DISABILITY EQUITY COLLABORATIVE

Accessible Healthcare for People with Disabilities:

An Implementation Guide for Healthcare Organizations

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Introduction

More than 1 in 4—or over 70 million—Americans have a disability.[1] The Americans with Disabilities Act (ADA) defines a person with a disability as someone who has a physical or mental impairment that substantially limits one or more major life activities; has a history or record of such an impairment; or is perceived by others as having such an impairment.[2] This can include mobility, communication, hearing, cognitive, visual, mental health or other disabilities, some of which may not be visibly apparent.

Federal civil rights laws, namely the ADA and Section 504 of the Rehabilitation Act of 1973, prohibit discrimination on the basis of disability.[3-5] These laws generally apply to entities that serve the public or receive federal financial assistance, including hospitals, healthcare providers, and other healthcare organizations. Such organizations are mandated to provide full and equal access to care and services for people with disabilities.[6]

Despite the large population of Americans with disabilities and federal law mandating equal access to care, a growing body of literature finds that people with disabilities experience significant disparities in health and healthcare outcomes. For example, compared to non-disabled people, people with disabilities are more likely to have a greater number of chronic conditions and have higher rates of asthma, hypertension, emphysema, cardiovascular disease, diabetes, and arthritis.[7] People with disabilities are also more likely to rate the quality of their health as fair or poor.[8,9]

While multiple factors contribute to poor health outcomes, inadequate access to high-quality care—despite high rates of health insurance—is a major barrier for people with disabilities. People with disabilities are more likely to report difficulty finding a clinician,[7] and when they do access care, they report low satisfaction with the quality of care and communications they receive.[7,10] Persistent disparities in cancer screenings such as colorectal cancer screenings,[11] Pap tests,[12] and mammographies[13] exist, and a significantly larger percentage of people with disabilities have at least one hospitalization and emergency department visit within a year compared to people without disabilities.[7]

While significant progress has been made over the past 50 years, healthcare organizations—even the most well-intentioned—remain largely inaccessible and inequitable for people with disabilities.[14] For example, clinics rarely have accessible equipment available, such as wheelchair accessible weight scales, and clinicians report rarely providing accommodations.[15-21]

We have found few comprehensive, evidence-based resources available to support healthcare organizations, clinicians, and staff in delivering high-quality care for patients with disabilities. This Implementation Guide seeks to fill this gap.

How to Use the Implementation Guide

This Implementation Guide is based on existing data and learnings from healthcare organizations across the country that are working to improve the quality of care provided to patients with disabilities. This information is intended to provide guidelines which are adaptable to your local context.

The Guide is designed for healthcare organizations of all sizes, from small rural clinics to large health systems, and to be used by any role within an organization, from frontline staff and clinicians to executive leadership.

Each chapter provides step-by-step guidance for healthcare organizations to deliver high-quality care to people with disabilities across the following areas:

1. **Building a Disability Accessibility Program**: Critical infrastructure and foundational components necessary to provide accessible care in your organization.
2. **Documenting Disability Status and Accommodation Needs:** Collecting patients' disability status and accommodation needs in the electronic health record.
3. **Providing Accommodations:** Operationalizing the provision of disability accommodations during a patient's healthcare visit or stay.
4. **Effective Communication**: Implementing effective communication in the healthcare setting.

Each chapter includes an introduction to its topic, actionable steps for implementation, and appendices containing tools and resources to utilize while completing each step. Every chapter is intended to be used independently depending on your organization's needs.

General Resources

The appendices listed below are General Resources for implementing any aspect of disability accessibility in healthcare. Each chapter can be used independently; they are not dependent on one another. The following General Resources are referenced across multiple chapters.

Appendices Table

NAME	DESCRIPTION
Appendix 0.1: Definitions	Defines key terms used throughout the Implementation Guide.
Appendix 0.2: Appropriate Disability Language	Provides guidance for appropriate terminology when communicating with and about people with disabilities.
Appendix 0.3: Federal Requirements for Providing Accessible Care	A high-level overview of existing regulations regarding healthcare accessibility.
Appendix 0.4: Disability Organizations	Lists disability organizations to engage with the disability community.
Appendix 0.5: Policy Writing Guidance	Provides guidance for creating or modifying policies.
Appendix 0.6: Project Planning	A how-to guide for creating workflow maps and goal setting.
Appendix 0.7: Accessibility Screening Tool Template	A worksheet to identify gaps in accessibility at an organization or clinic.
Appendix 0.8: Disability Accommodations Examples	Categorizes and lists examples of disability accommodations. Explains personal disability items and lists several examples.
Appendix 0.9: Disability Accommodations Inventory Table	A table to help staff plan and track potential disability accommodation and service processes and training.
Appendix 0.10: Leadership Support: Key individuals	Lists leadership roles that could be consulted when building an accessibility initiative.

Authors and Acknowledgements

Dr. Megan Morris, PhD, MPH, CCC-SLP
Founder and Director, Disability Equity Collaborative
Associate Professor and Vice Chair of Research
Department of Rehabilitation Medicine, Department of Population Health
NYU Langone Health

Eve Schoenberg
Project Coordinator, Disability Equity Collaborative
Department of Rehabilitation Medicine
NYU Langone Health

Dr. Jennifer Oshita, PhD, CCC-SLP
Post-Doctoral Fellow
Department of Rehabilitation Medicine
NYU Langone Health

Chapter 1: Building an Accessibility Program

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Appendix 0.1

Definitions

This document includes definitions of terms used throughout the Implementation Guide. Please see the references below for more information on any particular term.

Ableism
"The discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior…Ableism is rooted in the assumption that disabled people require "fixing" and defines people by their disabilities. Like racism and sexism, ableism classifies entire groups of people as 'less than,' and includes harmful stereotypes, misconceptions, and generalizations of people with disabilities."[1]

Accessibility
Ensures that a person with a disability is afforded the opportunity to acquire the same information, engage in the same interactions, and enjoy the same services as a person without a disability in an equally effective and equally integrated manner, with substantially equivalent ease of use. The person with a disability must be able to obtain information as fully, equally, and independently as a person without a disability.[2]

Auxiliary aids & services
Communication tools or assistance offered to ensure that people with disabilities can effectively access information and participate in services.[3]

Care partner/Caregiver/Support person
A person (typically a family member or close friend) designated by a person unable to fully care for themselves due to illness, disability, or age to assist them in managing their health or daily needs.[4] Caregivers, care partners, and support persons may engage in shared decision-making, communicate with the healthcare team, and provide physical, emotional, or logistical support.[5]

Communication strategies
Modifications in clinician or staff communication behaviors to support patients' understanding or expression. Examples include providing patients with communication disabilities more time to express themselves, writing out key words while speaking, or asking yes/no questions.

Digital accessibility
Inclusive practice of removing barriers that prevent interaction with or access to web content, digital tools, and technologies by people with disabilities.[6]

Disability
The Americans with Disabilities Act (ADA) defines a person with a disability as someone who:

- has a physical or mental impairment that substantially limits one or more major life activities,
- has a history or record of such an impairment (such as cancer that is in remission), or
- is perceived by others as having such an impairment (such as a person who has scars from a severe burn).[7]

- **Example disability types**[8]
  - **Mobility**: Difficulty walking or climbing stairs.
  - **Communication**: Difficulty understanding others or being understood.
  - **Hearing**: Deafness or difficulty hearing, even with hearing aids.
  - **Vision**: Blindness or difficulty seeing, even with corrective lenses.
  - **Cognitive**: Difficulty concentrating, remembering, or making decisions due to a physical, mental, or emotional condition.

Disability accessibility coordinator
Disability accessibility coordinators, also called ADA Coordinators, 504 Coordinators, Section 1557 Officers, etc., can have varying responsibilities depending on the organization. Generally, this role is designated by a healthcare organization as the "responsible employee" for coordinating its efforts to comply with and carry out its responsibilities under federal disability rights laws and applicable accreditation standards. They may be involved in or responsible for an organization's accessibility program and policies, complaints and grievance procedures, facility and program accessibility evaluations, and more.[9]

Disability accessibility program
A disability accessibility program is comprehensive of any aspect of care that ensures the needs of people with disabilities are specifically considered, and products, services, and facilities are built or modified so that they can be used by people of all abilities.[10]

Disability as identity
Refers to the recognition and affirmation of disability as an integral part of a person's self-concept and social identity. This perspective rejects the notion that disability is solely a medical deficit or limitation, framing it instead as a lived experience, cultural identity, and source of community belonging.[11]

Effective communication
Ensuring that communication with people with disabilities is equally effective as communication with people without disabilities through accommodations such as auxiliary aids and services, communication strategies, and care modifications.[12]

Equity
Absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation).[13]

Identity first language
Language which puts the disability first in the description, e.g., "disabled person" or "autistic individual." Use of this language acknowledges disability as an identity rather than a condition.[14]

Implementation strategy
Actions taken to enhance adoption, implementation, and sustainability of evidence-based interventions. A comprehensive list of each strategy and their definitions can be found here.[15]

Organizational priorities
Set of goals that set strategic direction for an organization. Organizational priorities have implications on budgets, designated employee Full Time Equivalent (FTE), and organizational structure.

People first or first-person language
A way of speaking and writing that emphasizes the individual before their condition, disability, or diagnosis. Instead of defining someone by a label or adjective, it describes what a person has rather than what a person is. For example, it uses phrases like "a person with diabetes" instead of "a diabetic," or "a person with a disability" instead of "a disabled person."[14]

Reasonable accommodation
Changes in rules, policies, practices, or services that make medical services accessible to a patient or visitor with disabilities. Reasonable accommodations are practical, effective, and don't drastically change operations.[16]

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Appendix 0.2

Appropriate Disability Language

This document provides guidance for appropriately communicating with and about patients with disabilities. People may have personal preferences on the use of Person-First versus Identity-First language when referring to their disability. Either is acceptable and you should ask their preference.

Understanding the Terminology Approaches[1]

Person-First Language

Person-first language (e.g., "patient with epilepsy," "individual with a mobility impairment") places the person before the disability condition.

Examples in healthcare settings:

- "The patient with diabetes is scheduled for 2:00 PM"
- "We provide services for children with learning disabilities"
- "The woman with a visual impairment requires these accommodations"

Identity-First Language

Identity-first language (e.g., "disabled patient," "autistic child") acknowledges disability as an inherent aspect of a person's identity.

Examples in healthcare settings:

- "Deaf patients may request an ASL interpreter"
- "Our facility is designed to be accessible for Autistic adults"

"10 Commandments of Communication"

These guidelines provide ways to respectfully interact with people with different kinds of disabilities. They were developed based on the experiences of people with disabilities and slightly modified by DEC to add context. The list was originally developed by the U.S. Department of Labor's Office of Disability Employment Policy and was accessed from Rutgers University Access and Disability Resources.[2]

1. When talking with a person with a disability, speak directly to that person rather than through a companion or sign language interpreter.

2. When introduced to a person with a disability, it is appropriate to offer to shake hands. Consider asking, "is it okay if I shake your hand?" before initiating contact. People with limited hand use or who wear an artificial limb can usually shake hands. Shaking hands with the left hand is an acceptable greeting.

3. When meeting a person with a visual impairment, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.

4. If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.

5. Treat adults as adults. Address people who have disabilities by their first names only when extending that same familiarity to all others. Never patronize people who use wheelchairs by patting them on the head or shoulder.

6. Leaning or hanging on a person's wheelchair is similar to leaning or hanging on to a person and is generally considered annoying. The chair is part of the personal body space of the person who uses it.

7. Listen attentively when you're talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a nod, or a shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow that person to respond. The response will clue you in and guide your understanding.

8. When speaking with a person who uses a wheelchair or a person who uses crutches, place yourself at eye level in front of that person to facilitate the conversation.

9. To get the attention of a person who is deaf or hard of hearing, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly. Not all people with a hearing impairment can lip read. For those who do lip read, be sensitive to their needs by placing yourself facing the light source and keeping hands, cigarettes, and food away from your mouth when speaking.

10. Relax. Don't be embarrassed if you happen to use accepted, common expressions, such as "See you later" or "Did you hear about that?" that seem to relate to the person's disability. Don’t be afraid to ask questions when you’re unsure of what to do.

Communicating With and About People with Disabilities (CDC)[3]

PEOPLE FIRST LANGUAGE	LANGUAGE TO AVOID
Person with a disability	Handicapped
Person without a disability	Normal person, healthy person
Person with an intellectual, cognitive, developmental disability	Retarded, slow, simple, moronic, defective, afflicted, special person
Person with an emotional or behavioral disability, or a mental health or a psychiatric disability	Insane, crazy, psycho, maniac, nuts
Person who is hard of hearing	Suffers a hearing loss
Person who is deaf	Deaf and dumb, mute
Person who has a communication disorder, is unable to speak or uses a device to speak	Mute, dumb
Person who uses a wheelchair	Confined or restricted to a wheelchair, wheelchair bound
Person with a physical disability, physically disabled	Crippled, lame, deformed, invalid, spastic
Person with multiple sclerosis	Afflicted by MS
Person who had a stroke	Stroke victim
Person with a congenital disability	Birth defect
Person who is successful, productive	Has overcome his/her disability, is courageous

Adapted from https://www.ohsu.edu/sites/default/files/2019-01/CDC-People-First-Language.pdf.

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1. Employer Assistance and Resource Network on Disability. Person-First and Identity-First Language. 2025. https://askearn.org/page/people-first-language
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Appendix 0.3

Federal Requirements for Providing Accessible Care

This document outlines federal regulations regarding the provision of accessible healthcare for people with disabilities. The requirements are organized by topic area. The relevant regulation for each requirement is cited.

NOTE: This document does not take the place of legal advice and is up to date as of April 2026. When implementing any chapter or section of this guide, work closely with your compliance and/or legal department to ensure your organization is compliant with current federal, state, and local laws and regulations.

Generally, the requirements listed here apply to any healthcare organization that receives federal funding and/or serves the public. However, it is your organization's responsibility to keep up to date with the specific requirements and regulations applicable to your status and context (for example, whether your organization falls under Title II or Title III of the Americans with Disabilities Act).

Federal Laws

The regulations listed under each section below are authorized by the following federal laws:

Americans with Disabilities Act (ADA) of 1990: The ADA is a federal civil rights law that prohibits discrimination against people with disabilities. Healthcare organizations must provide full and equal access to people with disabilities.[1]

- Title II: Covers healthcare agencies run by state and local governments.
- Title III: Covers private or nonprofit healthcare organizations.

Section 504 of the Rehabilitation Act of 1973: Section 504 prohibits discrimination on the basis of disability in programs and activities that receive federal financial assistance, including Medicare and Medicaid reimbursements.[2]

Section 1557 of the Patient Protection and Affordable Care Act (ACA): Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs and activities that receive federal funding.[3]

Federal Regulations

Antidiscrimination

No person with a disability shall be excluded from participating in or denied access to healthcare, benefits, or services.[4-7] To ensure equal access to facilities and services for patients with disabilities, healthcare providers must:[8]

- Make reasonable modifications to policies, practices, and procedures;[9-12]
- Ensure that communication with people with disabilities is as effective as communication with patients without disabilities, including by providing auxiliary aids and services when necessary;[13-16] and
- Ensure that facilities and medical equipment are accessible.[17]

No healthcare organization may deny, limit, or provide treatment to a person with a disability when the same care would or would not be provided to a patient without a disability.[18] Healthcare organizations shall not use any measure, assessment, or tool that discounts the value of life extension on the basis of disability when determining eligibility for any care or other service.[19]

Disability Accessibility Program

Coordinator: Healthcare organizations that employ 15 or more people must designate at least one employee responsible for compliance with Section 1557 and/or Section 504, including grievances, recordkeeping, language access, effective communication, reasonable modifications, training, and documentation procedures.[20,21] State and local government services that employ 50 or more people must designate an ADA Coordinator.[22]

Policies and procedures: Healthcare organizations with 15 or more employees must implement written policies for nondiscrimination,[23,24] grievances,[25,26] and procedures related to implementing reasonable modifications,[27] effective communication,[28] and language assistance services.[29] Relevant employees must be trained on required policies and procedures.[30] Organizations must provide notice of its nondiscrimination policy to patients and members of the public.[24,31]

Setting: All care and other healthcare activities must be delivered in the most integrated setting appropriate.[32-34] Healthcare organizations may not create policies or practices that provide greater benefits or care in segregated settings, establish more restrictive rules and requirements for people with disabilities in integrated settings, or fail to provide community-based services so that patients with disabilities are institutionalized or at serious risk of institutionalization.[35]

Physical Accessibility: Facilities and Equipment

Building and Room Construction: All buildings, including those built before the ADA was enacted, must meet certain accessibility requirements. View the 2010 ADA Standards for Accessible Design here, including sections 223 and 805 specific to Medical Care Facilities.

