ACCESS EQUALS OPPORTUNITY:
OUTPATIENT MEDICAL & HEALTH CARE FACILITIES

Q. Are outpatient medical and health care facilities considered to be places of public accommodation?

A. Yes, privately operated medical and health care facilities are covered by Title III. Examples of such facilities are the offices of private doctors, dentists, optometrists, opticians, chiropractors, psychiatrists, psychologists and other therapists, acupuncturists, and nutritionists; clinics; family planning facilities; occupational and physical therapy facilities; laboratories and radiology facilities; an day care surgery centers located in facilities separate from hospitals. The public accommodation provisions of the Americans with Disabilities Act (ADA) also apply to the offices of private medical and health care providers located in private homes. This publication addresses all of these types of facilities. Private hospitals and other in-patient facilities, which are also public accommodation under Title III of the ADA, are not addressed here.

Q. Are there other federal laws protecting the civil rights of people with disabilities that medical and health care facilities should know about?

A. Yes. Section 504 of the 1973 Rehabilitation Act, which applies to recipients of federal financial assistance, may apply to medical and health care facilities. The ADA does not supersede Section 504. Facilities that have been subject to Section 504 must still comply with that law; these facilities may also be subject to additional requirements under the ADA.

Q. Are outpatient medical and health care facilities required to have TTYs (TeleTYpewriters)?

A. No. For making calls to or receiving calls from patients or clients with hearing or speech impairments who use TTYs, health care facilities will be able to rely on the relay systems that telephone companies must establish by July 26, 1993. Operators employed by relay systems will relay communications between TTY-users and people using conventional telephones. Only those businesses that allow their patients or clients to make outgoing calls on more than an incidental convenience basis must provide TTYs.

Health care facilities can ensure effective communication by training staff who answer the telephone to anticipate incoming calls through the relay services. Handling these calls may take longer because an operator at the relay system will be receiving typed communications from the caller and will also be using the relay system equipment to type

communications from the health care facility staff person to the caller. Training should be undertaken as soon as possible because at least 40 states already offer some type of relay service.

For your information, however, a TTY is relatively inexpensive, usually costing about $275 and would be welcome service for patients or clients with hearing or speech impairments. If you have a TTY, be sure to list your telephone number followed by "Voice/TTY" in any publications or advertisements to signify that patients and clients can communicate with them by voice or TTY.

Q. Are health care facilities that offer parking required to provide accessible parking spaces for people with mobility impairments? If such parking is required how many spaces must be provided?

A. Yes. If a health care facility owns and operates the parking lot, it must provide accessible parking if it is readily achievable to do so. If a health care facility is a tenant, responsibility for providing accessible parking rests with both the landlord and the tenant. These responsibilities may be allocated between the landlord and tenant in the lease or other contract.

The spaces must comply with the dimensions specified in the ADAAG if it is readily achievable to meet those standards. The ADAAG also specifies a formula for determining the appropriate number of accessible spaces which must be followed if it is readily achievable to do so. If it is not readily achievable to comply with the ADAAG standards for the number and dimensions of accessible spaces, a health care facility must provide as many spaces as readily achievable and of readily achievable dimensions. If it is not readily achievable to provide any accessible spaces, a health care facility could consider providing valet parking as an alternative method of providing access.

Q. Are health care facilities required to remove barriers posed by sidewalk curbs?

A. Curb cuts (also known as curb ramps) enable people who use wheelchairs or other mobility devices to have ready access to health care facilities. If the only parking available is on a city street and the facility does not own or control the sidewalk, the municipality, not the health care facility, is responsible for providing curb ramps. If a health care facility owns or controls the sidewalk, it must provide curb ramps if readily achievable. If a health care facility is a tenant, responsibility for providing curb ramps rests with both the landlord and the tenant. These responsibilities may be allocated between the landlord and tenant in the lease or other contract.

The ADAAG establishes standards for construction of curb ramps that must be followed if readily achievable.

