



# **Health Care Access and the ADA**

**An ADA Knowledge Translation Center Research Brief**

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## What is the ADA?

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The Americans with Disabilities Act (ADA) passed on July 26, 1990. It provides a legal framework for people with disabilities to challenge discrimination. The ADA's importance extends well beyond the court system. The ADA is also a broader symbol of bipartisan support for disability inclusion in all parts of public life. Under the ADA, disability is formally recognized as a source of discrimination. It is similar to how "race, color, religion, sex, or national origin" is recognized by the Civil Rights Act of 1964. The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public. The larger goal of the law is to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for all individuals with disabilities.

## Health Care Access

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Over twenty-seven years after the passage of the Americans with Disabilities Act (ADA), Americans with disabilities continue to experience disparities in health and in accessing health care. People with disabilities continue to be underserved and poorly served by the health care system.<sup>1</sup> While access to health care is largely treated as a public health issue, disability has not been recognized as a Medically Underserved Population under the Public Health Services Act.<sup>2</sup> Furthermore, there is very limited research on how health care barriers impact people with disabilities from different race and ethnic groups.<sup>3</sup> Within health care settings the ADA actually plays an important role in ensuring that people with disabilities can access health care services and equipment. The purpose of this brief is to provide an overview of research related to how the ADA impacts health care, and reviews how the law applies to health care practices.

This research brief provides highlights of current research affecting ADA implementation and health care access for people with disabilities and provides on-the-ground examples of practitioners working with health care and the ADA.

### HIGHLIGHTS OF FINDINGS

- People with disabilities experience significant and ongoing environmental, attitudinal, and policy barriers in accessing health care.
- Inaccessible medical equipment is a documented barrier to health promotion and preventative care and treatment, and adversely affects health outcomes.
- Health care workers need to understand issues around application of ADA beyond physical access. This includes their roles in providing accommodations to ensure equal access to health care for people with disabilities.
- The ADA also affects health care professionals and medical students with disabilities who encounter barriers to access.

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# Research about the ADA and Health Care Access

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Below are key issues identified regarding health care and ADA implementation.

## Getting in the Door

ADA-related barriers in health care access for people with disabilities begin before they even reach the door; encountering barriers in transportation and parking, accessibility of the building, and emergency and preventative services.<sup>4,5,6</sup>

Emergency services is an area that has been receiving increasing attention in the disability community. This has been partially due to increased awareness of gaps in disaster preparedness facing people with disabilities.<sup>1</sup> There has not been much research on ADA implementation in emergency services, and much of what we do know has been anecdotal.<sup>4</sup> It is important to note that while the ADA does not include language specific to emergency services, the ADA does prohibit discrimination and exclusion in emergencies. Equal access to emergency services primarily pertains to Title II of the ADA (services, programs, and activities provided by State and local government) but it also can be a Title III issue (public accommodations) whenever state and local governments are contracting with local organizations.<sup>7</sup>

People with disabilities experience disparities in accessing primary and preventative care. For example, 61.4% of women with disabilities reported having mammograms while 74.4% of women without disabilities received this test.<sup>8</sup> For pap tests the numbers are even more disparate, where 64.6% of women with complex disabilities received pap tests compared to 82.5% of women with no impairments.<sup>9</sup> Furthermore, men with disabilities were found to be 19% less likely to report a prostate-specific screening test.<sup>10</sup> One qualitative study identified barriers to primary and preventive services and grouped them into two main categories: structural-environmental barriers and process barriers. First, structural-environmental barriers include which services are being offered, accessibility of provider offices and diagnostic equipment, and insurance coverage. Second, process barriers emerge in interactions with service providers and during health care service delivery. Important factors that affect process barriers include provider knowledge and skill set, accommodation procedures, professional flexibility, and courtesy.<sup>11</sup>

Another contributing factor to inadequate access to health care is the systematic exclusion of people with disabilities from health literacy interventions. Health literacy research aims to place health promotion within a relevant context for health care recipients, but much of the research does not reflect the diversity, such as cultural and linguistic, within the disability community limiting the potential benefits.<sup>3</sup>

Furthermore, consequences of barriers to health care access can be categorized as: social, psychological, physical, economic, and issues related to independence. Social consequences have to do with one's relationships, social role, and social participation. Psychological consequences often involve depression, frustration, and stress along with experiences of stigma. Physical consequences may lead to a deterioration in one's health due to limited or skipped diagnostic and health screening procedures and related limitations in activities of daily living. Economic consequences involve potential lost wages, financial strain, and additional health service expenditures one has to undertake. With regards to independence, barriers to health care access can lead to a greater dependency on others than individuals would require otherwise.<sup>12</sup> Researchers have also noted that the detrimental impact of these