Medical Diagnostic Equipment (MDE): No person with a disability shall be denied access to care that requires MDE because a facility or provider’s MDE is not readily accessible or usable by them.[36,37]

- *New MDE*: At least 10% of each type of medical diagnostic equipment (MDE), but not less than one of each unit, must meet the Standards for Accessible MDE. Facilities that specialize in treating mobility impairments must meet 20%.[38,39]
    - By July 8, 2026, healthcare organizations subject to Section 504 that use exam tables and/or weight scales must have at least one exam table and/or one weight scale that meets the Standards for Accessible MDE.[40,41]
- *Existing MDE*: Existing MDE does not necessarily need to be modified or replaced with accessible MDE; an organization can comply with accessible MDE requirements by reassigning or delivering MDE-necessary activities to alternate accessible locations, home visits, or other means, as long as those means ensure people with disabilities access the same quality of care as people without disabilities.[42,43]
- Organizations must ensure their staff are able to operate accessible MDE, including assisting with transfers and positioning of individuals with disabilities.[44,45]

Documenting Disability Status and Accommodation Needs

Any federally conducted or supported healthcare or public health program, activity, or survey must collect data on disability status.[46]

By January 1, 2026, all electronic health record (EHR) vendors, health systems, payers, and any other organization using health IT modules were required to update their EHR's to comply with the United States Core Data for Interoperability (USCDI) Version 3. This version includes a disability status data element.[47]

Providing Accommodations

Healthcare organizations must make reasonable modifications to policies, practices, or procedures when necessary to provide services to patients with disabilities, unless they can demonstrate that making the modifications would fundamentally alter the nature of the program or activity or result in an undue financial burden.[9-12] Steps must be taken to ensure that no person with a disability is denied access to care because of the absence of accommodations.[48]

Healthcare organizations may not charge patients to cover the cost of accommodations.[23,49-51]

Effective Communication

Organizations must ensure that communications with people with disabilities are just as effective as communication with people without disabilities, including by providing auxiliary aids and services when necessary.[13-16]

Healthcare organizations may **not** require a patient with a disability to bring their own interpreter or rely on an adult accompanying a patient to interpret for them, except in an emergency when a qualified interpreter is not available or when the patient requests that they do, the adult agrees, and it is appropriate under the circumstances. An organization may also not rely on a minor child to interpret for them, expect in an emergency when a qualified interpreter is not available.[52-54]

Healthcare organizations that use video remote interpreting (VRI) services must ensure it provides real-time, full-motion video and audio over high-speed, wide-bandwidth connectivity through an image large enough to display both the patient and interpreter's face, arms, hands, and fingers. Staff must be trained to use the VRI.[55-57]

When communicating over the phone, text telephones or equally effective systems must be used to communicate with those who are deaf, hard of hearing, or have speech impairments. Automated messaging systems must be able to communicate with individuals using auxiliary aids and services in real time.[58-60]

Information and signage must be accessible to people with low vision or hearing loss. Signage must be posted at all inaccessible entrances to each facility with directions to an accessible entrance or location with information about accessible facilities.[61,62]

Web content and mobile apps must be readily accessible to and usable by people with disabilities.[63-65] Healthcare organizations must ensure web content and mobile apps comply with Level A and Level AA criteria in the Web Accessibility Initiative's Web Content Accessibility Guidelines 2.1 by either 2026 or 2027—depending on size—unless the organization can demonstrate this would prove an undue burden or fundamentally alter services.[66,67]

Healthcare organizations must implement written procedures describing the process for ensuring effective communication for individuals with disabilities. This procedure must at least include current contact information for the Section 1557 Coordinator; how an employee obtains the services of qualified interpreters, including the names of any qualified interpreter staff members; and how to access appropriate auxiliary aids and services.[28]

Comparison Table

This table compares federal law requirements and common hospital accreditation standards.

Requirement	ADA	Section 504 (including Final Rule)	Section 1557	NCQA HEDIS Measures	The Joint Commission Excellent Outcomes for All Certification
Provide accommodations	X	X	X		X
Effective communication	X	X	X		X
Accessible MDE	X (Title II ONLY)	X			
Building/facility accessibility	X				
Nondiscrimination in clinical decision		X	X		
Web accessibility	X	X	X		
Written policies		X	X		
Document disability			X	X	X
Disability coordinator	X (50 or more employees)	X (15 or more employees)	X (15 or more employees)		

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Appendix 0.4

Disability Organizations

Engaging your local disability community is integral to improving accessibility at your organization. This document outlines several types of disability organizations and names specific organizations that could be engaged to connect with people with disabilities in your community.

Federally Funded

ADA National Network: 10 regional centers funded by the U.S. Administration for Community Living's National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) that provide technical assistance, training, referrals, and accessibility assessments on how to implement the Americans with Disabilities Act (ADA). Find your region here.

Centers for Independent Living (CILs): Community-based, cross-disability, non-residential private nonprofit organizations that are designed and operated by people with disabilities. They are federally and state-funded and provide core services including advocacy, independent living skills training, information and referral, peer support, and assistance in accessing community resources. Their goal is to help people with disabilities achieve greater independence and full community participation. Find a CIL in your area here.

Protection and Advocacy Systems (P&As): Nation's largest provider of legal advocacy services for people with disabilities. Often provide information and referrals, as well as training and technical assistance to service providers, state legislators, and other policymakers. They also conduct self-advocacy training and raise public awareness of legal and social issues affecting individuals with developmental disabilities and their families. Find your state P&A Agency here.

State Commissions for the Blind: State-level agencies dedicated to empowering individuals who are legally blind or visually impaired through vocational rehabilitation, independent living support, and advocacy for equitable opportunities. Their services vary by state but share common goals of fostering independence and societal integration. Find your state's commission here.

State Councils on Developmental Disabilities: Federally funded, self-governing organizations charged with identifying the most pressing needs of people with developmental disabilities in their state or territory. Councils work to address identified needs through advocacy, systems change, and capacity building. Find your state's council here.

University Center for Excellence in Developmental Disabilities (UCEDD): Advance knowledge, provide support, and promote the rights and inclusion of individuals with developmental disabilities through interdisciplinary approaches combining research, education, and direct services. Find UCEDDs in your state here.

Veterans Service Organizations (VSOs)

Blinded Veterans Association: Only congressionally chartered VSO created for, consisting of, and led by visually impaired veterans focused on the issues, advocacy, and mentorship vital to all veterans and families with sight loss regardless of service connection.

Disabled American Veterans: Provides free, professional assistance to veterans and their families with Department of Veterans Affairs benefits, in addition to conducting outreach, advocating for policy change at the federal, state, and local levels, facilitating a support program for caregivers, and sharing resources.

Paralyzed Veterans of America (PVA): VSO dedicated to helping veterans with spinal cord injuries and disorders (SCI/D), including MS and ALS. Provide caregiver support, legal services, medical services from nurses, physicians, and support staff trained on SCI/D, employment resources, assistance with benefits, and adaptive sports.

Examples of National Organizations

Across Disabilities

- American Association on Health and Disability (AAHD)
- American Association of People with Disabilities (AAPD)
- The Arc (I/DD)
- Association of University Centers on Disabilities (AUCD)
- Disability Belongs
- Disabled in Action (DIA)
- Disability Rights Education and Defense Fund (DREDF)
- Easterseals
- National Council on Independent Living (NCIL)
- National Disability Rights Network
- People First (I/DD)

Professional Societies

- Alliance for Disability in Healthcare Education
- Patient Provider Communication Network
- Docs with Disabilities Initiative

Disability-Specific

- American Foundation for the Blind (AFB)
- Amputee Coalition
- Autistic Self Advocacy Network (ASAN)
- CommunicationFIRST
- Hearing Loss Association of America

- Les Turner ALS Foundation
- Muscular Dystrophy Association (MDA)
- National Association of the Deaf
- National Down Syndrome Society
- National Federation of the Blind (NFB)
- Special Olympics
- United Cerebral Palsy (UCP)
- United Spinal Association

Appendix 0.5

Policy Writing Guidance

This document contains questions to consider, guidance, and additional resources to utilize when planning, drafting, or modifying an accessibility-related policy at your organization. The information below is not exhaustive. Consult your organization's compliance office or department (if applicable) when drafting.

Questions to Consider

Any questions that are not applicable can be skipped.

WHAT is the reason for the policy?

- Compliance with federal and/or state requirements
- Set expectations/accountability for staff, leadership, or patients
- Limit liability
- Improve care quality or safety
- Other:____

HOW does this policy align with other organizational priorities?

WHAT funding is necessary for the policy change?

WHO will the policy apply to? Select all that apply.

- Clinical staff
- Non-clinical staff
- Leadership
- Patients
- Visitors
- Other:____

WHO (department, individual(s), team (s)) is typically responsible for organizational policies?

WHO will you include to help draft the policy?

WHO will review drafts and ultimately approve the policy?

HOW will you communicate the policy to staff, providers, patients, scheduling, medical assistants, managers, etc.?

- Training
- Other:____

HOW will you measure compliance with the policy?

Sample Steps for Creating or Changing Policy

1. Build a team. You should include a variety of roles, such as leadership, providers, front desk staff, medical assistants, schedulers, etc. Each role will know how your policy could be integrated in their workflows. This will also help with buy-in during implementation.
2. Write a first draft of your policy or modification. Have your organization’s mission and/or vision statement(s), as well as your reason for creating or modifying the policy, in mind.
3. Work with your team to edit your draft. Ensure your policy is stated clearly so that all staff, patients, leadership, and community members can understand it.
4. Set a date effective for your policy.
5. Seek approval from appropriate areas in your organization.
6. Schedule short-term and long-term reviews to monitor implementation and effectiveness of your policy.

Additional Resources

Below are resources for policy writing compiled by other institutions and two sample policies.

- University of Colorado Office of Policy and Efficiency: User Guide to Writing Policies (PDF) https://www.cu.edu/sites/default/files/APSwritingguide.pdf
- Weill Cornell Medicine Office of Compliance: Policy Writing 101
- U.S. Department of Health and Human Services Example Nondiscrimination Policy (PDF)
- Sample Nondiscrimination Policy: Santa Clara Valley Healthcare (PDF) https://compliance.weill.cornell.edu/compliance/policy-office/policy-writing-101

Appendix 0.6

Project Planning

When implementing new programs or activities, it is recommended that you plan for implementation using tools such as SMART goals and workflows/process maps. Below are general tips, guidance, and resources for using such tools.

SMART Goals

SMART is a framework for setting actionable, realistic goals. If your overarching goal is broad, such as creating an accessibility program, you may need to break it down into multiple smaller SMART goals. SMART goals are:[1]

S: Specific. Target an area for improvement and be specific about what you want to accomplish.

- Outline the who, what, when, where, and why of your goal.
- What specific actions will you take?

M: Measurable. Determine what metrics or data you will use to track progress.

- What does success look like?
- Do you have data collection methods to track your goal? Reports, audits, surveys, work products, etc.?

A: Achievable. How will you reach your goal?

- Do you have the skills and resources necessary? Do you need to develop them?
- Is your goal challenging but possible?

R: Relevant. Define why your goal is important for your organization/department/clinic etc.

- Does your goal align with organizational priorities?
- How will you secure support from leadership?

T: Time-bound. Set timelines and deadlines for completion.

- What is the deadline for accomplishing this goal?
- What will you accomplish by the halfway mark?

SMART Example: The Quality Improvement team will implement a disability screening and accommodation program by 9/30/2024, with EHR screening beginning by 8/15/2024.

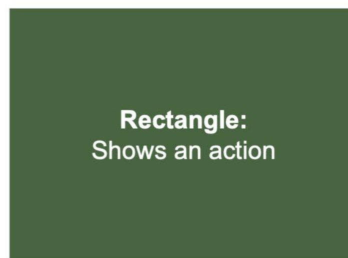
Not SMART: Our team plans to implement a disability program.

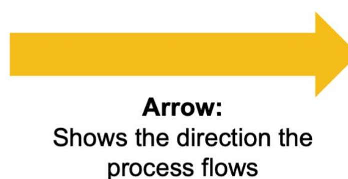
Workflows and Process Maps

Workflows and process maps are diagrams that illustrate the sequence of steps to completing a task. Roles such as Practice Facilitators or Practice Managers are typically responsible for creating these diagrams. In a healthcare setting, workflows and process maps can help identify problems and potential improvements, be used for training, hold staff accountable, and more.

Below are examples of workflows and process maps in a healthcare setting. The Agency for Healthcare Research and Quality created a module with additional information here.

