces. So we've gone through a whole process where purchases had to be made. And on the next slide, the pictures of equipment, I've identified the types of equipment that we actually look at. Beds were a little bit complex, and I think I'll talk about it quickly, but the bed frames are under the 17 to 19. However, you do not want your care practitioners to use a mattress that is less than a good amount of space. And our system actually requires pressure ulcer relieving mattresses in all of our care. And so as a result those mattresses are thicker than others. So we had to be quite complex about that and think it through in terms of how people use the beds.

Exam tables and procedure chairs, in this realm there pretty much is good accessible equipment out there that has been developed. It's exciting to see that happen. And we have had some successes even in fields -- so, for example, our infusion chairs, which were a specialty type of equipment, what we found was that at the time we started sourcing for these kinds of chairs more recently, there wasn't anything out there.

But as we talked to vendors, what we found is they were able to adapt their model to meet the Access Board criteria. And so that's quite exciting. The fields of medical equipment is evolving, and I think we'll see more evolution over time.

Equipment capturing weight -- and I have to tell you, we started talking about scales, but as we looked at the way people with disabilities and the way healthcare works, we realize actually that it's way more effective to have something that is already used in the care being the way that the patient gets weighed.

For example, there's now accessible exam tables out there that actually capture weight. And so if you know anything about care, you know that reduces the amount of needed transfers. So it's a great way to go. And we recommend that, even though those chairs are a little more expensive, but it eliminates the need for scales when you have those kinds of equipment.

Lift equipment, again, the big thing with lift equipment is making sure it works with your other equipment. It's got to be -- go under, for example, your equipment that you're lifting the person on to. And far more complex was medical imaging and mammography equipment. And in healthcare, those are all seen as the same type of thing, but I will say that here we found that we needed a different procedure for mammography processes. And so you'll note that we had a separate policy for that.

So moving on, I think I talked about how important problem-solving for the patient and the family, companion issues is. You want to designate and train staff who can assist in problem-solving for patient issues.

The best practice is to have knowledge of disability and how people with disabilities navigate and live in the world. And, you know, the best practice always is to bring in people who understand disability. But obviously it's also important that those people can work in the healthcare culture, because there is -- it's definitely -- it has its own culture and it's really important to modify it so that people understand people with disabilities much better.

So you want to think about that and you want to make sure that you bring in that expertise so that people understand why it's important with those around them.

One of the reasons I touched on this earlier, but it really does differ from the clinical understanding and diagnosis of disability. So having an understanding of how people navigate the world and how that is going to impact in the care, in the examination, in the procedure, is really critically important.

So I described on my next slide the accommodations. You see I have a definition that we have used, and I have a definition from the Center for Disease Control. It's important to understand that and to help people -- we've had a lot of discussions about this over the years.

On the next slide, I've depicted sort of our process for gathering accommodation needs. You want to -- to determine the need, you want to consult with the patient about what will work. You want to ask function-based questions. Again, this is an important piece. Because healthcare practitioners are used to thinking in terms of diagnosis. But a diagnosis is not usually going to tell them what they need to know.

So what they need to know is how -- what's needed. For example, there is nothing in any diagnosis around eye issues that will tell you what kind of print the person needs. You need to understand by talking with the person how the person gets information. They may get it through audible means. They may get it through large print. And they may get it through their own computer that may read to them.

So that's an example of function-based questions.

And the question -- and we've grappled with this a lot. I think, you know, given all the complexity in healthcare, you know, in scheduling, the question format that we've come up with is "Do you need disability-related accommodation or assistance?."

The complaint process. In healthcare, pretty much everyone is going to already have a complaint or a grievance process in place. But the things that you need to focus on are the ways in which you make sure that alternative formats are done, if a complaint is required in a certain form, is there assistance to help people get the complaint in that form. And you need to train those who respond to complaints on disability access issues, and the importance of talking with the person with a disability.

So oftentimes you have to -- when talking with folks, it doesn't always occur to them that they need to go back to the person making the complaint to really understand it. And that is usually an important component.

Remove barriers in existing facilities. The building codes provide accessibility to buildings but it's triggered only when you remodel or construct new facilities.

So, one of the big differences -- you know, this is something that takes a lot to educate people around, is it's really important to realize, when you acquire any kind of new facilities, they're likely not going to be fully accessible. They're not going to meet the current standards. And so you have to go in and remove barriers. And the intent is, in the law, is to do that over time. So, by doing it over time, the ideal is that you provide and you prioritize those things that are most important and are biggest barriers to your patients. It's important sometimes to have additional strategies for how you approach this.

Okay. So, it's a common belief that having plans approved by the building official assures full accessibility.

Beyond the survey... so you do want to have surveys done. And, again, part of that survey is to help prioritize the importance of the different barriers. So you want to have someone who is knowledgeable about why things -- and give an assigned value to how big a barrier something is. And that's going to vary depending on how severe the barrier is.

So it's very important to do that.

You can also use advisory group to help with prioritizing those things. So there are a number of different ways that you get that information.