Q. Must all entrances to existing health care facilities be accessible?

A. No, but one entrance, preferably the main entrance, must be accessible, making it possible for people with disabilities to "get through the door." In multi-use facilities, a

sufficient number of entrances must be accessible if readily achievable so that people with disabilities can reach all services offered at a particular facility. For most health care facilities that have steps, ramping one step or even several steps will be readily achievable.

Installation of a permanent ramp, rather than a portable one, is required unless such installation is not 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, a portable ramp if readily achievable. Portable, i.e., moveable, ramps also must be safe. Most portable ramps are relatively inexpensive to purchase or construct.

A health care facility using a portable ramp should install a doorbell or intercom (with an appropriate sign) to summon an employee to bring the ramp to the door if readily achievable. 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.

If none of these barrier removal options is readily achievable, health care facilities must provide service through readily achievable alternate methods. For example, a doctor could examine a patient at no additional charge at a hospital where the doctor had privileges or at the patient's home.

Q. How does a health care facility know if the doorway for the accessible entrance is wide enough for customers who use wheelchairs or other mobility devices?

A. The ADAAG standard states that a minimum of 32 inches of clear opening measured between the face of the door and the opposite stop when the door is opened 90 degrees is required to provide access for customers who use wheelchairs or other mobility devices. Offset hinges can increase the amount of clear space by several inches.

Automatic or push button doors are the best for providing access. Whether installing them is readily achievable or not depends on the circumstances of the individual health care facility.

Another measure that makes doors easier to use, not only for customers who use mobility devices but also for those who have conditions that limit their manual dexterity, is to install lever or U-shaped handles. Some retrofit levers cost less than $10 and can improve access significantly.

Adjusting door closers or springs and oiling hinges are also inexpensive steps that make it easier to open doors and prevent them from closing too quickly. Widening doors, installing accessible door handles, and making door adjustments are examples of modifications that will be readily achievable for most businesses.

Q. Are the offices of health care providers located in private homes required to make their facilities accessible to patients who use wheelchairs or other mobility

devices?

A. All areas of the home used by clients or patients are places of public accommodation under the ADA. Therefore, health care providers must remove barriers to access in those areas if it is readily achievable to do so. As with other public accommodations, barriers at the entrance to the home office, as well as barriers to approaches, rest rooms, and hallways, must be removed if readily achievable.

Q. Can a health care facility deny service to a person with a disability because his or her disability or behavior resulting from the disability may be disturbing to other customers?

A. No. The ADA specifically prohibits this type of discrimination against people with disabilities.

Q. Must health care facility allow service animals, including guide dogs, to accompany customers with disabilities into medical and health care facilities?

A. Yes, except in the rare circumstances that the presence of an animal would compromise health and/or safety standards, such as in an operating room.

Q. Are health care facilities allowed to ask patients or clients with disabilities about their medical history or whether they have certain conditions or diseases?

A. Medical and health care facilities may only ask questions that are necessary for the treatment and care of patients. Such questions must have a legitimate medical purpose. Facilities may not ask such questions as a method of eliminating patients or clients from services to which they are entitled. Nor can such questions be asked because of fear, myths, or stereotypes about certain conditions or diseases.

Q. Can health care facilities refer a patient or client with a disability to another practitioner solely because the other practitioner is familiar with the patient's type of disability?

A. Medical and health care facilities that routinely make referrals may refer an individual with a disability to another facility for service only if the patient seeks or requires treatment or services outside the referring facility's area of specialization. For example, a clinic specializing exclusively in drug rehabilitation could refuse to treat a person who is not a drug addict but could not refuse to treat a person who is a drug addict simply because the patient tests positive for HIV. Conversely, a clinic that specializes in the treatment of individuals with HIV could refuse to treat an individual who does not have HIV, but it cannot refuse to treat a person for HIV infection simply because that person is also a drug addict.

Q. How can a health care facility determine whether its premises are accessible to

people who use wheelchairs or other mobility devices? What steps must they take to provide access?