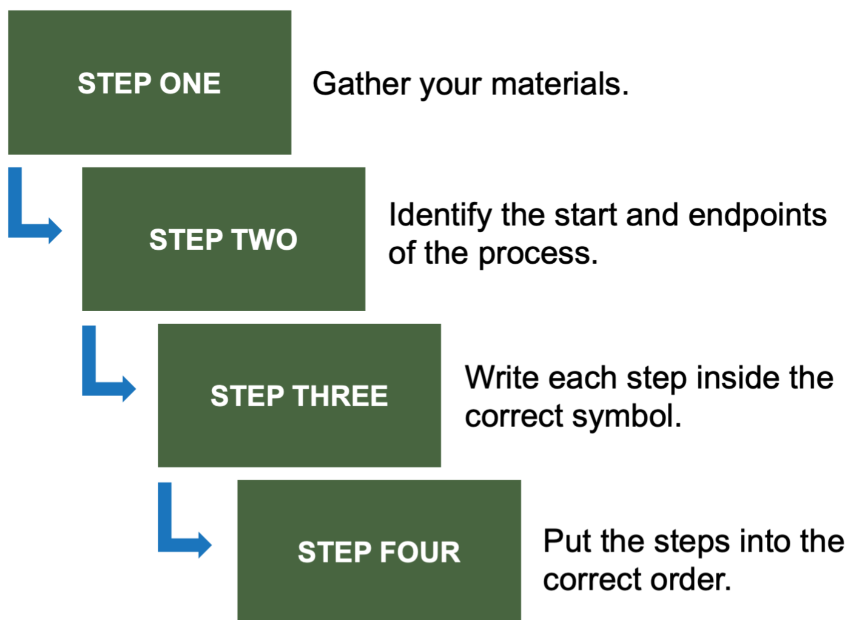
Symbols for Creating a Process Map



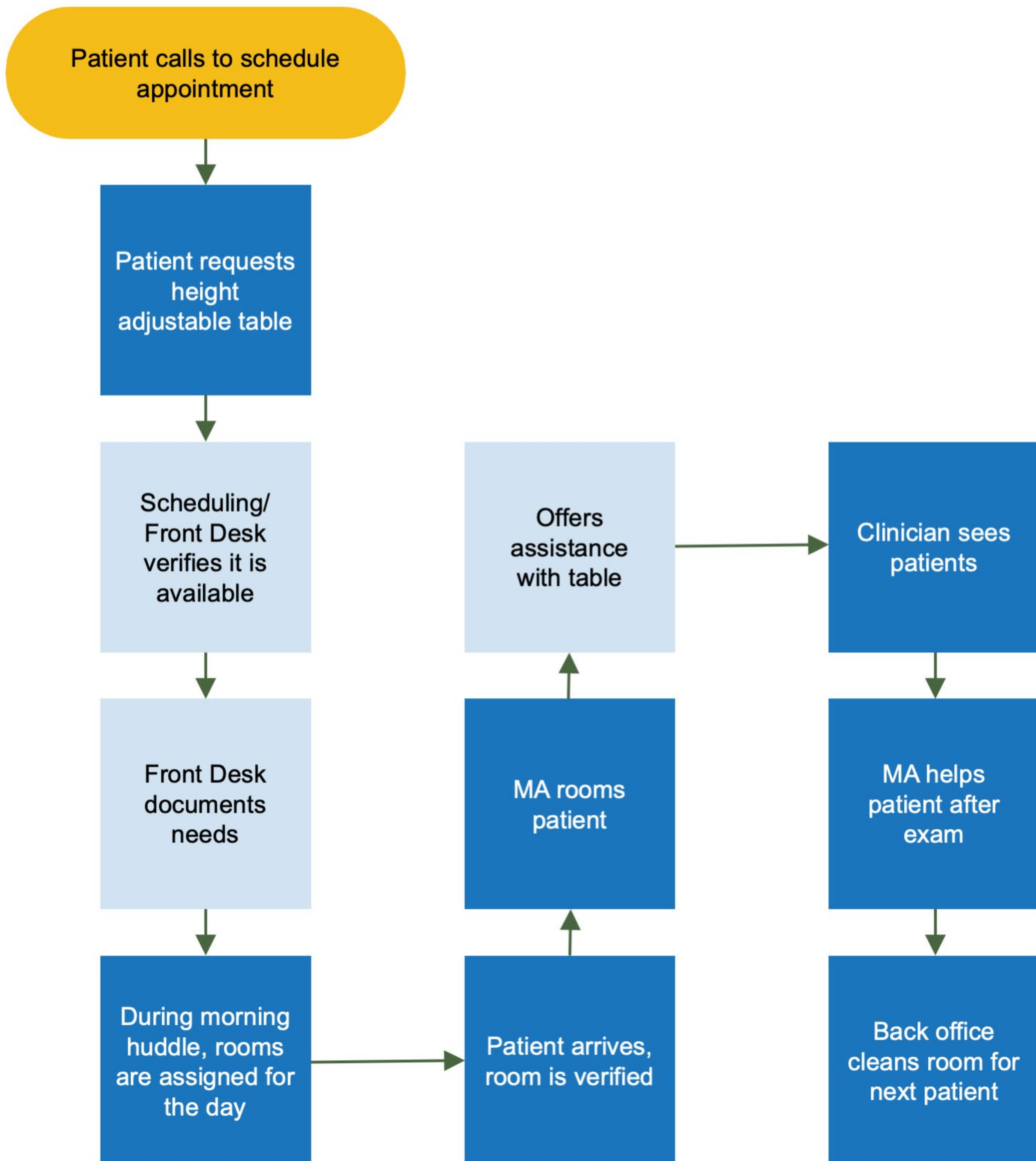


Arrow:
Shows the direction the process flows

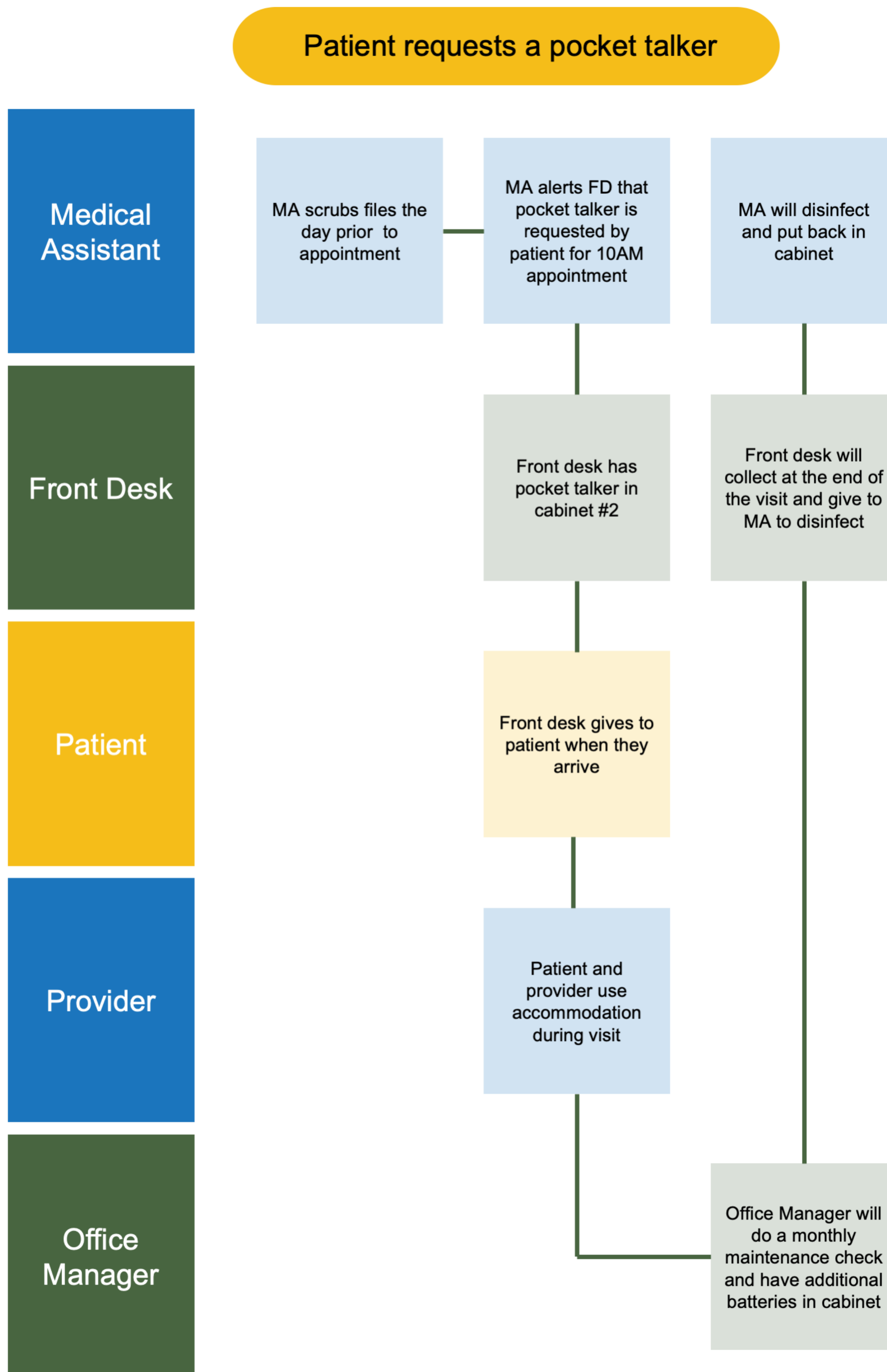
Steps for Creating a Process Map



Example 1: Providing a Height Adjustable Exam Table



Example 2: Providing a Pocket Talker



Appendix 0.7

Accessibility Screening Tool Template

This tool is designed to be used:

- **By clinic staff**. It is not designed to be used by a patient. The individual completing the assessment will likely need to engage other staff and clinicians and your disability council/advisory board to complete sections of the tool.
- **To identify gaps in accessible care and services**. This tool is not comprehensive in assessing whether a clinic is Americans with Disabilities Act (ADA) compliant. For a more comprehensive evaluation, please refer to the ADA Checklists for Existing Facilities.
- **As a template**. There are likely other items you should consider in ensuring that your clinic or hospital is accessible. This tool should be customized to your setting/site.
- **Following the care delivery flow for a patient**. While there are many ways this information could be organized, the screening tool is organized by a patient's journey. You will think through each activity your patients participate in before, during, and after their visit to ensure all patients have access to these activities.

If you do not know the answer to a question, either skip the question or identify a colleague who could answer the question. Some questions may not be applicable to your organization. For additional examples and descriptions of accommodations, please refer to Appendix 0.8: *Disability Accommodations Examples*. For more detailed evaluations of the accessibility of the physical space, please refer to the ADA Checklists for Existing Facilities.

An Excel version of this screening tool is available HERE.

PRE-VISIT

	Available			Established process exists?			Staff/Clinician training exist?		
	YES	NO	UNSURE	YES	NO	UNSURE	YES	NO	UNSURE
Are there accommodations available for registering? Are there multiple modalities available to register?									
If yes, what accommodations are available: *Example: Assistance with entering information online instead of via phone*									
Are there accommodations available for scheduling appointments? Are there multiple modalities available to schedule?									
If yes, what accommodations are available: *Example: scheduling online instead of via phone*									
Is disability status being asked during registration or scheduling?									
Are accommodation needs being asked during registration or scheduling? OR Can patients request an accommodation prior to the appointment? *Example: through the Patient Portal*									
Are patients asked whether they plan to bring any supports or assistive devices or tools with them?									
Is there contact information available for requesting an accommodation (e.g., Disability Accessibility Coordinator's information)?				N/A	N/A	N/A			

If so, where is the information posted? *Example: website; clinic rooms; waiting rooms*				N/A	N/A	N/A			
If a patient requests an accommodation prior to the visit, is the information shared with the care team?									
Can accommodations be ordered or scheduled prior to an appointment?									
If yes, what accommodations are available: *Examples: qualified note taker; extra appointment time; end of day appointment*									
Is patient disability or accommodation request information documented in the Electronic Health Record?									
Are accommodation requests and delivery reports available? *Example: A weekly report identifying the number of patients with physical disability provided care in the clinic.*									
Are there accommodations for appointment reminders?									
If yes, what accommodations are available: *Example: written or electronic appointment reminders able to be requested and provided (in lieu of a phone call reminder)*									
Additional information about pre-visit accessibility:									

NAVIGATING TO THE CLINIC

	Available			Established process exists?			Staff/Clinician training exist?		
	YES	NO	UNSURE	YES	NO	UNSURE	YES	NO	UNSURE
Are there accessible parking spaces available in the parking lot? *How many? At least 10%, but not less than one accessible parking space(s) are required.*				N/A	N/A	N/A			
Is there an accessible pathway from the nearest public transportation stop to the facility?				N/A	N/A	N/A			
Are there accommodations available in the parking lots, garages or entrances to the facility?									
If, yes, what accommodations are available: *Example: valet services*									
If a patient needs to travel from the entrance of the facility to the entrance of the clinic, are there accommodations available?									
If yes, what accommodations are available: *Example: wheelchairs at the entrance, staff available to assist with navigation*									
If there is a security check-in at the entrance of the facility, are there accommodations available?									
If yes, what accommodations are available: *Example: Service animal exception policies, protocols for neurodivergent patients*									
Is there accessible signage throughout the clinic or facility?									
Is there accessible pathways to the clinic or facility? *Example: clear pathway, elevators to different floors*									
Is there a plan to monitor the pathway to make sure nothing gets placed in the pathway?									
Additional information about navigating to the clinic accessibility:									

CHECK-IN AND WAITING ROOM

	Available			Established process exists?			Staff/Clinician training exist?		
	YES	NO	UNSURE	YES	NO	UNSURE	YES	NO	UNSURE
Is the check-in counter accessible? *Examples: low height, quiet area for patient with hearing disability*				N/A	N/A	N/A			
If there is a kiosk, are accommodations available?									
If yes, what accommodations are available? ***Example**s: height appropriate; screen-reader compatible; staff to assist*									
Are there accommodations available for patients to complete the check-in paperwork?									
If yes, what accommodations are available? *Examples: Staff assistance with writing or reading; signature guides; magnifiers*									
Are alternative formats of check-in documents available?									
If yes, what documents are available and in what formats? *Examples: Braille or large print HIPAA forms*									
Are disability status and/or accommodation needs asked or confirmed during check-in?									

If a patient requests an accommodation at check-in, is there an established process for delivering that accommodation?									
If a patient brings supports or assistive devices or tools with them, is there an established process accommodating this during the appointment? *Examples: Process for accommodating a service animal, a large enough exam room if the patient is in a power wheelchair*									
Are there alternative options to call patients into their appointment?									
If yes, what accommodations are available*?* *Example: vibrating pager*									
Are there waiting room accommodations available?									
If yes, what accommodations are available? *Examples: noise-canceling headphones; bariatric chairs; patient room early or in a sensory-sensitive environment; open floor space and wheelchair-accessible space; outlets available for adaptive equipment; spaces for wheelchair users*									
Is there a plan to monitor the accessibility of the space? *Example: no items moved into pathways or accessible rooms*									
Additional information about check-in and waiting room:									

CLINIC ROOM, UNIT, AND CLINICAL ENCOUNTER/INTERACTION

	Available			Established process exists?			Staff/Clinician training exist?		
	YES	NO	UNSURE	YES	NO	UNSURE	YES	NO	UNSURE
Are there physically accessible exam or patient rooms available? (If so, how many and what percentage of total number of rooms?)									
If yes, what accessibility features are available? *Examples: floor space next to exam table clear of equipment, adequate space between exam tables and walls for transfers, accessible bathrooms in hospital rooms, overhead lifts*									
Is there accessible diagnostic equipment available? (If so, how many and what percentage of total equipment?)									
If yes, what accommodations are available*?* *Examples: height-adjustable exam tables; bariatric tables; accessible weight scale; Hoyer lift*									
Are staff available for additional assistance if needed?									
If yes, what accommodations are available? *Examples: changing into gown; patient transfers*									
Are there sensory accommodations available in the rooms?									
If yes, what accommodations are available? *Examples: light dimmers; staff provide room orientation*									

Are there effective communication accommodations available?									
If yes, what accommodations are available? *Examples: white boards; sound amplifiers; communication boards, communication toolkit*									
Can patients request preferences for how the team interacts with them?									
If yes, what accommodations are available and how will staff be made aware of them? *Examples: avoid touching the patient; specific communication strategies; role of a care partner*									
Is there a process to alert the team that the patient has an accommodation or assistive services prior to when the team enters a patient room? *Examples: Patient requires dim lights in exam room, patient has a service animal*									
Is there a plan to monitor the accessibility of the space? *Example: Post reminders in accessible rooms that no items can be moved into pathways*									
Additional information:									

POST VISIT

	Available			Established process exists?			Staff/Clinician training exist?		
	YES	NO	UNSURE	YES	NO	UNSURE	YES	NO	UNSURE
Are there alternative formats for post-visit documents (e.g., After Visit Summary, patient education materials)?									
If yes, what accommodations are available? *Examples: Braille; large print; audio-recorded*									
Are there accommodations available to schedule follow-up appointments? Are there multiple modalities available to schedule?									
If yes, what accommodations are available? *Example: schedule while still in the exam room*									
If the patient needs to contact the healthcare team for follow-up questions, are accommodations available? Are there multiple modalities available for communication?									
If yes, what accommodations are available? *Examples: Patient portal accessibility; telephone; email*									
Additional information about post-visit:									

GENERAL ACCESSIBILITY

	Available			Established process exists?			Staff/Clinician training exist?		
	YES	NO	UNSURE	YES	NO	UNSURE	YES	NO	UNSURE
Are there accessible bathrooms available in the clinic or hospital?				N/A	N/A	N/A			
If yes, what accessibility features are available? *Examples: grab bars; raised toilet seats; call buttons*				N/A	N/A	N/A			
Are there automatic doors for all entrances of the clinic or facility?				N/A	N/A	N/A			
Are there accessibility features available for the patient portal?				N/A	N/A	N/A			
If yes, what features are available? *Example: Patient portal is screen-reader compatible*				N/A	N/A	N/A			
Is a patient able to indicate a disability or accommodation need in the patient portal?				N/A	N/A	N/A			
Is there contact information available for requesting a disability accommodation (e.g., Disability Accessibility Coordinator's information)?				N/A	N/A	N/A			
If so, where is the information posted? *Examples: website; clinic rooms; waiting rooms*				N/A	N/A	N/A			
Is there information posted on what disability accommodations are available?				N/A	N/A	N/A			
If so, where is the information posted? *Examples: website; clinic rooms; waiting rooms*				N/A	N/A	N/A			

Are non-discrimination policies available to patients?				N/A	N/A	N/A			
If so, where are they posted? *Examples: website; clinic rooms; waiting rooms*				N/A	N/A	N/A			
Is there a central repository or resource for staff and clinicians with information regarding available disability accommodations, training, and other applicable materials?									
Are images displayed and reading materials representative of people with disabilities?				N/A	N/A	N/A	N/A	N/A	N/A
Are policies adapted to be inclusive of people with disabilities? *Example: visitor exception policies*									
Is the website accessible, including PDFs?									
Is the mission statement, stated values, etc. free of discriminatory language?				N/A	N/A	N/A			

Appendix 0.8

Disability Accomodations Examples

This chart categorizes disability accommodations by the workflow necessary to provide them. Each category lists examples of disability accommodations depending on their availability in the outpatient vs. inpatient setting. The example accommodations can be applied to a range of disabilities. Because the same accommodation can often be applied to multiple disabilities, we did not organize the accommodations by disability type.

Disability accommodations in your facility must be made available to both patients and their caregivers with disabilities. This is not an exhaustive list. The items with an asterisk have been identified by the Disability Equity Collaborative's stakeholders as priority items.