So the next slide, I'm not really going to go over, but I have given an image or a chart that shows sort of the difference between accessibility laws and the building code, and there are differences. And it may help you to educate some of your facilities folks on this.

So, additional disability access principles, and I'm going to go through this pretty fast. So discrimination. Obviously that underlies all of the laws. So we would lay that out in one of our policies. It would be in our accessible facilities and services policy.

One of the things that I like to use with the staff in healthcare is the basic principle that underlies all activities. People don't think about it this way. And I list the things on the left, on the arrow, I list those things because they come out of the regulations. Specifically are all of the things that you have to make sure are accessible.

Now, that seems pretty obvious to many of us, but if you're designing your care practices in a certain way, sometimes people don't think about that as you're providing a benefit to your patients. And so you need to help people think that through. So if you provide it you must provide it to all.

So eligibility criteria must be relevant and neutral. I'm not going to spend a lot of time on that. I think it's self-explanatory. Your criteria for any service needs to be neutral and based on something. The obvious example is, you know, people like to ask for a driver's license when

they're loaning something out. And, you know, really what you're looking for is an ID or a driver's license.

Legitimate safety requirements are necessary for the safe operation, but you have to make sure that those are based on real risks.

So sometimes people have fears about something happening, and you really want to do an examination of what is going on here, how likely is that, is that a fear versus a fact.

No surcharge for access. And I think many of us know that, that it's considered to be an expected part of the care.

You need to modify policies and procedures that require to provide access. I will tell you this is a big deal in healthcare. So you may have to work with people around how to do this. People are not used to thinking about that. And I think you may have to modify scheduling practices to include a procedure that allows for accommodation needs as an example. And I've given some other examples as we have gone through this process.

Remove barriers that are readily achievable. I think I covered that enough. I'm going to move on.

And methods for providing program access. Keep in mind that your real goal is to make sure that people get access. And sometimes coming up with a practical way to do that, so reassigning someone to a different room, making sure that the equipment is there when it's needed. There are all kinds of ways to provide program access and to make sure that people get access to the care.

And I've given some examples here in my PowerPoint and, you know, sometimes staff assistance is a part of that.

DOJ requires web accessibility, and, you know, we have had a lot of discussion around this. Our website has been set up long ago, a number of years ago, so that it's designed to be accessible. But I can tell you that one of the big challenges in healthcare is sometimes the vendors. And, you know, some vendors say they're not used to being experts at accessibility. Your electronic healthcare records vendors are really important, and we spent a lot of time discussing that with various folks.

Everyone brings expertise to the table. This is one of those principles that you really want to make sure that you get out there, because your care people need to understand, here is what you're an expert in. And that helps them frame it. But the patient is an expert at what they need. And so that framework can really help care providers understand why this is so important. The patient experience should be at the heart of that.

Training that is relevant. One of the things I've used a lot of is, you know, we have groups -- so we have a large system, and sometimes, for example, all the compliance officers get together. Sometimes all the risk officers get together. And, you know, what I try to do is really

put my training together so that it speaks to those particular groups. Not everyone needs to know the same kind of information. And so the more you can target the training to the audience, the better everyone will understand.

So specialized training, requiring specific in-depth things is important, and figuring out who needs to know what.

Well, that's my basic slide presentation. So I believe we're going to go into questions now.
>> LEWIS KRAUS: All right, Carol, thank you so much. That was a really great in-depth summary of everything. So all of you who are listening, please remember to submit your questions in the chat window, and we'll get to those in a moment.

Before we get to those, I do want to remind everybody that -- or let you know that if you have a particular interest in some of the things that Carol was talking about, you may also be interested in the Pacific ADA Center's ADA Update Conference in September, the 9th and 10th in San Francisco, 12th and 13th in Los Angeles. And during those sessions we will actually have the Department of Justice coming out to talk about healthcare facility accessibility under the ADA, as well as some other conversations about -- or sessions on effective communication in healthcare and some research into accessibility in electronic health records and whatnot. So do remember to take advantage of that. You can go to ADApacific.org and you will see the links for the events coming up in northern California and southern California if you're interested in those.

All right. So let's get to some questions.

So, if you are -- Carol, if you were just starting out -- or some of the people might just be starting out and trying to get this happening in their organization. One question might be: How is it that they get the power to get people to actually do all of these things that you're talking about?
>> CAROL BRADLEY: Well, okay, a variety of things. And one of the ways to make sure that you have the expertise, i.e., you know, if you have an ADA coordinator certificate, for example, those kinds of things, having those kinds of background help convince -- and most care providers have a number of initials after their name. So that's one thing I will say. But I also think you need to look at your organization and how it's structured. Are there people who are natural allies?

I mean, we can all say that it's best if your position is located in the, you know, top leadership. That's not been the case for me in terms of the top leadership. You know, you sometimes have to work through the upper layers to move things as well as convincing other people. That's one of the things. I think you really want to look for people who are allies and who are interested in these topics. And they're all around you. So finding your natural allies, what department it is. I know when I started out, I was located in the ethics and compliance department, and what we found was, in healthcare, ethics -- although my program is a compliance program, it wasn't -- most healthcare folks don't see it as a compliance program.