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consequences is experienced at a higher rate among racial and ethnic minorities, but there has been limited research exploring this issue.<sup>3</sup>

## Medical Equipment and Devices

Lack of accessible medical equipment and devices prevents people with disabilities from receiving adequate health care and services and jeopardizes patient's safety.<sup>13</sup> For example, this may include equipment such as accessible scales for wheelchair users and individuals with mobility impairments, accessible exam tables, and accessible diagnostic equipment.<sup>14</sup> Access in medical settings is not limited to physical access. People with cognitive and sensory disabilities report experiencing barriers as well in the form of inaccessible information.<sup>5, 15</sup> Other accommodations that may be needed include: alternative print formats, sign language interpreters, augmented and alternative communication devices, and other forms of communication or assistive technology.

Health care providers are required to provide full and equal access to services and facilities under Titles II and III of the ADA. Reasonable modifications to policies, practices, and procedures must be made as necessary to ensure health care services and facilities are fully accessible, unless such modifications would "fundamentally alter" the nature of the services.<sup>16</sup> Research has found there is a significant correlation between knowledge about accessibility and accessible equipment being provided in health care clinics. Yet, in one study only 46% of health care administrators in clinical practices knew that accessible equipment existed, and only 25.4% were able to describe accessible equipment. While 44% of administrators had considered purchasing accessible equipment at some point, only 22% knew of the federal tax credit program that assists businesses in complying with the ADA.<sup>17</sup>

## Health Care Provider Knowledge

Compliance with the ADA is not just an issue related to buildings and physical structures, but it is also about medical practices and practitioners. Pharr and Chino (2013) conducted a study looking at comparing health care practice administrator's knowledge of the ADA with the number of access barriers in their clinics.<sup>18</sup>

The purpose of this research was to identify possible predictors of health care access barriers, such as: 1) age of practice administrator, 2) number of years working, 3) Buildings built before 1993, and 4) lack of administrator knowledge of the ADA.

Significant predictors identified included the age of the administrator and the number of years they had been working in that position. Individuals who were older and had been working longer were associated with fewer reports of barriers, perhaps because they had more experience with disability and more opportunity to learn about the ADA. Buildings built before 1993 tend to have more access barriers as they were constructed before buildings were required to comply with ADA standards. Moreover, few medical facility landlords or tenants of these non-renovated older facilities have proactively undertaken readily achievable barrier removal, that is, inexpensive actions that would improve access. Finally, the researchers found that administrators need education about the ADA and how it applies to their medical practice, along with information regarding the accessibility of their practice.

Conscious and unconscious biases held by health care providers are another underlying aspect of identified barriers to health care access for people with disabilities as well as other marginalized groups, such as racial and ethnic minorities. Negative stereotypes held by health care providers translate into lower quality and fewer services provided as well as contributing to poorer health outcomes for these groups of people.<sup>3</sup>

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Health care professionals need more opportunities to learn beyond physical accessibility and compliance with the ADA. Disability literacy encompasses this notion and is generalized to mean language, knowledge, and interactions reflective of understanding disability experiences and disability etiquette. Disability literacy should be an integral part of education and training for health care professionals.<sup>3</sup> One promising strategy is to involve people with disabilities in assessing the areas of training that are needed and in developing curricula for future health care professionals.<sup>19</sup>

## Medical Professionals with Disabilities

Title III of the ADA includes public accommodations within hospitals, universities, and medical schools. However, most medical schools fall short on providing reasonable accommodations to students with disabilities under the ADA. One study found the majority (77%) of medical schools' technical standards (regarding the admission, retention, and graduation of medical students) did not explicitly mention accommodating students with disabilities.<sup>20</sup> Together these findings illustrate a systematic exclusion of students with disabilities in medical schools. A similar problem also can be found in nursing schools.<sup>21</sup>

Inaccessibility does not only affect patients in health care settings; it also affects medical professionals with disabilities who encounter barriers to access. Title I of the ADA prohibits discrimination on the basis of disability in employment, including individuals who work in health care settings. It is not known how many medical faculty have disabilities. Further, anecdotal evidence suggests that some medical school faculty who have disabilities may be reluctant about asking for reasonable accommodations out of fear of experiencing further marginalization. Faculty report on issues related to needing job accommodations, perceived attitudes of colleagues and supervisors, and physical access barriers in the facilities within which they work.<sup>22</sup> An exploratory study found that nurses with disabilities needed to balance interacting with their environment, gaining acceptance from their peers, gaining support from their supervisors, and engaging with patients. Some nurses reported not having made a request for accommodations because they did not feel comfortable and worried about the consequences of making such requests.<sup>23</sup>