Disability Accommodations Examples

Accommodation Category and Definition	Accommodation Examples	
	Outpatient or Inpatient	**Inpatient *Only***

Adapting a policy or process: Modifications made to policies, processes, workflows, and/or systems.	1. Rooming and scheduling
	2. Minimize wait time once patient arrives
	3. *Allow patient to wait in a quiet area
	4. Schedule appointments at times of day with limited waiting or delays (e.g., first appointment of the day)
	5. *Longer appointment times or appointments scheduled for end of day
	6. Private space or room when possible
	7. If multiple appointments, schedule together or consider patient travel times to and within facility
	8. *Allow service animals in facility
	9. *Allow support person to stay with the patient
	10. Allow patient to remain in personal clothing
	11. Alternative placement for ID band
	12. Gender preference for healthcare provider
	13. Procedure adaptations
	    a. Needle alternative
	14. Minimal number of providers and staff in room (consistent staff and low numbers)
	15. Adapted care plan
	    a. Personalized care plan
	    b. Care passport
		N/A

Provide a "thing": Items provided to or used to accommodate a patient with a disability.	1. Transfer board
	2. Transfer belt
	3. Facility wheelchair
	4. *Communication boards (e.g., word boards, picture board, letter/alphabet boards)
	5. White board and dry erase marker
	6. Text-to-speech apps and speech-to-text apps
	7. *Verbal instructions and communications in writing
	8. Alternative appointment reminders
	    a. Text
	    b. Phone call
	    c. Email
	    d. Contact another person (e.g., parent, adult son or daughter, spouse)
	9. Picture schedules or social stories
	10. *Amplification device (e.g., sound amplifier, voice amplifier, portable hearing loop)
	11. *Clear masks
	12. *Print or written materials in alternative formats:
	    a. Pictures
	    b. Plain language
	    c. Audio
	    d. Video
	    e. Electronic Large print
	    f. Braille
	13. Auditory or adaptive pill bottles
	14. Signature guides
	15. *Magnifiers, including full page magnifiers
	16. Electronic Materials
	    a. Screen readers
	    b. Audio description of video informational materials
	    c. Audio treatment summary and instructions
	17. *Noise cancelling headphones
	18. *Sensory fidgets
	19. *Sunglasses
	20. Vibrating pagers for check-in
	21. Bump dots
	22. Writing guide kits, bold lined paper
		1. Adaptive phone
		    a. Captioned phone
		    b. Amplified phone
		    c. Video phone
		    d. Phone amplifier
		    e. Braille phone
		    f. Relay phone
		    g. Large buttons
		2. Bathroom equipment
		    a. Bedside commode
		    b. Raised toilet seat
		    c. Shower chair
		3. Adaptive silverware

Provide a service: Additional service(s) and associated staff scheduled during a patient's visit.	1. Lift (Hoyer or Ceiling track) 2. *Accessible medical diagnostic equipment: 3. Height adjustable exam table 4. Accessible weight scale 5. Knee crutch stirrups for exam table in gynecologic exam room 6. Radiology equipment 7. Bariatric wheelchair	N/A

Scheduling a patient where an accommodation is located: Equipment or device(s) that are not portable and require the patient to be scheduled/moved to the equipment.	1. *Lift (Hoyer or Ceiling track) 2. *Accessible medical diagnostic equipment: a. Height adjustable exam table b. Accessible weight scale c. Knee crutch stirrups for exam table in gynecologic exam room d. Radiology equipment Bariatric wheelchair	1. Bariatric bed
Change in clinician/staff interaction style (effective communication): Staff and clinician adapt their communication and interaction style.	1. *Ask the patient how best to communicate with them 2. Allow extra time for patient to speak 3. Speak slowly 4. Look directly at the patient when speaking/listening 5. Use age-appropriate language 6. Use plain language 7. Write down key words Explain examinations and procedures before performing them. Ask for permission and announce before touching the patient.	N/A
Staff provide assistance: Staff assists and supports the patient with tasks or activities related to their care	Staff available to assist with: 1. *Reading, notetaking, or completing written forms 2. Reading written information aloud in private location 3. Patient kiosks 4. Changing clothes 5. *Navigating within facility 6. Push wheelchair 7. *Physical transferring 8. *Positioning on exam table, imaging equipment, or other surfaces 9. *Procedural support (e.g. tapping the patient to hold still during MRI) 10. Room orientation	1. *Activities of daily living (ADLs) a. Eating b. Dressing c. Bathing
Modify the environment Changes made to the patient's surroundings	1. *Low noise 2. *Low odor 3. *Low light 4. Bright light	1. *Adaptive call lights 2. *Visual tactile alert systems

*High-priority accommodations. When creating an accessibility program or identifying the first accommodations your organization will provide, start with those denoted with an asterisk.

Patient Disability Items

Below is a list of personal items, medical devices, or supports a patient may bring to a healthcare facility to accommodate their disability(ies). Like other personal belongings, such as clothing or medications brought from home, personal disability-related items should be documented in the electronic health record. Care might need to be adapted if a patient brings these items. For example, if a patient brings their power wheelchair to their appointment, staff will need to ensure the patient is in a room large enough to maneuver.

These items are typically not provided by healthcare organizations as disability accommodations. Patient disability items may include:

- Prescription glasses
- Hearing aid(s)
- Service animal
- Support animal
- Companion
- Certain mobility devices
    - Power wheelchair
    - Motorized scooter
    - Crutches
    - Orthopedic equipment
    - Prosthetics
    - Cane
    - Walker
- White cane
- Braille device
- Specific communication devices, such as an augmentative and alternative communication (AAC) tablet
- Screen reader

While these items are not usually provided by healthcare organizations as disability accommodations, remember that under the Americans with Disabilities Act, **patients cannot be required to provide or cover the cost of reasonable disability accommodations**. Regardless of whether a patient brings a personal disability item, it remains your organization's responsibility to provide reasonable accommodations that facilitate access to care.

For example, if a patient with a disability is accompanied by a caregiver, the caregiver cannot be enlisted or expected to help staff transfer the patient to an exam table. While a patient may request that their caregiver assist, it is solely your organization's responsibility to ensure staff are trained and prepared to safely transfer patients with disabilities.

Appendix 0.9

Disability Accommodations Inventory Table

ADAPTING A POLICY OR PROCESS

	Process for patient to request	Process for alerting staff & clinicians	What is the workflow process to provide?	How will you document the policy/process adaptation was provided?	How will you let patients know it is available?	How will you train staff to implement?
Example: Wait in private room rather than waiting room	*Patient can request at scheduling or check-in*	*Front desk can notify at morning huddle or when patient checks in*	*QI will develop and test the workflow.*	*Document in EHR under ________________*	*Provider can inform during visit for next visit, front desk can offer at check-in, scheduler can offer when scheduling patient*	*QI team will train during staff meeting and repeat every 6 months*

PROVIDING A "THING"

	How many available?	Process for patient to request	Process for alerting staff and clinicians	Who will provide the accommo-dation?	How will you document the "thing" was provided?	Who will clean and maintain?	Where will it be stored?	How will equipment be ordered and paid for?	How will you let patients know it is available?	How will you train staff to use?
Example: Assistive Listening Devices	*2*	*Patient can request at scheduling or check-in*	*During morning huddle, MA will be notified*	*MA when rooming the patient*	*Note to be documented in* ________	*MA will clean and office manager will replace batteries monthly*	*Store room – top shelf*	*Office manager will order and pay out of general operating funds*	*Front desk and MA will offer*	*Office manager will train 2x per year at all clinic meeting*

PROVIDING A SERVICE

	Process for patient to request	Process for alerting staff and clinicians	What is the workflow process to order?	How will you document the service was provided?	How will you let patients know it is available?	How will you train staff to use?
Example: ASL Interpreter	*Patient can request at scheduling or check-in*	*Front desk can notify at morning huddle or when patient checks in*	*QI will develop and test the workflow.*	*Document in EHR under____________*	*Provider can inform during visit for next visit, front desk can offer at check-in, scheduler can offer when scheduling patient*	*QI team will train during staff meeting and repeat every 6 months*

SCHEDULING WHERE AN ACCOMMODATION IS LOCATED

	How many available?	Process for patient to request	Process for alerting staff and clinicians	How will you schedule patients where the item is?	How will you document the scheduling was provided?	Who will clean and maintain?	Do you need any extra staff assistance to use?	How will equipment be ordered and paid for?	How will you let patients know it is available?	How will you train staff to use?
Example: Hoyer Lift	*1*	*Patient can request at scheduling*	*During morning huddle, MA will be notified*	*MA when rooming the patient*	*Note to be documented in__________*	*MA will clean during standard cleaning*	*In exam room ______*	*Office manager will order and pay out of general operating funds*	*Front desk, MA and provider can offer*	*Lead MA will train all new staff*

CHANGE IN CLINICIAN/STAFF INTERACTION STYLE

	Process for patient to request change	Process for alerting staff and clinicians	How will you document the change in interaction style/environmental modification was provided?	How will you let patients know it is available?	How will you train staff to implement?
Example: Ask the patient how best to verbally communicate with them	*Patient can request at scheduling or check-in*	*Front desk can notify at morning huddle or when patient checks in*	*QI will develop and test the workflow.*	*Document in EHR under ____________*	*Provider can inform during visit for next visit, front desk can offer at check-in, scheduler can offer when scheduling patient*

STAFF PROVIDE ASSISTANCE

	Process for patient to request	Process for alerting staff and clinicians	What is the workflow process to provide?	How will you document the assistance was provided?	How will you let patients know it is available?	How will you train staff to provide assistance?	What staff will provide the assistance?	Is there a process to make sure the sufficient number of staff are available to provide accommodation?
Example: Assistance with transferring	*Patient can request at scheduling or check-in*	*Front desk can notify at morning huddle or when patient checks in*	*QI will develop and test the workflow.*	*Document in EHR under ________*	*Provider can inform during visit for next visit, front desk can offer at check-in, scheduler can offer when scheduling patient*	*QI team will train during staff meeting and repeat every 6 months*	*MA's will provide the transfer – additional assistance from office manager, front desk and back office if needed*	*3 MA's are always on duty, additional assistance can be provided by office manager, front desk and back office*

MODIFY THE ENVIRONMENT

	Process for patient to request	Process for alerting staff and clinicians	How will you document the change in interaction style/environmental modification was provided?	How will you let patients know it is available?	How will you train staff to implement?
Example: Low light	*Can request at scheduling or check-in*	*Front desk can notify at morning huddle or when patient checks in*	*QI will develop and test the workflow.*	*Document in EHR under ______________*	*Provider can inform during visit for next visit, front desk can offer at check-in, scheduler can offer when scheduling patient*

Appendix 0.10

Leadership Support

Below is a list of example individuals who could be included when gathering support to start or build accessibility initiatives in a healthcare organization.

- C-Level Executives
  - Chief Executive Officer
  - Chief Financial Officer
  - Chief Operating Officer
  - Chief Medical Officer
  - Chief Medical Information Officer
  - Chief Information Officer
- Nursing leaders
- Diversity, equity, and inclusion directors
- Hospital administrators
- Inpatient- and outpatient-specific leadership
- Disability Accessibility Coordinators (ADA, 1557, and/or 504)
- Directors from the following departments:
  - Human Resources
  - Compliance/legal/regulatory
  - Patient experience
  - Information Technology
  - Construction or design
  - Materials management (for purchasing equipment)
  - Language services
  - Interpreting services
  - Patient safety/quality officers
  - Patient registration and call centers
  - Security
  - Social work
  - Rehabilitation
  - Parking
  - Public Affairs
  - Patient advocates (within hospital systems)
  - Patient Navigators and Community Health Workers
  - Volunteer services
- Patient and family advisory committees and councils
- Employee resource groups
- Foundation lead

Chapter 1

Building a Disability Accessibility Program

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Orientation to Accessibility Program Chapter

This document is one chapter of a broader Implementation Guide on providing accessible healthcare for people with disabilities. The chapter will guide you through creating a foundation for accessibility in your organization. We recommend reviewing this chapter before implementing other chapters in this guide.

The information in this chapter is a synthesis of existing research and learnings from health systems across the country. This information is intended to provide guidelines adaptable to your local context.

This chapter includes: 1) an introduction to the topic, 2) six steps for implementation, and 3) a variety of appendices. Under each step, the ***Actions and Tasks*** section outlines best practices and questions to consider while creating and implementing an accessibility program at your organization. The ***Materials and Resources*** section lists the relevant appendices, which include worksheets, templates, examples, and other resources to assist you in completing the ***Actions and Tasks*** of each implementation step.

Appendices can also be used independently. For example, you could use Appendix 1.4: *Accessibility Program Costs and Funding* if you are only interested in understanding the items and activities associated with an accessibility program in a health system that may need allocated funding.

Introduction to Building a Disability Accessibility Program

Accessible care affects all aspects of care delivery. Whether you represent a standalone clinic, a hospital, or a health network, providing accessible healthcare to patients with disabilities requires integrated action across your entire organization. **This chapter provides practical steps for establishing a disability accessibility program at your organization.**

There are six components to building an accessibility program:

A. Engage the Disability Community
B. Develop Leadership Support
C. Conduct Needs Assessment
D. Define Activities of the Program
E. Determine Organizational Structure
F. Implementation Planning

We have situated these components in a non-linear fashion.

Your sequence of steps will depend on your position within the organization and your organizational needs. You may also need to re-visit steps. For example, you might need to start with gaining leadership support to begin a Needs Assessment process. After you conduct your Needs Assessment, you might need to return to leadership to gain additional support to define your program. If any of the building blocks or parts of a section are not applicable to your organization, it may be skipped.

Core Components for Building a Disability Accessibility Program

A. Engage the Disability Community

Implementing accessible care for patients with disabilities starts with engaging people with disabilities within your community and organization. Navigating healthcare as someone with a disability is best understood by people with disabilities. Engaging people with disabilities will build trust, inform your understanding, and ensure you meet your community's needs.

Actions and Tasks

1. Include people with disabilities and caregivers of people with disabilities into existing patient advisory boards.
2. Consider developing a disability-specific patient advisory board.
3. Solicit feedback from patients with disabilities about the quality of care delivered within your organization.
4. Solicit feedback from people with disabilities in your community about challenges they may face when accessing care at your organization.
    - Feedback could be collected by integrating disability accessibility questions in patient feedback surveys, focus groups, listening sessions, sharing circles, or partnerships with local disability groups.
    - Ensure there are multiple opportunities and modalities for providing feedback.
5. Review existing feedback and complaints from patients with disabilities.
6. If available, engage your disability employee resource or affinity group.
7. Share accommodation and accessibility features at your organization with your community, through community seminars, conferences, or other means.
8. Partner with and support the visibility of nearby disability organizations to build trust with your local disability community.
    - For example, invite an organization to set up a booth in your clinic or hospital to advertise their services.
9. Ensure marketing and communication materials are inclusive and representative of people with disabilities. Use appropriate disability language.

Across all efforts, it is important to engage people across varying types of disabilities, racial and ethnic identities, sexual and gender identities, levels of health literacy, age groups, as well as caregivers of people with disabilities.

Materials and Resources

- Appendix 0.1: Definitions
- Appendix 0.2: Appropriate Disability Language
- Appendix 0.4: Disability Organizations
- Effectively Including People with Disabilities in Policy and Advisory Groups
- Creating an Accessibility Committee
- Creating Family and Patient Advisory Councils

**Appendices 0.1, 0.2, and 0.4 can be accessed in the General Resources chapter.*

B. Develop Leadership Support

Building an accessibility program requires system level engagement, including support from your organization's leadership. Leadership support will ensure you have the necessary resources to make meaningful change. You will likely need to continue to engage leadership throughout building and sustaining the accessibility program. Each of the subsequent chapters in this guide includes suggestions to engage leadership.

Actions and Tasks

1. Identify what types of leadership support and buy-in you will need.
2. Identify potential champions across your organization.
    - Often, champions are individuals who work in disability specific disciplines (e.g., rehabilitation), are people with disabilities, or are people who have family members with disabilities.
3. Identify how a disability accessibility program will fit within your organization's existing priorities and initiatives (e.g., health equity, quality and safety, patient experience goals).
4. Determine if your organization is involved in regulatory initiatives that align with a disability accessibility program (e.g., Joint Commission Excellent Health Outcomes for All Certification, U.S. Centers for Medicare and Medicaid (CMS) requirements, state-level requirements, etc.)
5. Identify potential concerns leadership may have and possible solutions.
6. Create necessary charters, strategic plans, and presentations to present to leadership and garner their support.