Now, every other field would see it that way. Most other fields see it that way. But there's so many governmental things and Medicare and Medicaid legs that healthcare compliance people have to deal with that it's not always seen as a compliance program. And so right now I'm located in complex litigation. But certainly the values of a legal approach is not always conducive to -- because I consider my program really an implementation program. It's not purely a legal program, although you have to understand how to analyze things in order to be effective at it. But I think, you know, it is important to think about what your options are and pick your bats sometimes.

So finding allies. Maybe finding groups that you can go speak to. You know, sometimes working your way through those groups helps you get allies. What committees operate, and what is their interest? What are the things you both have in common that people are interested in?

And, you know, that takes a lot of creativity. So that's a starting point. You know, also maybe using some voice to have patient. I have to tell you that, you know, most of us in the field -- and we all know that we would rather not see complaints. We would rather have everything set up, but when you work in the ADA field, sometimes that is the way that everyone else understands why something is important. And so I will say that sometimes you -- you know, making people aware why something is an issue, and bringing them into the solution can be an important strategy.

So hopefully I've given a number of things on that. You really want to figure out who your allies are and how you can work with them.
>> LEWIS KRAUS: Okay. Great. Thank you. Another question here. Does the joint commission accreditation review for hospitals include issues related to accessibility and communication and policy, etc.?
>> CAROL BRADLEY: In my experience, not really. I mean, they may -- occasionally there may be someone who asks a few things, but it's not been my experience that they spend a lot of time focused on those things. You know, it's rare that I've heard those things have been brought up.
>> LEWIS KRAUS: Okay. The next question. How does Sutter handle VRI versus in-person interpreter services? Our agency frequently receives complaints from patients who find VRI ineffective or less effective than in-person. And maybe for everyone you can explain VRI a little.
>> CAROL BRADLEY: Okay. Well, VRI is video remote interpreting, and video remote interpreting is the way that you bring an interpreter from a distance. So it's through a -- you're looking at a screen to see the interpreter rather than having a person sitting in the room with you.

And, you know, many people do prefer an in-person interpreter, and there are actually situations where you absolutely do not want to use video remote interpreting.

Our system has developed a set of protocols that we're educating people around when you can and can't use video remote interpreting. For example, some examples are, you know, it might depend on the position of the patient. You know, there are going to be times when

someone is not going to be able to see the screen. We actually have -- we use a large screen for our video remote interpreting. So, you know, in general you want to put together a set of protocols and train people about when you can and can't. One of the challenges in today's world is it seems like there are fewer interpreters out there. And I hope that's not true, but we have found that sometimes we have had difficulties getting someone in person, even when we have requested it.

So it is important to have both options, but it's not a panacea. There are going to be times when it's not as effective as having an in-person interpreter.
>> LEWIS KRAUS: Okay. Great. Another question. How do you get the feedback from the frontline that there is a need to modify a policy?

>> CAROL BRADLEY: Oh, good question. You know, generally, because I'm at the system level versus the local level, what generally is going to happen is they're going to talk to their ADA coordinator. And if an ADA coordinator brings things up, we will talk about them. Because there are times when the way the policies were drafted -- and, you know, what starts out, when you first draft policies, they're usually drafted by lawyers. And, you know, in the early days I really tried to get as much feedback as I could from the local -- each of the local entities, because you want the policies to work. But in general, sometimes people overlook that.

So that is basically how we generally do it, is the ADA coordinators are at their facility. They're the people that generally that information would go to. And when we've had -- we've actually reworked our policies quite a bit over the years.
>> LEWIS KRAUS: Okay. And remind us -- so you have ADA coordinators in every facility, is that right?
>> CAROL BRADLEY: Yes, every patient care entity has an ADA coordinator.
>> LEWIS KRAUS: Okay.
>> CAROL BRADLEY: So they're the people who are implementing at the local level.
>> LEWIS KRAUS: Okay. Great. All right. Well, if anyone has any more questions, please send them in, and if not, we are going to -- if you have any more questions, there is Carol's contact information on the screen. Feel free to contact her and she might be able to answer.

If you have a general ADA question, you can contact your regional ADA center for confidential advice and information on the Americans with Disabilities Act, and that number again is 800-949-4232.

All right, so everyone you will receive an email with a link to an online session evaluation shortly. Please complete that evaluation for today's program, as we really value your input and want to demonstrate its impact to our funders.

We want to thank Carol today for sharing her time and knowledge with us. And a reminder to all of you that the session is being recorded and it will be available for viewing next week at ADAPresentations.org in the Archives section under the healthcare webinar link.

Our next webinar on August 22nd, we will cover opioid use disorder and the Americans with disability act in healthcare settings.

We hope you can join us for that. Watch your email two weeks ahead for the announcement of the opening of registration for that webinar.

And with that, Carol, I want to thank you once again for your time. And it was a fantastic presentation.

And for all of you who are listening, thank you very much for attending today's session. And have a great rest of your day!
>> CAROL BRADLEY: Thank you!

>> AUTOMATED VOICE: Recording stopped.