A. These are some common sense approaches medical and health care facilities can use to determine whether their premises are accessible

After determining whether "get through the door" is possible, facilities should determine whether aisles between office furniture and equipment are wide enough for a person using a wheelchair or other mobility device to pass. Examination, treatment, and dressing room doorways must also be wide enough for individuals using wheelchair or other mobility devices. (See earlier question for information about doorway widths.)

Widening doors and rearranging furniture and storage items are examples of methods to provide access that will be readily achievable for most health care facilities.

Registration and patient interview areas with built-in counters should be evaluated to determine whether individuals using wheelchairs can use them. If readily achievable, accessible counters (28 to 34 inches high, 30 inches wide, and 19 inches deep) must be made available. If it is not readily achievable to provide accessible counters, then readily achievable alternative measures must be taken to provide access, such as providing a table or clipboard which patients and clients can use while filling out forms.

Facilities should also evaluate whether there are level changes between treatment and service areas. For most health care facilities, providing a ramp for one or even several steps is readily achievable measure to provide access. If it is not readily achievable to install a permanent ramp, then a facility must use a portable ramp if it is save and readily achievable.

Q. Must health facilities provide accessible rest rooms? How can rest rooms be made accessible?

A. Rest rooms are an integral part of a health care facility's services. Therefore, these facilities must take readily achievable measure to remove barriers to and in rest rooms.

Certain relatively simple steps can increase access and usability. Widening entry and stall doors; moving obstacles such as vending machines; rearranging toilet partitions to increase maneuverability for customers using wheelchairs; installing a raised toilet seat; installing grab bars near the toilet; repositioning paper towel dispensers; installing lever handles on at least one sink; and installing insulation material around exposed lavatory pipes to prevent wheelchair users from burning their legs while sitting at the sink are examples of readily achievable measures for most businesses.

If a medical or health care facility provides more than one rest room and not all are accessible, a sign should indicate where the accessible rest room(s) is (are) located.

Simple symbols indicating which facilities are for men or women are easier for some people with cognitive impairments (such as mental retardation) to understand than words or other images. Raised letters and Braille differentiating men's and women's rest rooms

are important for people who are blind, and large, high-contrast signs help people with limited vision. Health care facilities must take all of these measures if readily achievable.

Q. Are health care facilities with offices on both the ground floor and another floor reached only by stairs required to install an elevator?

A. Although installing an elevator will not be readily achievable for most facilities, some means of providing access to floors above or below the ground level may be required. If there are only several steps to reach the additional levels, a ramp is required if it is readily achievable to install one. If there are many steps, installation of a wheelchair lift, which is much less expensive than an elevator, is required if readily achievable. Other alternatives include using accessible routes such as a freight elevator or service entrance.

When it is not readily achievable to provide some type of access to the other level(s), medical and health care facilities must take other readily achievable steps to provide services to people with disabilities. For example, they may be able to provide services at alternative locations such as a colleague's office on the ground floor, the home of the patient or client, or another suitable location.

Q. For health care facilities that have elevators what is required to make them accessible?

A. If readily achievable, facilities must install raised letters and Braille on the control panels and outside the doors for blind customers.

Placing a large, high-contrast sign indicating the floor number outside the elevator and opposite the elevator door helps orient people with limited vision.

If elevator controls are mounted out of reach of wheelchair users and it is not readily achievable to lower them, installing a stick or pointer near the control panel will help some customers operate the elevator independently. Door timers must also be adjusted so the doors do not close too quickly.

Q. What assistance must health care facilities provide for patients and clients who use wheelchair or other mobility devices to ensure equal and effective treatment and services?

A. Individuals with mobility impairments often find it difficult or impossible to use certain standard equipment found in medical and health care facilities. For example, people who are not ambulatory cannot use standard-height examining tables.

Therefore, health care providers cannot conduct certain examinations that require patients to lie prone or supine unless the individual is lifted onto the table. Such measures can be unsafe, embarrassing, and undignified for many patients. Although people who use wheelchairs or other mobility devices are most often affected by this particular barrier to treatment, older patients and others who are semi-ambulatory also can experience difficulty.