Materials and Resources

- Appendix 0.3: Federal Requirements
- Appendix 0.10: Leadership Support: Key Individuals
- Appendix 1.2: Accessibility Program Implementation Planning
- Appendix 1.3: Accessibility Program Barriers & Strategies
- Appendix 1.4: Accessibility Program Costs and Funding
- Appendix 1.5: Accessibility Program Leadership Support Slides Template

**Appendices 0.3 and 0.10 can be accessed in the General Resources chapter.*

C. Needs Assessment

Identify the current state of accessibility initiatives and activities at your organization.

Actions and Tasks

1. Identify what disability accessibility initiatives are currently happening, including who is leading the work and the department or unit the work is happening within.
2. Engage with other healthcare organizations to understand their healthcare accessibility programs, including what is and isn't working for them. Consider joining the Disability Equity Collaborative's Leaders workgroup to create a peer network.

Materials and Resources

- Appendix 0.7: Accessibility Screening Tool Template
- Appendix 0.8: Disability Accommodations Examples
- Appendix 1.1: Accessibility Program Needs Assessment
- Disability Equity Collaborative's Leaders workgroup

**Appendices 0.7 and 0.8 can be accessed in the General Resources chapter.*

D. Define Activities of the Program

Identify the activities of your accessibility program. Activities could include but are not limited to documenting disability status in the electronic health record (EHR), purchasing accessible diagnostic equipment, and conducting disability competency training. The activities will be informed by your Needs Assessment, engagement with the disability community, institutional priorities and resources, and the structure of your accessibility program.

Actions and Tasks

1. Identify existing activities and how they will be incorporated in your new accessibility program.
2. Identify new, high priority activities to include in the accessibility program (i.e., those related to legal compliance).
3. Identify new, low priority activities that should be implemented in the future.
4. Identify current funding and potential funding resources for your activities.
5. Review federal, state, and accreditation requirements to ensure your activities are compliant.

Materials and Resources

- Appendix 0.3: Federal Requirements
- Appendix 1.4: Accessibility Program Costs and Funding
- Appendix 1.6: Accessibility Program Activities
- Appendix 1.7: Accessibility Program Activities Priority Worksheet

**Appendix 0.3 can be accessed in the General Resources chapter.*

E. Determine Organizational Structure

To establish an accessibility program, your organization will need to determine where the program is situated within the organization at large. This is influenced by available funding and resources, priority activities, and the Needs Assessment.

Actions and Tasks

1. Identify department(s) the program will exist in. Consider integrating your accessibility program's goals and objectives into your organization's existing quality improvement, patient safety, or population health initiatives.
2. Determine if accessibility activities will be driven by a single or multiple departments.

3. Determine what position(s) will oversee the accessibility program or the different aspects of the accessibility program.
    - Create and post job descriptions as needed.
4. Create an advisory committee to oversee the accessibility program. This should include key institutional members, as well as people with disabilities.

Materials and Resources

- Appendix 1.6: Accessibility Program Activities
- Appendix 1.8: Accessibility Program Organizational Structure
- Appendix 1.10: Example Disability Coordinator Job Description
- Effectively Including People with Disabilities in Policy and Advisory Groups
- Creating an Accessibility Committee
- Creating Family and Patient Advisory Councils

F. Implementation, Evaluation, and Monitoring

Using the information identified in the Needs Assessment, complete the Implementation Planning worksheet to create a plan for developing an accessibility program at your organization.

Actions and Tasks

1. Define goals and successful outcomes of your accessibility program. Create a workplan and timeline to achieve your goals.
2. Identify how you will measure progress.
    a. Identify relevant data sources to measure success.
    b. Identify how you will include patients' perspectives in your evaluation.
3. Execute and document any needed adaptations.
4. Consider integrating your accessibility program's goals and objectives into your organization's existing quality improvement, patient safety, or population health initiatives.
5. Federal, state, and accreditation requirements update frequently. Closely monitor these requirements to ensure your program is compliant.

Materials and Resources

- Appendix 0.6: Project Planning
- Appendix 1.1: Accessibility Program Needs Assessment
- Appendix 1.2: Accessibility Program Implementation Planning
- Appendix 1.7: Accessibility Program Activities Priority Worksheet
- Appendix 1.9: Accessibility Program Monitoring Progress and Adaptations

**Appendix 0.6 can be accessed in the General Resources chapter.*

Appendices Table

NAME	DESCRIPTION
Appendix 1.1: Accessibility Program Needs Assessment	A worksheet to review the current landscape of the organization, identify gaps and strengths, and identify specific goals for the accessibility program.
Appendix 1.2: Accessibility Program Implementation Planning	A worksheet to identify the future direction and processes that will be followed when developing an accessibility program.
Appendix 1.3: Accessibility Program Barriers and Strategies	Lists possible barriers to developing an accessibility program and potential implementation strategies that could address those challenges.
Appendix 1.4: Accessibility Program Costs and Funding	Lists the expenses to consider that are associated with an accessibility program in a health system, as well as possible sources for health systems to leverage in identifying funding resources.
Appendix 1.5: Accessibility Program Leadership Support Slides Template	A slide deck template that can be used by health systems to present to leadership to garnish leadership support for accessibility initiatives.
Appendix 1.6: Accessibility Program Activities	A list of all the possible initiatives, activities, and tasks of a disability accessibility program in a healthcare organization.
Appendix 1.7: Accessibility Program Activities Priority Worksheet	A worksheet to prioritize program activities by: existing activities; high priority/need for immediate implementation; low priority/future implementation.
Appendix 1.8: Accessibility Program Organizational Structure	Describes possible organizational structures for the disability accessibility program.
Appendix 1.9 Accessibility Program Monitoring Progress and Adaptations	A worksheet to track progress and adaptations to the implementation plan.
Appendix 1.10: Example Disability Coordinator Job Description	Sample responsibilities and qualifications to include in a Disability Coordinator job description.

Appendix 1.1

Accessibility Program Needs Assessment

Instructions

- This assessment can be completed by anyone at any point of developing an accessibility program. Questions that are not applicable to your organization or clinic can be skipped.
- Please note that needs assessments are long processes that require input and commitment from multiple partners within the organization and community to develop a robust and sustainable plan.

Current State of Accessibility

This section will offer a snapshot of the current landscape of accessibility at your organization or clinic. These questions will work to identify existing resources, opportunities for growth, and describe the current culture of accessibility at your organization.

Background

1. What is the motivation driving the development of the disability accessibility program?
   - Patient complaint
   - Lawsuit
   - Adherence to accreditation standards
   - Legal compliance
   - Improve quality of care for patients with disabilities
   - Other:____

   a. Are there specific populations you are focused on (e.g., people with physical disabilities, intellectual or developmental disabilities, etc.)? If so, why?

   b. Are there certain settings you are focused on (e.g., scheduling, specific specialty appointments, outpatient, inpatient, etc.)? If so, why?

2. What is the specific goal or desired outcome of developing an accessibility program?

3. How does the accessibility program align with current organizational priorities (e.g. quality and safety; health equity; patient experience; Diversity, Equity, and Inclusion)?

4. What, if any, leadership support is there for the accessibility program? What levels of support do you need?

5. Is disability/accessability included in any existing initiatives or efforts?
   - Compliance
   - Health equity

- Quality and safety
- Patient experience
- Interpreting services
- Population health
- Human resources
- Other____

6. How does your organization define disability?

    a. Do your mission statements include disability appropriate language (in other words, not ableist language)?

7. Is there a disability- or accessibility-specific budget?

    a. What type of budget exists?

    b. What types of initiatives or supplies are covered by that budget?

8. What, if any, regulatory requirements are there for establishing an accessibility program (e.g., Joint Commission Excellent Health Outcomes for All Certification, CMS requirements, state-level requirements, etc.)?

<u>Partnering with People with Disabilities</u>

1. What existing partnerships does your organization have with local disability organizations?

2. Does your organization have a disability employee resource or affinity group?

3. Are there people with disabilities in your patient and family advisory groups?

4. What disability types are included in the above efforts? (e.g., developmental disabilities, physical disabilities, etc.)

5. Are there existing employee or Human Resources initiatives to increase representation of employees with disabilities?

People

**Reminder: questions that are not applicable can be skipped.*

1. Does your organization have the following, and if so, who is it?
   - Disability Coordinator
   - ADA Coordinator
   - Section 1557 Coordinator
   - Section 504 Coordinator
   - Name:____
2. Is there one person or multiple individuals responsible for accessibility services? Who?
   a. In what department is this person/people located?
   b. What is their current role and responsibilities?
   c. Are there separate roles responsible for patient needs verses staff needs?
   d. Does this person/people have dedicated full-time equivalent (FTE)? If so, how much?
   e. Who manages patient complaints?
   f. Who do patients go to with accommodation needs?
3. Are the people who are leading disability activities in positions to enact change?
4. Do you have any clinician champion(s) (formally or informally designated)?
   a. If no, is there someone you could recruit?

b. Do you have other champions within your organization? This could be a Nurse, Medical Assistant (MA), front desk or office manager; someone who may not have a leadership position, but a vested interest in program success.

5. Who in your organization might have expertise on providing accessible care (e.g., interpreting services, rehabilitation services)?

6. If any, what is the role of your Compliance Office in enforcing accessibility requirements?

Activities

1. What accessibility activities are currently offered? See Appendix 1.6: *Accessibility Program Activities* for a list.
   - o Documenting disability status and accommodation needs in the electronic health record (EHR)
   - o Accommodations (See Appendix 0.8 in the General Resources chapter for a list of accommodations)
   - o Digital accessibility
   - o Disability-related training modules for staff and clinicians
   - o Environmental and architectural accessibility
   - o Activities for patients with intellectual and developmental disabilities
   - o Other:____

2. In which clinics or units are the activities available?

3. Are there specific individuals, groups, or departments within your organization who are excelling at accessibility activities?

4. What disability populations are included in current accessibility initiatives?

5. Is there a disability-specific budget available for the activities?

   a. What types of budget(s) exist?

   b. Who or what department is responsible for the budget(s)?

c. What types of initiatives or supplies are covered by the budget(s)?

6. What infrastructure is available to support disability accessibility initiatives?
   - Internal website with resources
   - Systems to order equipment
   - EHR builds
   - Training modules that include disability
   - Other:____

Policies

1. What disability-related policies currently exist (i.e., grievances/complaints, service animals, interpreter services, use of lifts or scales)?

2. Do non-discrimination and other patient policy statements include disability?

Evaluation

1. How is your organization monitoring the quality and safety of care delivered to patients and subpopulations? Are patients with disabilities included as a subpopulation?

2. How are patient complaints regarding accessibility monitored and addressed?

3. Do your patient surveys include questions about accessibility?

   a. Can you filter patient survey responses by disability status?

Identify Gaps and Strengths

This section will help you identify existing gaps and opportunities for future initiatives.

Based on the above information, describe your organization's:

1. Strengths: What internal factors exist that could facilitate developing or expanding your accessibility program?

2. Weaknesses: What internal barriers exist that inhibit developing or expanding your accessibility program at your organization?

3. Opportunities: What favorable external factors exist that could promote developing or expanding your accessibility program at your organization?

4. Threats: What external factors exist that have the potential to inhibit the success developing or expanding your accessibility program at your organization?

Appendix 1.2

Accessibility Program Implementation Planning

The following plan will help guide your work in developing or expanding an accessibility program in your organization.

INSTRUCTIONS: Use this worksheet to guide your overall organization/clinic plan for building or expanding an accessibility program. Questions that are not applicable may be skipped. The following could serve as a practical worksheet or a thought exercise for your implementation team.

GOAL FOR THIS PLAN:

____

(Examples: "We plan to focus on developing an effective communication initiative."; "We plan to focus on improving access to care for our patients with intellectual and developmental disabilities.")

Engaging the Disability Community

WHICH disability organizations or groups will you collaborate with? What disability types do these organizations represent?

HOW will you include people with disabilities in your patient and family advisory committees?

- Representation on existing committees
- Create a disability-specific advisory committee
- Other:____

HOW will you engage with your disability employee resource group or affinity group?

HOW will you elicit feedback from **disabled people in the community** (not necessarily patients) about how you are doing and your plans for improving? Who will you invite to these activities? Select all that apply.

- Listening sessions
- Focus groups
- Sharing circles
- Surveys
- Other:____

HOW will you elicit feedback from your **patients with disabilities** about how you are doing and your plans for improving? Who will you invite to these activities?

- Listening sessions
- Focus groups
- Sharing circles
- Patient feedback surveys
- Advisory committee

- Other:____

HOW will you ensure multiple identities (e.g., racial/ethnic populations with disabilities) are represented?

LEADERSHIP SUPPORT AND BUY-IN

WHICH members of leadership do you need to support from? For what purpose?

WHAT charters, strategic plans, presentation, etc. do you need to create (see Appendices 1.5 & 1.6 for examples)?

WHAT regulatory requirements must your accessibility program meet?

- ADA
- Section 1557
- Section 504
- Joint Commission Excellent Outcomes for All Certification
- Other:____

TEAM

WHO will oversee the accessibility program?

- ADA Coordinator
- 1557 Coordinator
- Section 504 Coordinator
- Disability program coordinator
- Other:____

WHO else will be on the team to oversee, monitor, and evaluate the program?

WHAT department(s) will the accessibility program exist within?

WHAT FTE amounts are allocated to the people implementing the program?

WHO will be your champions throughout your organization?

RESOURCES

WHAT budget(s) is available to the accessibility program? Will you have:

- A centralized budget
- Activity-specific budgets
- Budget to cover FTE
- Other:____

WHAT resources—such as accessible medical diagnostic equipment, staff training materials, policies, electronic health record build—will you need? Reference your completed Needs Assessment.

HOW will you identify resources needed?

- Internal
- External
- Other:____

ACTIVITIES OF THE PROGAM

WHICH activities are you currently providing and that you will continue to provide? See Appendix 1.7 for a list of activities.)

WHAT new activities will you provide?

WHAT activities will be available to entire organization?

WHAT activities will be available to specific clinics or units? List each clinic/units and the activities.

WHICH disability types could benefit from program activities?

WHAT gaps in patients' needs will the activities address?

METHODS FOR IMPLEMENTATION

This step will aid you in creating workflows for each accessibility program activity. This is an involved process. See Appendix 0.6 in the General Resources chapter for workflow examples.

WHO is leading each of the activities?

WHAT departments are involved in each of the activities?

WHAT resources are needed to begin each activity?

WHAT budget(s) is needed for each activity?

TRAINING AND BUY-IN

HOW will you inform staff and clinicians that your organization has an accessibility program?
- Newsletters
- Presentations at staff meetings
- Email announcements
- Other:____

HOW will you engage staff and clinicians and increase buy-in for the accessibility program?
- Training
- Kudos
- Patient stories
- Other:____

HOW will you train staff and clinicians on applicable accessibility program activities?

WHERE will training materials be located?
- Internal website
- Other:____

HOW often will you provide training?
- New employee orientation
- Yearly
- Other:____

HOW will you inform patients of your accessibility program?
- Notice by placards/flyers at front desk, waiting room, exam rooms
- Emails
- Other outreach:____

HOW will you inform patients of their rights and other non-discrimination policies?
- Notice by placards/flyers at front desk, waiting room, exam rooms
- Emails
- Other outreach:____

ARE patient facing materials available in multiple modalities?
- Large print
- Braille
- Plain language
- Other:____

CULTURE OF ACCESSIBILITY

HOW will you promote a general culture of accessibility and inclusion?

- Ensure mission statements don't include ableist language
- Patient education and other patient-facing materials are accessible
- Patient education, artwork, promotional materials, and other patient-facing materials have images that are inclusive of people with disabilities
- Other:____

PLANNING FOR IMPLEMENTATION AND EVALUATION

WHAT is your timeline for implementing your accessibility program?

WHAT are the target outcomes of your accessibility program?

- Improve health outcomes for patients with disabilities
- Comply with federal/state regulations
- Reduce patient complaints
- Other:____

HOW will you monitor the outcomes of your accessibility program?

WHAT are the data sources for monitoring your accessibility program?

- Dashboards
- Patient feedback surveys
- Other:____

HOW will your monitoring activities be integrated into your organization's existing quality and safety monitoring activities?

- Include disability as a subpopulation in quality measurement
- Other:____

HOW often will you monitor your progress?

- Weekly
- Monthly
- Quarterly
- Other:____

HOW will you monitor whether your program aligns with federal, state, accreditation, etc. standards?

- Work with your compliance office
- Other:____

HOW will you continue to engage leadership support in this work?

- Regular reporting of data

- Highlight positive patient stories
- Other:____

HOW will you continue to engage people with disabilities in this work?