There is growing attention to address the concerns of medical professionals with disabilities. Steinberg and colleagues (2002) provide a list of recommendations compiled by the University of Pennsylvania Subcommittee on Faculty with Disabilities.<sup>22</sup> There are four main topics included in these recommendations: strategies to address non-physical barriers, physical barriers, different pathways in evaluation and promotion, and reasonable accommodations. The Nisonger Center at the Ohio State University also produced core competencies for medical education and are currently working to integrated into existing curricula for future health care providers.<sup>24</sup> There is a critical need for more research regarding the experiences of doctors, nurses, and other health care professionals with disabilities.

## Conclusions

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This brief described themes in research related to health care access for people with disabilities. Through this review, environmental, attitudinal, and policy barriers to accessing health care have been identified. Many of these barriers have negative consequences on social, psychological, physical, and economic wellbeing and issues related to independence for people with disabilities. It is noted that health care providers have limited knowledge about interacting with people with disabilities as well as how to make medical facilities and equipment accessible. In addition to physical accessibility, there is also a need for understanding other types of accommodations, such as providing alternative and effective types of communication. Furthermore, health care professionals and students in the field who have disabilities have reduced access to training and accommodations in the workplace..

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Increasing education about the ADA and other aspects of disability inclusion, such as disability literacy and enhancing access for medical professionals with disabilities, is an important step for expanding health care access. Some promising practices to increase access include integrating disability related curricula into health care provider education and including people with disabilities to assess and develop strategic improvements for medical facilities.

## Experts on the ADA and health note two key areas that require further attention:

**Accessible Equipment:** The ongoing physical and architectural barriers, also including the lack of accessible medical equipment, is a nationwide problem that people with disabilities experiences in health care access. For example, people with mobility disabilities require accessible equipment, which is not routinely available. To learn more about this issue, see this link <https://dredf.org/healthcare-stories/>

**Provider Education:** There is limited training for medical professionals on how to more broadly serve different types of patients/clients with disabilities and work with colleagues with disabilities. Limited knowledge about how to serve communities with disabilities can compound already existing barriers. Effective change requires more than adaptation of training modules; rather, including requirements through the accrediting bodies of professional providers and implementing dedicated training and educational programs could be more effective and sustainable over the longer term.

## Examples from the ADA National Network

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Below are a few examples of how the ADA National Network is addressing the issues raised in this brief. For further information on how the ADA Centers can help with issues related to the ADA, please contact the [ADA National Network](#).

- **Responsibilities for effective communication:** One ADA Center was contacted by a small, individually owned medical practice that wanted to gain a better understanding of the ADA requirements and obligations for providing services to deaf patients. The ADA technical assistants explained the effective communication requirements under Title III of the ADA and provided specific information related to 1) definition of a qualified interpreter, 2) definition of undue burden, and 3) the specific language from Title III on effective communication. The ADA center suggested that the medical practice contact local sign language interpreter agencies and to review applicable state laws. The medical practice was appreciative of the information and had a better understanding of ADA obligations, potential defenses, and available resources to identify and locate sign language interpreters.
- **Generating solutions to accommodate all:** Another ADA center was contacted by a health care provider with a question about accommodating a patient who uses a service animal. The health care provider specialized in treating individuals with allergies, including allergies to dog dander, and they were concerned that a service animal could negatively impact other patients. Technical assistants from the ADA center explained the ADA requirements regarding service animals and the limited instances where service animals could be excluded. They also discussed ways in which the patient with the service animal and other patients with dog dander allergies could be accommodated such as with scheduling, alternative waiting areas, etc. The health care provider was appreciative of the information and interested in exploring options to ensure all patients could be accommodated.
- **Training on accessibility standards:** A major hospital in a metropolitan city contacted one of the ADA Centers after reaching a settlement agreement with the Department of Justice. The hospital contracted with the ADA Center to provide five days of training on the ADA Standards

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for Accessible Design and state accessibility regulations. The hospital wanted to ensure that they had information on both federal and state accessibility requirements. As a result of the training, the architects and facilities managers reported a deeper knowledge of the ADA Standards and state regulations.

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