An adjustable-height examining table is an ideal solution if it is readily achievable to obtain one. Such tables can be lowered to the height of a wheelchair seat, thus enabling some patients who use wheelchairs to move independently or with minimum assistance from their wheelchairs to the table and back again. The adjustable feature also allows medical or health care personnel to elevate the table to a comfortable height to conduct an examination.

If it is not readily achievable to obtain such a table, facilities must obtain if readily achievable, an inexpensive, padded table the height of a wheelchair seat for use by patients who cannot use the conventional tables. This type of low table can also be used for some examinations of and consultations with patients who do not have disabilities. A group of physicians could purchase such a table and make arrangements to share its use.

If neither of these options is readily achievable, then medical and health care facilities must provide assistance to help patients onto the high tables, including lifting them if necessary. Such measures must be undertaken in a safe manner to avoid injury to both the health care personnel and the patient and to preserve the dignity of the patient as much as possible.

Similarly, health care facilities must provide such assistance to patients with mobility impairments who are having radiology exams or other tests conducted on surfaces that cannot be adjusted for height or that are inaccessible in some other way.

In all of these situations, medical and health care personnel should follow the instructions and preferences of the patient with regard to lifting or providing other assistance.

Modifications to the manner in which certain examinations are conducted are also required. For example, some X-ray equipment used to take mammograms is built so the patient must stand to have the X-ray taken. Other mammogram equipment requires the patient to sit on a wheeled stool with a swivel seat. In both situations, a woman with a disability that presents her from standing or sitting safely on such a stool would not be able to undergo the X-ray examination.

Replacing the stool with a stable chair or allowing the patient to undergo the examination from her wheelchair are appropriate methods of providing access.

Medical and health care facilities must provide assistance to undress and dress as needed or requested by patients with disabilities unless doing so fundamentally alters the services provided.

If they have a blanket policy prohibiting individuals other than patients in examination or treatment facilities, medical and health care facilities must modify the policy to allow a family member, friend, or personal care assistant to accompany a patient or client when necessary during the examination or treatment.

Q. What access problems do patients with mobility impairments encounter at dentists' offices?

A. Some patients who use wheelchairs either cannot independently transfer into the dentist's chair or must remain in their wheelchairs because of their disabilities. For a patient who does not have to remain in his or her wheelchair and wishes to transfer to the dentist's chair, dental staff must provide assistance in transferring unless doing so would fundamentally alter the service provided.

Staff should follow the instructions and preferences of the patient with regard to lifting or providing other assistance. Cushions or pillows may be necessary to enable a patient to sit comfortably in the dentist's chair for the examination or treatment.

Some procedures do not require the patient to transfer from the wheelchair. In these cases dentists should allow the patient to remain in the wheelchair if he or she wishes. Dentists must take steps, however, to ensure that the patient is made as comfortable as possible. If a patient can be treated only while seated in his or her wheelchair, dental staff must take whatever steps are necessary to conduct the examination and provide treatment unless doing so would fundamentally alter the nature of the treatment provided.

Q. How can health care facilities provide effective communication with patients who are blind or who have limited vision?

A. Patients and clients with vision impairments may need orientation to locate the examination or treatment room within the medical or health care facility. It is customary to offer to orient a person with a vision impairment to his or her surroundings. If he or she accepts the offer of assistance, the staff person should offer his or her arm to the patient or client and guide the person to the appropriate area, alerting him or her to obstacles along the way.

Printed material and information used by the health care facility such as consent-to-treatment and insurance forms must be accessible to people with vision impairments. Information about the condition for which the individual is seeking treatment, instructions that must be followed before certain tests, and release-of-information forms must also be made available in an accessible format.

The best way to provide access to this information depends on the needs of the individual patient, the type of facility, its resources, and whether a particular option would pose an undue burden.