- Regular reporting of data via publicly available webinars
- Regularly meet with advisory committee
- Other:____

Appendix 1.3

Accessibility Program Barriers and Strategies

Below is a list of potential barriers that might be encountered when establishing an accessibility program and the far-right column lists implementation strategies to address the barriers. You could use one or a combination of the implementation strategies listed for each barrier.

Refer to ERIC Discrete Implementation Strategies Table for descriptions of each strategy.

Category of Barrier	Barriers to Developing an Accessibility Program	Possible Implementation Strategies
Leadership, staff, and provider attitudes	Not seen as priority Not viewed as valuable	• Designate a formal implementation team • Develop a formal implementation blueprint • Identify and prepare champions • Promote adaptability • Provide ongoing consultation • Provide resources (e.g. Leadership Support slide deck) • Provide training • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
	Insufficient buy-in and being “voluntold”	• Designate a formal implementation team • Develop a formal implementation blueprint • Promote adaptability • Identify and prepare champions • Provide resources • Provide training • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
Staff and provider knowledge and comfort	Lack of knowledge about disability, including prevalence, types, and disability language	• Identify and prepare champions • Provide ongoing consultation • Provide training • Provide staff and providers with tools (scripts, cheat sheets, quick guides)
	Concern that system/clinic might not have needed accommodations or accessibility features	• Conduct a needs assessment • Workflow mapping • Identify and prepare champions • Provide ongoing consultation • Provide centralized technical assistance • Provide resources (e.g., 3 types of accommodations for a certain disability) • Provide training • Provide staff and providers with tools • Audit and provide feedback • Kudos to high preforming staff/clinicians/sites • Patient-facing education materials

<table>
<tr><td rowspan="3">Workflow and logistics</td><td>Challenges coordinating across departments and roles</td><td>• Designate a formal implementation team
• Conduct a local needs assessment
• Develop a formal implementation blueprint
• Workflow mapping
• Identify and prepare champions
• Promote adaptability
• Provide ongoing consultation
• Provide centralized technical assistance
• Provide training
• Relay clinical data to responsible individuals/roles
• Review staff performance data to inform changes</td></tr>
<tr><td>Limited time available

Competing demands</td><td>• Conduct a local needs assessment
• Workflow mapping
• Identify and prepare champions
• Promote adaptability
• Provide ongoing consultation
• Establish centralized technical assistance
• Provide resources
• Use reminders (EHR alerts, tents, signs)
• Provide staff and providers with tools
• Relay clinical data to responsible individuals/roles
• Review staff performance data to inform changes
• Audit and provide feedback
• Kudos to high performing staff/clinicians/sites</td></tr>
<tr><td>Not assigned responsibility for tasks</td><td>• Change record systems/EHR
• Designate a formal implementation team
• Conduct a needs assessment
• Develop a formal implementation blueprint
• Workflow mapping
• Identify and prepare champions
• Promote adaptability
• Provide ongoing consultation
• Provide centralized technical assistance
• Relay clinical data to responsible individuals/roles
• Review performance data to inform changes
• Audit and provide feedback</td></tr>
</table>

Appendix 1.4

Accessibility Program Costs and Funding

Below is a list of sample accessibility program costs that may need an allocated budget, as well as a list of potential sources that could be leveraged to fund your program.

Costs

- Employee salaries (% Full Time Equivalent (FTE) or salary in dollars)
    - Person(s) leading the accessibility program
    - Person(s) to train staff and providers
    - Person(s) to provide accommodations
    - Person(s) to ask patients' disability status and accommodation needs
- Training costs
    - Training materials used during New Employee Orientation
    - Disability training materials for current employees
    - Employee time to complete training
- Building modifications for existing facilities
- Electronic Health Record (EHR) updates or changes
    - Integrating disability status and/or accommodation needs fields in EHR
- Accessibility compliance of websites and printed documents
- Adaptation of patient education materials into accessible formats
- Compensation for disability partners: interns, advisory committee members
- Legal fees
- Adaptive safety equipment
- Program evaluation and quality improvement
- Accommodations*
    - Disability-specific medical equipment
    - Auxiliary aids and services
    - Interpretation supplies or Virtual Remote Interpreting

**See Appendix 0.8 in the General Resources chapter for a comprehensive list of accommodations.*

Funding Sources

- Central health system budget
- Departmental budget (if the accessibility program has its own department)
- Internal health system grants
- External grants, such as federal or foundation grants
- Research grants
- Donations
- Technology companies

Appendix 1.5

Accessibility Program Leadership Support Slides Template

The following PowerPoint template was created to help you prepare a presentation to your organization's leadership about the value of your accessibility program.

LEADERSHIP SUPPORT SLIDE DECK LINKED HERE

Appendix 1.6

Accessibility Program Activities

Below is a list of activities that are typically included under an accessibility program and are the responsibility of the role(s) managing the program.

Lead and Provide Subject Matter Expertise

- Raise awareness of disability needs within organization
- Lead culture changes in organization
- Support accessibility across all departments

Manage Accessibility Policies

- Ensure organizational compliance with federal and state accessibility requirements and accreditation standards
- Ensure policies posted for patients are comprehensive and accessible
- Manage accessibility policies across the organization
- Manage disability-related policies, such as service animal policies

Assess Organization Accessibility

- Maintain inventory of accommodations
- Maintain inventory of accessible medical diagnostic equipment
- Evaluate building and facility accessibility
- Evaluate digital accessibility
- Ensure compliance with federal and state requirements

Establish Partnerships

- Manage relationships with other departments
- Engage with disability employee resource or affinity groups
- Engage with local disability community
- Facilitate professional business relationships when needed
- Engage marketing and outreach teams
- Collaborate with patient navigators
- Work closely with patient advisory councils

Conduct and Oversee Disability/Accessibility Training

- Conduct organization-wide disability competency training
- Facilitate skill-specific training for staff when necessary
    - Ex) Training staff to safely transfer patients with physical disabilities onto an exam table

Oversee Specific Initiatives or Projects, such as:

- Effective communication
- Documenting disability status in the electronic health record
- Autism and sensory programs
- Environmental/facility accessibility

Manage Patient Accommodations

- Develop workflows for delivering accommodations
- Review and adapt process for accommodation delivery
- Oversee physical maintenance of accommodations

Assist with Purchasing

- Identify necessary equipment and accommodations

Advocate During Emergency Planning

- Learn the needs of people with disabilities in emergency situations
- Include the needs of people with disabilities in emergency planning

Participate in Architecture Planning

- Contribute expert knowledge of federal and state requirements for building/facility accessibility
- Provide guidance for remodeling existing buildings/facilities
- Provide guidance for new builds

Participate in Digital Accessibility Initiatives

- Provide expertise to ensure website and patient portal accessibility
- Contribute expert knowledge of federal and state requirements for digital accessibility
- Provide expertise to ensure telehealth accessibility

Manage Complaints

- Respond to patients' disability and accommodation requests and complaints
- Respond to employees' disability and accommodation requests and complaints
- Review and adapt (if needed) complaint processes

Monitor Accessibility Program

- Evaluate progress towards goals of program
- Evaluate outcomes of program
- Evaluate processes and effectiveness of program
- Implement change when necessary to improve program effectiveness

Appendix 1.7

Accessibility Program Activities Priority Worksheet

Using Appendix 1.6: *Accessibility Program Activities*, organize your accessibility program's activities in the following categories:

1. Existing activities
2. New, higher priority activities to implement immediately
3. New, lower priority activities to implement in the future

Existing Activities	Higher Priority Activities for Immediate Implementation	Lower Priority Activities for Future Implementation

Appendix 1.8

Accessibility Program Organizational Structure

The structure of your accessibility program will depend on your organization's size, existing departments, staff, and budget. This appendix provides guidance and examples on how to structure your accessibility program.

Disability Accessibility Coordinator

Organizations with 15 or more employees are legally required to have a Coordinator responsible for managing their organization's compliance with Section 1557 of the Patient Protection and Affordable Care Act[1] and Section 504 of the Rehabilitation Act of 1973.[2] Organizations with 50 or more employees are required to have a Coordinator responsible for compliance with the Americans with Disabilities Act.[3] These titles and responsibilities can be combined into one role.

At least one employee must be allocated to oversee accessibility initiatives in your organization. The amount of FTE designated for the role will depend on the size of the organization and the number of responsibilities assigned to the person. Large healthcare organizations, for example, will likely need multiple employees to manage the accessibility program.

To be successful, the Coordinator must have training and experience in facilitating accessible care. Do not assume a person has the level of knowledge and expertise necessary to take on this role based solely on their current job title. For example, sign language interpreters do not necessarily have knowledge about physical accessibility. However, several positions may have an existing knowledge base that could help them more easily serve or be trained to serve as the Disability Accessibility Coordinator, such as:

- Civil Rights Coordinators
- Interpreter Services Coordinators/Managers/Directors
- Language Access Program Managers
- Quality Program Managers
- Program Directors for Diversity and Inclusion
- Practice Managers

Sample job titles for dedicated Disability Accessibility Coordinators include:

- 504 Coordinator/504 Officer/504 Compliance Manager
- 1557 Coordinator/1557 Officer/1557 Compliance Manager
- ADA Coordinator/ADA Officer/ADA Compliance Manager
- Disability Program Manager
- Inclusion Specialist
- Assistive Services Program Manager
- Accessibility Coordinator or Manager
- Program Manager for Facilities Compliance

Departments

When determining what department(s) will house the accessibility program and the Disability Accessibility Coordinator, consider the following:

1. How will the mission of the department influence the Program? For example, if the program exists within your Legal or Compliance Office, how might this affect its priorities and activities?
2. How does the department affect the authority or ability of the Disability Accessibility Coordinator to enact change in the organization? For example, will the Coordinator be included in regular meetings with leadership?
3. Do people within the department have the knowledge and skills to support an accessibility program?

The accessibility program could be housed within departments such as:

- Disability Resource Department or Center
- Quality and Safety
- Patient Experience/Patient Care Services
- Health Equity and Inclusion
- Clinical Operations (e.g., Ambulator Operations, Nursing)
- Compliance and Regulatory/General Counsel
- Interpretive Services

Models

There are a wide variety of models for structuring the accessibility program. In considering the model that will work for your organization, ensure you have sufficient personnel with the appropriate training, expertise, time, and resources to carry out program activities. The following are three different examples of how a health system might organize the personnel overseeing their disability accessibility activities.

Example Model #1: The Disability Accessibility Coordinator or a team lead all disability accessibility activities. These individuals will collaborate and work within all departments in their organizations to carry out disability initiatives. They are considered the accessibility experts within their organization.

Example Model #2: For large healthcare systems, a system-level Disability Accessibility Coordinator will oversee local Coordinators who work within the systems' hospitals or clinics. The local Coordinators have other job titles and responsibilities (e.g., Practice Manager), and this is just one of their responsibilities. The local Coordinators will be the staff members implementing disability activities within their hospital or clinic. They rely on the system-level Disability Accessibility Coordinator for advice and support.

Example Model #3: Accessibility activities and initiatives are divided amongst different departments. For example, someone in the legal department is responsible for federal compliance, someone in Interpreter Services is responsible for providing effective

communication to patients with hearing loss, and someone in the Patient Experience office manages disability accessibility complaints.

References

1. U.S. Department of Health & Human Services. Designation and responsibilities of a Section 1557 Coordinator. 45 CFR §92.7. 2024. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-92/subpart-A/section-92.7
2. U.S. Department of Health & Human Services. Designation of responsible employee and adoption of grievance procedures. 45 CFR § 84.7(a). 1977. https://www.ecfr.gov/current/title-45/part-84#p-84.7(a)
3. U.S. Department of Justice. Designation of responsible employee and adoption of grievance procedures. 28 CFR §35.107(a). 2010. https://www.ecfr.gov/current/title-28/part-35/section-35.107#p-35.107(a)

Appendix 1.9

Accessibility Program Monitoring Progress and Adaptations

Use this appendix to start tracking progress and adaptations made to your original plan during implementation. In this plan, include a space to describe what changes or adaptations were made to the original implementation plan and the reason for the adjustment. Below are a few examples of adaptations that could be tracked.

HAVE practice leaders proactively removed organizational barriers (such as attitudes and culture) to establishing and maintaining an accessibility program?

- Not started
- Just beginning
- Actively addressing
- Completed

HAVE practice leaders established relationships with other departments, the local disability community, patient advisory councils, and others to inform the accessibility program?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT stage is the organization at in the process of hiring a disability accessibility coordinator?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT stage is the organization at in the process of disseminating accessibility policies to patients and staff?

- Not started
- Just beginning
- Actively addressing
- Completed

HAVE staff evaluated the accessibility of the organization, including:

- Building and facility accessibility
  - Not started
  - Just beginning
  - Actively addressing
  - Completed
- Digital Accessibility
  - Not started
  - Just beginning
  - Actively addressing
  - Completed

- Compliance with federal and state requirements
    - Not started
    - Just beginning
    - Actively addressing
    - Completed

HOW many departments/units/teams/staff have received disability/accessibility training?

- None
- 25%
- 50%
- 75%
- All
- Other:____

ARE there standardized protocols in the practice workflow to receive requests for and provide accommodations?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT modifications have been made to the original implementation plan across your organization and at each site?

- When?
- Where?
- Why?
- Who requested the modification? Who executed the modification?
- How has this improved implementation?

Appendix 1.10

Example Disability Coordinator Job Description

Below is an extensive list of sample descriptions, responsibilities, and qualifications that could be included in a disability coordinator's job description. Each example was adapted from existing healthcare organizations' descriptions of the role. You may choose or alter any of the descriptions below to meet your organization's needs and the scope of your disability coordinator's role.

Position Summary Examples

"The Disability Coordinator reflects the mission, vision, and values of [Organization], adheres to the organization's [Code of Ethics and Corporate Compliance Program], and complies with all relevant policies, procedures, guidelines, and all other regulatory and accreditation standards."

"The Coordinator is responsible for developing and leading projects to support the [Accessibility Program] mission and to target developing our people, culture, and resources. The Coordinator is the [Organization]'s central resource for disability inclusion."

"A Coordinator uses project management skills, change management techniques, and robust communication tactics to engage with diverse stakeholders across the organization. This role leads and develops [Organization]'s system-wide disability inclusion initiatives in compliance with applicable laws, regulations and standards. The Disability Coordinator is responsible for monitoring and maintaining compliance with the [Implementation Plan (if applicable)]; responding to patient and employee concerns about access to care for patients with disabilities; providing subject matter expertise to develop training materials or contribute to internal/external marketing materials; and to assist in reviewing accessibility changes on [Organization] campuses (physical, sensory, or other related changes)."

Sample Responsibilities

- Lead organization's implementation of federal, state, and local accessibility requirements and accreditation standards
- Design, implement, manage, and evaluate local, regional, and system-wide accessibility initiatives
- Manage small to large scale regional and system level projects using project management and interpersonal skills to effectively coordinate all aspects of a project
- Lead and facilitate project-specific meetings
- Independently develop high impact presentations to engage and garner support from organization leadership
- Develop effective verbal and written communication materials for internal and external audiences
- Translate large amounts of information into clear, succinct language for communications in meetings, presentations, and strategic planning
- Establish and maintain partnerships with clinical and administrative teams
- Document work to reference during short- and long-term planning

- Lead and facilitate change efficiently and effectively in a changing legal and cultural environment
- Completes other duties as assigned

Sample Qualifications

- Bachelor's degree in healthcare management or related field
- MBA/MHA/MPH or other relevant graduate degree preferred
- 2-3 years of project management related experience
- 2-3 years' experience in addressing accessibility issues and working with the disability community strongly desired
- 8-10 years of related healthcare administration or clinical leadership experience
- Knowledge of state and local laws
- Ability to work with diverse groups of healthcare professionals in a matrix environment
- Proven change management skills
- Proven software competencies (MS Office Suite, project management applications)
- Demonstrated organizational and leadership skills
- Strong prioritization skills
- Excellent analytical and critical thinking skills
- Effective problem solving and multi-tasking skills
- Excellent verbal and written communication skills
- Self-directed and comfortable with ambiguity
- Knowledge of the rules, regulations, laws, and practices on accessibility for persons with disabilities, such as Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, the Fair Housing Act, and the Architectural Barriers Act
- Experience reviewing public access to facilities and services
- Experience engaging with people with a broad range of disabilities
- Able to handle confidential matters judiciously
- Some experience developing curriculum or training materials
- High level of energy and enthusiasm
- Ability to travel to all [Organization] sites as needed to review and/or evaluate facilities by observing or gathering information about entrances, accessible routes, furniture and equipment, and other elements of accessibility

Other Items

Management Responsibilities

- This position will supervise [Department] staff and other administrative staff as assigned for projects

Additional Scope

- Guides initiatives that aim to ensure equal access to care for all, including but not limited to patients with disabilities

- Designs and implements a program, in compliance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (“Section 504”), for dignified and equal access by patients, families, companions, visitors, and other individuals so that their entire healthcare experience at [Organization] is improved
    - Incorporated into this design are a respect for a patient’s right to control healthcare decisions and the beliefs that all patients shall have equal access and receive equal care; dignity is never compromised; caring and compassion are as important as technology; and education and information are vital to informed healthcare decision-making

Additional Responsibilities

- Act as a system-wide resource for disability issues
- Serve as a central resource throughout the [Organization] for information concerning Section 504/ADA issues, accessibility of [Organization] facilities and services, resources to individuals with disabilities, and compliance initiatives and obligations
- Assess and advise leadership regarding Section 504 and ADA compliance
- Provide leadership and/or consultation on decisions impacting services provided to patients, families, companions, and visitors with disabilities
- Maintain current knowledge of and monitor [Organization] compliance with local, federal, and state regulations, laws, and regulatory actions
- Work collaboratively with stakeholders and key leaders across [Organization], including individuals with disabilities, to ensure compliance with local and federal standards and regulations and to implement strategies to address issues of equal access to healthcare for individuals with disabilities
- Play an active role in improving quality of care and patient safety by working to ensure availability of resources necessary to meet the needs of patients and visitors with disabilities
- Develop or ensure that the institution has appropriate written guidelines and policies for reasonable accommodations
- Create and maintain a program to measure compliance

Complaint and Grievance Resolution

- Establish and maintain effective Section 504/ADA grievance procedures consistent with [Organization] policies and procedures
- Partner with Patient Relations staff at [Organization] facilities to field, investigate, manage, and respond to concerns and complaints from patients, families, companions, visitors, and [Organization] staff on issues relating to disabilities
- When appropriate, and in collaboration with [Office of General Counsel] and the [Office of Corporate Compliance & Integrity], serve as the [Organization] liaison to the Office for Civil Rights (OCR)

Training/Education

- Develop and update policies and procedures consistent with the requirements of Section 504 and the ADA
- Develop program to provide on-going training and support to [Organization] staff regarding Section 504 and the ADA

- Work with [Organization] Academy, Marketing and Communications, and others to develop educational and promotional materials on disabilities and access issues
- Establish expectations and assist in educating staff and physicians concerning these issues
- Create environment in which care for individuals with disabilities is coordinated in a cohesive manner with minimal impediments across the organization

Facilities and Equipment Access

- Ensure process for 24/7/365 availability, maintenance, and repair of reasonable accommodations and services, including interpreters and video remote interpreting, to meet the needs of patients, families, companions, and visitors with disabilities. Monitor use and continuously improve resources and processes
- Be familiar with the use and operation of reasonable accommodations and other accessible equipment made available by [Organization] to its patients, families, and visitors, and where such auxiliary aids and equipment are stored
- Maintain inventory of accessible equipment to optimize the use of high-cost equipment by multiple departments, where such sharing is effective, and to ensure patients have access to up-to-date and appropriate equipment for their healthcare
- Work with individual departments to assess their readiness to receive and accommodate a patient, family member, companion, or visitor with a disability
- Support Facilities leadership as needed to:
  - Regularly conduct evaluations of physical space, accessible furniture and equipment, and auxiliary aids and services
  - Provide recommendations for any changes to physical space, accessible furniture and equipment (existing or newly acquired) and auxiliary aids and services throughout [Organization] to maximize accessibility
  - Oversee institutional processes for ensuring that capital projects comply with the requirements of the ADA and Section 504.
  - Recommend the allocation of funds towards physical space changes and/or equipment purchases determined necessary to adhere to local or federal regulations and/or recommended to enhance a patient, family, companion, or visitor’s experience at [Organization]

Information Dissemination/Community Relations

- Establish processes to communicate across the continuum of care about issues of accessibility for individuals with disabilities
- Work towards enhancing [Organization] reputation in the community and achieving the objective of becoming the provider of choice for patients with diverse needs
- At the direction of the [Vice President, Integrity], assist in communicating with local, national, and international agencies providing expertise and resources relating to disability issues
- Direct relevant staff in creating, updating, and maintaining accessible internal and external web presence for [Organization]’s internet and intranet
- Direct the development and maintenance of a database of community disability resources
- Serve as a resource to [Organization] staff on ADA and Section 504 compliance

- Ensure and monitor effective communication on websites, libraries, and other resources
- Promote confidentiality, respect, and dignity for all persons at [Organization]
- Keep current on best practices, regulatory and accreditation standards, and data collection/survey techniques on disability and accessibility issues
- Communicate regularly with patients and other organizations involved in disability advocacy, regulators, accrediting agencies, community groups, etc.

Chapter 2

Documenting Disability Status and Accommodation Needs

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Orientation to Documentation Chapter

This document is one chapter of a broader Implementation Guide on providing accessible healthcare for people with disabilities. The chapter will guide you through how to implement documenting disability status and accommodation needs at your clinic or organization. The information in this chapter is a synthesis of existing research and learnings from health systems across the country. It is intended to provide guidelines adaptable to your local context.

This chapter includes: 1) an introduction to the topic, 2) seven steps for implementation, and 3) a variety of appendices. Under each step, the ***Actions and Tasks*** section outlines best practices and questions to consider while creating and implementing documentation of disability status and accommodation needs at your organization. The ***Materials and Resources*** section lists the relevant appendices, which include worksheets, templates, examples, and other resources to assist you in completing the ***Actions and Tasks*** of each implementation step.

Appendices can also be used independently as resources for documenting disability status and accommodation needs. For example, you could use Appendix 2.5: *Documentation LOINC Codes* if you are only interested in understanding what LOINC codes related to disability exist.

Introduction to Documenting Disability Status and Accommodation Needs

Why is it important to collect disability status?

1. To identify and address potential disparities in care, patients' disability status needs to be systematically and accurately documented.
2. Healthcare organizations are required to provide patients with disability accommodations,[1-3] including auxiliary aids and services.[4] To effectively provide these resources, healthcare organizations first need to know patients' disabilities and accommodation needs.

A growing body of literature finds that people with disabilities experience disparities in health and healthcare outcomes. For example, compared to people without disabilities, people with disabilities are more likely to have a greater number of chronic conditions and have higher rates of asthma, hypertension, emphysema, cardiovascular disease, diabetes, and arthritis.[5] People with disabilities are also more likely to rate the quality of their health as fair or poor.[6,7]

What are the requirements for documenting disability status?

Section 4302 of the Patient Protection and Affordable Care Act requires the collection of disability status by organizations that receive federal funding.[8]

How does disability relate to other patient characteristics?

Disability is a patient-reported demographic characteristic like race, ethnicity, preferred language, gender identity, or sexual orientation. Processes for documenting other patient demographics should incorporate documentation of disability status.

Can a clinician assess a patient's disability status?

Disability status and accommodation needs *must be patient-reported*. Disability status is different than a clinical assessment that is used to inform care provision. If a clinician suspects a patient has disability needs or that a patient would benefit from a disability-related accommodation, they should ask the patient the questions provided in this guide to facilitate that conversation.

Will we offend patients by asking about their disability status?

In multiple research studies, patients report little discomfort in disclosing a disability. Patients have the option to decline to answer.

How much work is it to ask patients about their disability status?

In a study in which registration staff asked one screener question followed by six disability status questions, call times increased by 18 seconds.[9] Other methods for collection such as intake forms or the patient portal are potentially more time efficient for staff and providers.

Steps to Document Disability Status and Accommodation Needs

Step 1: Develop Leadership Support

When implementing any new accessibility initiative at your organization, earning buy-in from leadership is essential. Support from leadership will ensure you have the resources necessary to successfully build and implement the documentation of disability status and accommodation needs.

Actions and Tasks

1. Identify what types of leadership support and buy-in you will need.
2. Identify potential champions across your organization.
3. Identify how documentation of disability status and accommodation needs will fit within your organization's existing priorities and initiatives (e.g., health equity, quality and safety, patient experience goals, etc.).
4. Determine if your organization is involved in any regulatory initiatives that require documentation (e.g., Joint Commission Excellent Health Outcomes for All Certification, National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) reporting, U.S. Centers for Medicare and Medicaid (CMS) requirements, state-level requirements, etc.)

Materials and Resources

- Appendix 0.3: Federal Requirements
- Appendix 0.10: Leadership Support: Key Individuals

**Appendices 0.3 and 0.10 can be accessed in the General Resources chapter.*

Step 2: Identify Implementation and Leadership Team

The implementation team will be responsible for designing, leading, and monitoring the documentation of disability status and accommodation needs across your organization.

Actions and Tasks

1. Identify the implementation team for documenting disability status and accommodation needs.
    a. Consider including people across different departments and units within your organization.
    b. Include leadership and others who have the authority to make changes.
    c. Include staff who will be doing the work; they will know how the system works and will be helpful in implementing and piloting the project. This will also help with buy-in for the staff—who will more eagerly participate—and sustainability will be more attainable.
        i. It could be helpful to start with a pilot team to work through challenges before expanding to the entire clinic or healthcare system.
2. Determine the implementation team meeting structure.

   a. How often will the team meet?
   b. Is this a project that will be part of a quality improvement team or embedded within another team?
3. Identify champion(s) for the project.
   a. Who is this person(s) going to be?
   b. Are they able to implement changes?
   c. Will this be a clinical champion or a non-clinical team member champion? Are both clinical and non-clinical needed?
   d. Is there someone at the *system level* with whom you can partner? For example, a Disability Coordinator?
4. Establish common goals for team.
   a. Ensure that it fits within organizational goals.
   b. Use SMART Goals (Specific, Measurable, Attainable, Realistic, and Time-bound).

Materials and Resources
- Appendix 0.6: Project Planning
- Appendix 2.1: Documentation Implementation Teams
- Appendix 2.6: Documentation Barriers & Strategies

**Appendix 0.6 can be accessed in the General Resources chapter.*

Step 3: Needs Assessment

Identify the current state of documenting disability status and accommodation needs at your organization using Appendix 2.2: *Documentation Needs Assessment*.

Actions and Tasks
1. Engage with other healthcare organizations to understand their documentation processes, including what is and isn't working for them. Consider joining the Disability Equity Collaborative's Documentation workgroup to create a peer network.

Materials and Resources
- Appendix 2.2: Documentation Needs Assessment
- Disability Equity Collaborative's Documentation workgroup

Step 4: Electronic Health Record Build

Part 1: Features

Determine what disability and accommodation questions will be in the electronic health record (EHR) and the EHR features.

Actions and Tasks
1. Establish the team responsible for determining what disability status and accommodation needs questions will be available in the EHR.

2. Determine what EHR features will be included in your build.
3. Define the disability questions that will be listed in the EHR.
4. Define what potential accommodations will be listed in the EHR.
5. Determine if there are already related forms/fields in the EHR that can be used or modified.

Materials and Resources

- Appendix 0.8: Disability Accommodations Examples
- Appendix 2.1: Documentation Implementation Teams
- Appendix 2.3: Documentation Implementation Planning
- Appendix 2.4: Documentation EHR Features
- Appendix 2.7: Documentation Disability Questions

**Appendix 0.8 can be accessed in the General Resources chapter.*

Part 2: EHR Build

Develop the EHR build.

Actions and Tasks

1. Identify who will be responsible for the EHR build.
    a. Do you have a team that is identified specifically for EHR changes or builds?
    b. Will you incur a cost to build and implement?
2. Using questions that were identified in the previous step, complete EHR set up and build.
3. Complete a trial run using test patients.

Materials and Resources

- Appendix 2.1: Documentation Implementation Teams
- Appendix 2.4: Documentation EHR Features
- Appendix 2.5: Documentation LOINC Codes

Step 5: Determine When and Who Will Collect Disability Status and Accommodation Needs

Decide when and who will collect disability status and accommodation needs. Aim to integrate the process into existing clinic and system-level workflows when possible.

Actions and Tasks

1. Identify local barriers and facilitators to documenting disability status and accommodation needs (see Appendix 2.6).
2. Continue to utilize Appendix 2.2: *Documentation Implementation Planning* to specify site or clinic goals, strategies, timelines, milestones, and measures for successful routine collection of patients' disability status and accommodation needs.
3. Create a workflow map, a visual representation of the actions, decisions, and tasks to be performed for successful routine collection of patients' disability status and

accommodation needs. Appendix 0.6: *Project Planning* includes example workflow maps.

4. Determine what can and cannot be adapted in the process for documenting disability status. For example, can each clinic decide whether to collect at front desk or by Medical Assistant in exam room?
5. Determine the resources needed to implement routine collection of patients' disability status and accommodation needs. For example, you will likely need to dedicate time for staff to complete trainings.
6. Following decisions made on workflows, processes, and roles, revisit the composition of the implementation team. Determine if additional individuals from the departments or units that will be involved in documentation should be included.

Materials and Resources

- Appendix 0.5: Policy Writing Guidance
- Appendix 0.6: Project Planning
- Appendix 2.3: Documentation Implementation Planning
- Appendix 2.6: Documentation Barriers and Strategies
- Appendix 2.8: Documentation Workflows
- Appendix 2.10: Documentation Who and When

**Appendices 0.5 and 0.6 can be accessed in the General Resources chapter.*

Step 6: Pre-implementation

Ahead of implementation, consider the following actions to ensure staff, patients, and your organization's systems are prepared to successfully document disability status and accommodation needs.

Actions and Tasks

1. Determine who will provide consultation to assist with collecting patients' disability status and accommodation needs.
   a. This person will offer expert guidance, feedback, and problem-solving to a site longitudinally.
   b. This can be a practice facilitator or similar role.
2. Determine who will provide technical assistance and what this will include.
3. Identify or develop tools and reminders that staff and providers will use to encourage collection (see Appendices 2.9 and 2.11).
4. Implement training for staff and providers (see Appendix 2.12).
5. Identify or develop patient-facing education materials to inform patients of the new processes for collecting disability status, its purpose, and what to expect.
6. Determine how collected information will be integrated into other data structures in the organization (e.g., dashboards, quality reporting, scheduling templates and software, etc.)
7. Determine how success will be defined for documenting disability status and accommodation needs, including appropriate metrics (e.g., acceptable rates of completion, patient complaints, staff and clinician satisfaction with the process, etc.).

   a. Develop an evaluation plan to reflect your definition of success (see Appendix 2.13).

Materials and Resources

- Appendix 2.9: Documentation Frequently Asked Questions
- Appendix 2.11: Documentation Sample Script and Question Prompts
- Appendix 2.12: Documentation Training Materials
- Appendix 2.13: Documentation Monitoring Progress and Adaptations

Step 7: Implementation, Evaluation, and Monitoring

Roll out the implementation plan developed in previous steps to collect disability status and accommodation needs in the EHR.

Actions and Tasks

1. Track and communicate rates of collection of disability status to responsible individuals (e.g., clinic or site leadership, individuals who are collecting data) and the implementation team.
2. Review site-level data on documentation rates and determine if changes in workflow or strategies are needed.
3. Make and document all needed adaptations.
4. Conduct Audit and Feedback, an implementation strategy that includes providing site-level staff, provider, or team-level data on collection to those assigned to perform tasks.
   a. For example, run EHR reports stratified by provider, or create a progress chart to display in a staff breakroom.
   b. This Audit and Feedback article details how to employ the strategy.
5. Recognize high performing staff, clinicians, or specific clinics or sites to recognize and celebrate high completion rates.