Methods to make material accessible may include providing audio cassette tapes of the material and a cassette player. Offering large print materials is another inexpensive way to achieve effective communication with many patients and clients who have limited vision. An inexpensive magnifier is also useful for some patients with limited vision. Brailled materials are an option for patients or clients who are blind, but not all people who are blind read Braille. Another method to provide effective communication to patients and clients who are blind or have limited vision is for staff to read the materials to them.

It is also helpful to explain in advance the various procedures that are going to be performed. If instruments are going to be used, an explanation about their function and purpose is important. If possible, allow the person to touch the implements. Let patients

handle three dimensional models if they are available in the office to explain procedures and treatments.

Q. What are the best ways to make signs and other written information accessible to people with vision impairments?

A. Office directories must be made accessible if this does not pose an undue burden. Options to improve access include printing the directory in large print and providing good lighting near the directory, providing the directory information on audio tape, and providing personal assistance to read the directory and/or help the person find the particular office or service he or she is seeking.

Large print formats for signs and documents are useful to people with limited vision, including older patients or clients. Large print directories are also helpful to those reading directories from a distance, such as people who use wheelchairs.

Q. How do health care facilities communicate with patients or clients who have hearing or speech impairments? Must they provide sign language interpreters to communicate with individuals who are deaf?

A. For communications that are short and straightforward, such as when a patient is having a simple blood test, using a pen and note pad or taking turns at a computer terminal are adequate ways to communicate effectively with a patient or client who is deaf or hard of hearing.

Sign language interpreters are required in situations when they are necessary for a doctor or other health care provider to communicate effectively with a patient or client and when providing an interpreter would not pose an undue burden. For example, when a doctor needs to discuss with a deaf patient a complex matter like treatment options for cancer and that patient is someone who communicates through sign language, a physician who can locate a qualified sign language interpreter and absorb the fee in his or her overhead without undue burden is required to provide interpreter service for communicating with that patient.

It is also important for medical and health care facilities to communicate effectively with patients with speech impairments. Allowing sufficient time for a person with such a disability to express himself or herself or to spell out a message on his or her word board are examples of methods to achieve effective communication.

Q. What auxiliary aids and services must health care facilities provide to ensure effective communication with people with cognitive impairments such a mental retardation?

A. It is important to communication clearly and simply with an individual with a cognitive impairment. In situations involving complex matters, people with cognitive impairments can benefit from the careful restatement or interpretation of concepts that fosters effective communication. For example: Explain the purpose of the examination or treatment and give a step-by-step account of what will happen; speak slowly using simple, clear

concepts; repeat the information if necessary; provide simple drawings or diagrams if they will aid the communication process.

If it is necessary to obtain a signed consent-to-treatment form, make sure the patient is capable of making an informed decision about the proposed treatment or action. If the individual is not able to provide his or her informed consent, consent must be obtained from a parent or guardian.

Q. Must health care facilities install visual fire and other emergency alarms?

A. Where audible alarms are provided, visual alarms must be added if readily achievable. The ADAAG specifies the types of alarms that meet this requirement.

People who are deaf or hard of hearing depend on visual alarms to alert them to fire or other emergencies. It is suggested that signs be placed next to alarms indicating their purpose. Directories should also point out the location of visual alarms.

Q. Must health care facilities have accessible drinking fountains?

A. Facilities with drinking fountains must make them accessible if it is readily achievable to do so. To make fountains accessible, mount them low enough to be easily reached from a sitting position or install a paper cup dispenser within easy reach.

Q. Are health care facilities that provide public telephones required to provide accessible public telephones?

A. If a facility provides public telephones, at least one telephone must be accessible to people who use wheelchairs or other mobility devices if readily achievable.

If providing an accessible telephone is not readily achievable, then readily achievable alternative methods of providing access to a telephone are required. For example, facilities can offer patients or clients who cannot use the public telephone the use of a private telephone. A sign should be posted near the public telephone(s) specifying the location of an accessible telephone and/or whom the person should contact to arrange for its use.

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