Materials and Resources

- Appendix 2.6: Documentation Barriers and Strategies
- Appendix 2.9: Documentation Frequently Asked Questions
- Appendix 2.13: Documentation Monitoring Progress and Adaptations

Appendices Table

NAME	DESCRIPTION
Appendix 2.1: Documentation Implementation Teams	A list of all the individuals who could participate on the implementation team.
Appendix 2.2: Documentation Needs Assessment	A worksheet to review the current landscape of the organization, identify mission, priorities, gaps, strengths, and specific goals for documentation.
Appendix 2.3: Documentation Implementation Planning	A worksheet to identify the future direction and processes that will be followed for documenting disability status and accommodations.
Appendix 2.4: Documentation EHR Features	A list of all the electronic health record (EHR) fields that might be available, places to look within the EHR for disability fields and accommodation needs, functions by role, auditing and report for Quality Improvement, and research support.
Appendix 2.5: Documentation LOINC Codes	A list of Logical Observation Identifiers Names and Codes (LOINC) codes that are specific to documenting disability. Includes LOINC number, method or type, classification, question description, and status.
Appendix 2.6: Documentation Barriers and Strategies	A list of potential barriers to documenting disability status and possible strategies for addressing the barriers. Barriers are organized categorically.
Appendix 2.7: Documentation Disability Questions	Three recommended question sets that can be asked to patients to collect disability status and accommodation needs.
Appendix 2.8: Documentation Workflows	A document with example workflow templates for how documenting disability status and accommodation needs can be operationalized in a health system. Provides guidance on when to ask, what fields in the EHR to use, how to collect, and who should ask.
Appendix 2.9: Documentation Frequently Asked Questions	A Frequently Asked Questions (FAQ) document for staff about implementing disability status and accommodation needs collection into the clinic workflow.
Appendix 2.10: Documentation Who and When	A comprehensive list of all the options for when to and who can collect disability status information. Includes considerations to discuss when deciding who will collect and when disability status needs to be collected.
Appendix 2.11: Documentation Sample Script and Question Prompts	An example script for healthcare staff that includes the disability and accommodation needs questions and a prompt to deliver before asking the questions.
Appendix 2.12: Documentation Training Materials	The training appendix includes six different parts: 1. Introduction 2. Training table that outlines who and how to train 3. Table tent template for staff collecting disability status and accommodation needs 4. Clinic signage examples 5. Training slide deck an organization can use or modify to train their staff 6. Videos accompanying training slide deck
Appendix 2.13: Documentation Monitoring Progress and Adaptations	A worksheet to track progress and adaptions made to the implementation plan.

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Appendix 2.1

Documentation Implementation Team

Below is a list of roles that could participate on an implementation team.

1. Executive/chief officers
2. Analysts
3. Compliance or regulatory teams
4. Operational and electronic health record analysts
5. Directors of each involved department or group (e.g. scheduling staff, registration staff, medical assistants, nursing staff)
6. Medical assistants and nurses
7. Clinic managers
8. Family or patient experience liaison
9. Disability Accessibility or ADA Coordinators
10. Interpreter service leads
11. Diversity, Equity & Inclusion leader(s)
12. Project managers
13. Workflow consultants
14. Case management staff
15. Patient navigator
16. Clinical quality specialists
17. Clinical operations leaders
18. Quality team members
19. Regulatory specialists
20. Clinical educators or professional development teams

Appendix 2.2

Documentation Needs Assessment

Instructions:
- This assessment can be completed by anyone at any point in implementing documentation of disability status and accommodation needs. Questions that are not applicable to your organization or clinic can be skipped.
- Please note that Needs Assessments are long processes that require input and commitment from multiple partners within the organization and community to develop a robust and sustainable plan.

Current State of Documentation

This section will help you capture the current state of disability status and accommodation needs documentation at your organization or clinic. The questions will work to identify existing resources, opportunities, and current processes.

Background

1. What is the motivation driving documentation of patients' disability status and accommodation needs?
    a. Are there specific populations you are focused on (e.g., people with physical disabilities, intellectual or developmental disabilities, etc.)? If so, why?
    b. Are there certain settings you are focused on (e.g., scheduling, specific specialty appointments, outpatient, inpatient, etc.)? If so, why?
2. What is the specific goal or desired outcome of documenting disability status and accommodation needs?
3. How does documenting disability status and accommodation needs align with current organizational priorities (e.g. quality and safety; health equity; Diversity, Equity, and Inclusion)?
4. What, if any, leadership support is there for documenting disability status and accommodation needs? What levels of support do you need (C-Suite, Director(s), Manager(s), etc.)?
5. What, if any, regulatory requirements are there for documenting disability status (e.g., Joint Commission Excellent Health Outcomes for All Certification, NCQA HEDIS reporting, CMS requirements, state-level requirements etc.)

Processes

**Reminder: Questions that are not applicable can be skipped.*

1. Are there any disability status or accommodation needs questions that are systematically asked of patients across your organization?

2. Are there certain clinics or settings in which disability status and accommodation needs are already documented?

    a. Are there specific individuals, groups, or departments within your organization who are excelling at documentation?

3. What question(s) about <u>disability needs</u> are systematically asked to patients?

    a. What questions are documented?

    b. Are the questions open- or closed-ended?

    c. Do you have options for “no disability” or “decline to answer”?

    d. Do you have an option for “other”?

    e. Is there a “screener question” or are patients asked a group of disability questions (i.e., ACS questions)?

4. What question(s) about <u>accommodation needs</u> are systematically asked to patients?

    a. What questions are documented?

    b. Are the questions open- or closed-ended?

    c. Do you have an option for “other”?

   d. Is there a “screener question” or are patients asked a group of accommodations questions?

5. What other demographic data is currently collected?
   a. Race/ethnicity
   b. Language
   c. Social determinants of health
   d. Sexual orientation/gender identity
   e. Other:____

   a. Where is this information asked?

   b. Who is collecting this information?

6. At what point(s) during the delivery of care are disability or accommodation questions asked to patients, if at all? (can select more than one)
   - During scheduling/registration
   - Electronic check-in
   - In-person check-in
   - Exam room
   - Patient portal
   - Other:____

7. Who (what role(s)) is currently collecting patient disability and accommodation needs information?

8. Provide a general, brief description of *how* documenting disability status and accommodations is going at your organization.

People

1. What existing champions or committees exist to improve disability equity?

2. Who oversees EHR builds and provides approval?

3. Who might be your champions or people already working on this initiative:
   a. Disability Coordinator (could be: “ADA Coordinator”, “Section 1557 Coordinator” or “Disability Accessibility Coordinator”)
   b. Clinician champion(s)?
   c. Practice managers?

d. IT department?

Institutional Support:

1. What initiatives exist for documenting patients' demographics?

Identify Gaps and Struggles

This section will help you to identify existing gaps and opportunities for future initiatives.

Based on the above information, describe your organization's:

1. Strengths: What internal factors exist that could facilitate the documentation of disability status and accommodations in your organization?

2. Weaknesses: What internal barriers exist that inhibit the documentation of disability status and accommodations?

3. Opportunities: What favorable external factors exist that could promote documentation at your organization?

4. Threats: What external factors exist that have the potential to inhibit the success of documentation at your organization?

Materials and Resources

1. Appendix 0.3: Federal Requirements
2. Appendix 0.6: Project Planning
3. Appendix 2.1: Documentation Implementation Teams
4. Appendix 2.6: Documentation Barriers & Strategies
5. Appendix 2.8: Documentation Workflows

**Appendices 0.3 and 0.6 can be accessed in the General Resources chapter.*

Appendix 2.3

Documentation Implementation Planning

The following plan will help guide your work to implement documentation of disability status and accommodation needs at your organization.

INSTRUCTIONS: Use this worksheet to guide your overall organizational/clinic plan for documenting disability status and accommodation needs. For each of the questions below, select or complete all that may apply. Questions that are not applicable may be skipped. The following could serve as a practical worksheet or a thought exercise for your implementation team.

GOALS FOR THIS PLAN:

____

(Examples: "We plan to implement collection of patients communication disability and accommodation needs."; "We plan to focus on collecting patients' disability status during new patient registration.")

Team

WHO will be on the team to implement collection of disability status and accommodation needs?

WHO will be on the team to monitor and evaluate collection of disability status and accommodation needs?

WHO will coordinate disability and accommodation screening in the clinics, call centers, etc.?

WHAT other institutional partners will you need to engage?

Questions and Electronic Health Record (EHR) Build

WHICH disability status questions or categories will you collect? See Appendix 2.7: *Documentation Disability Questions* or Appendix 2.11: *Documentation Sample Script and Questions Prompts* for a list of recommended questions.

- Mobility
- Visual
- Hearing
- Communication
- Cognition
- Activities of Daily Living
- General screening question
- Other: ____

Will all patients get all questions, or will they get the screening question first?

WHICH accommodations will you include in the EHR build? Refer to Appendix 0.8: *Disability Accommodations Examples* in the General Resources chapter for a list of recommended accommodations.

- Sound amplifier
- Height adjustable examination table
- Assistance with written forms
- Other:______________________________

WHAT EHR features will you include in your build? See Appendix 2.4: *Documentation EHR Features* for a list of the features.

Methods for Collecting

For each question, consider how methods may or may not differ for initial screening and subsequent verification.

WHICH method of collection will you use?

- Staff documentation screener
- Paper screener at the time of check-in
- E-check-in
- Patient kiosk
- Patient portal
- Other:______________________________

WHICH patients will be screened?

- All patients 18 and over
- Patients with a particular condition
    - Specify:
- Patients presenting for a health maintenance/preventative care visit
- Patients participating in telehealth or phone appointments
- All patients at all appointment types
- All admitted patients
- Other:______________________________

WHAT units will screening take place in?

- Outpatient
    - Primary care
    - Specialty care
    - Imaging
    - Other:______________________________
- Inpatient
- Emergency or urgent care

- Other:____

WHO will screen the patients?

- Registration staff
- Scheduler
- Triage nurse
- Front desk staff
- Medical assistant/Nurse
- Provider
- Patient (self-disclose)
- Other:____

WHEN will screening take place?

- Registration
- Scheduling (online or phone)
- Triage
- E-check-in
- Kiosk
- At check-in
- In the examination room
- At a patient's leisure (e.g., they will be prompted to complete via email)
- Other:____

HOW will the question be prompted to be completed?

- Registration workflow
- Scheduling workflow
- Send patient email or letter to prompt to complete
- Triage
- E-check-in
- In-person check-in workflow
- Rooming workflow
- Other:____

HOW often will patients complete/verify the <u>disability status</u> questions? Will all patients verify once completed, or only those with an indicated disability status?

- Once a year
- Once a quarter
- Each visit
- Beginning of hospitalization
- Other:____

HOW often will patients complete/verify the <u>accommodation needs</u> questions? Will all patients verify once completed, or only those with an indicated accommodation need?

- Once a year
- Once a quarter
- Each visit

- Beginning of hospitalization
- Other:____

Training and Buy-In

HOW will you inform staff and clinicians that your organization is collecting patients' disability status and accommodation needs?

- Newsletters
- Presentations at staff meetings
- Email announcements
- Other:____

HOW will you get staff and clinicians excited and increase buy-in for collecting patients' disability status and accommodation needs?

- Training
- Kudos
- Other:____

WHAT tools will you use to promote completion of the fields?

- EHR tools (e.g., hard stop or yield signs)
- Email reminders
- Reminders at staff meetings
- Other:____

HOW will you train staff to collect? Choose one or more.

- IT will turn on portal/online check in
- Medical staff will complete online training
    - Internal training materials
    - External training materials
- Monthly check in at staff meeting
- Other:____

WHERE will training materials be located?

- Internal website
- Other:____

HOW often will you provide training?

- New employee orientation
- Yearly
- Other:____

HOW will you inform patients of this screening? Choose one or more.

- Notice by placards/flyers at front desk, waiting room, exam rooms
- Communication during appointment scheduling
- Medical staff will communicate during visit

Other:____

Privacy and Equity

HOW will you ensure that the process of collecting disability status does not reinforce stigma and discrimination?

- Training staff and clinicians
- Using prompts before the questions
- Monitor patient complaints
- Use the data to track care delivered
- Other:____

HOW will you protect the security of the data collected?

HOW will you ensure that data isn't used in a problematic way? For example, how will you ensure the data will not be used to justify decisions that impact the quality of care delivered to the patient with a disability, such as avoiding scheduling appointments with certain providers?

- Regular monitoring
- Monitor patient complaints
- Other:____

HOW will you inform patients about your data security procedures and processes?

- Information posted on website
- Information posted in waiting rooms
- Email to patients
- Other:____

Planning for Implementation and Evaluation

WHAT is your timeline for implementing collection of disability status and accommodation needs?

HOW will you monitor your progress in collecting disability status and accommodation needs?

- EHR audits
- Meet with staff for feedback
- Other:____

HOW often will you monitor your progress?

- Weekly
- Monthly
- Quarterly
- Other:____

HOW will you monitor whether the staff is appropriately asking the questions?

- Observation
- Recordings of calls

- Other:____

HOW will you monitor whether your processes align with federal, state, accreditation, etc. standards?

- Work with your organization's Disability Coordinator
- Work with your compliance office
- Other:____

HOW will you continue to engage leadership support in this work?

- Regular reporting of data
- Highlight positive patient stories
- Other:____

Use of Data

HOW will you include disability status and accommodation needs in regular reporting?

- Quality dashboards
- Daily/weekly rounds
- Department appointment report
- Scheduling reports
- Other:____

HOW will you use collected disability status data?

- Monitor quality on the following metrics (e.g., cancer screening rates, vaccination rates, etc.)
- Other:____

HOW will you use collected accommodations data?

- Monitor what equipment is used
- Identify where in the organization more accommodations are needed
- Other:____

Resources

WHAT resources will you need?

- FAQ pages
- Training materials
- Scripts
- Other:____

WHERE will you identify resources needed?

- Internally
    - Team meetings
    - Other departments/clinics
- Externally
    - Disability Equity Collaborative

- Other:____

Materials and Resources

1. Appendix 0.8: Disability Accommodations Examples
2. Appendix 2.4: Documentation EHR Features
3. Appendix 2.12: Documentation Training Materials

**Appendix 0.8 can be accessed in the General Resources chapter.*

Appendix 2.4

Documentation Electronic Health Record (EHR) Features

Below are suggested electronic health record (EHR) features to include in your disability status and accommodation needs build. These recommendations are informed by learnings from health systems across the country actively implementing documentation of disability status and accommodation needs in their EHRs.

Disability Field and Accommodation Needs Field Requirements

- For both Disability and Accommodation fields
  - Timestamped for when last entered/updated
  - Multiple disability types and accommodation needs can be selected
  - Once completed by anyone (see next section for options of people), previous values/information carried forward across systems/encounters
    - If new disability/accommodations are identified during verification by anyone (see next section for option of people), the new information is now the "default/baseline" information that would then be verified in subsequent visits (this is independent on who entered the information)
    - If a patient's responses are not verified, then their original disability/accommodations remain
  - Appears in Storyboard
    - "Alert" within the Banner or Sideboard. The staff/clinician can click and hover on the disability and the disability types and accommodation needs appear
  - Lives in demographics or personal information
  - Identical fields for companion
- Accommodation field
  - Accommodation needs will need to be a drop-down.
  - All accommodation options are available to all patients
  - For patients with an identified accommodation need, prompt study team to record whether the accommodation(s) was used, if not, why it was not (including patient decline). (Note: For the inpatient setting, this will likely only occur once at the beginning of the patient's stay.)
    - Can be completed at the beginning or end of an encounter
    - Can be completed by Medical Assistant, clinician, or another clinic staff member

Functions by Role

- Registration or Scheduling Staff Requirements
  - New patients: need a prompt to ask about disability status
  - New patients: need a user-friendly form to ask disability status questions and record answers
  - New patients: need a prompt to ask about accommodation needs based on reported disabilities
  - New patients: need a user-friendly form to ask accommodation needs questions and record answers

- Return patients: need a prompt to verify, update disability status, or complete if field is empty
  - User-friendly form, same as for new patients
- Return patients: need a prompt to verify or update accommodation needs
  - User-friendly form, same as for new patients

- Patients and Proxies Requirements
  - Via patient portal: need the ability to enter or verify disabilities anytime
  - Via patient portal: need the ability to enter or verify accommodation needs anytime
  - Perform both activities via web-based and mobile patient portal applications
  - Prompt during e-check to enter or verify disability
  - Prompt during e-check to enter or verify accommodation needs
  - Via patient kiosks need ability to enter or verify disabilities anytime
  - Via patient kiosks need ability to enter, verify accommodation needs anytime
- Medical Assistants, Rooming Registered Nurses, Front Desk Staff
  - New patients: need a prompt to ask about disabilities
  - New patients: need a user-friendly form to ask disability status questions and record answers
  - New patients: need a prompt to ask about accommodation needs based on reported disabilities
  - New patients: need a user-friendly form to ask accommodation needs questions and record answers
  - Return patients: need a prompt to verify, update disability status, or complete if field is empty
    - User-friendly form, same as for new patients
  - Return patients: need a prompt to verify or update accommodation needs based on disabilities
    - User-friendly form, same as for new patients
  - Run templated report to identify upcoming scheduled patients' accommodation needs
- Clinicians or Care Teams
  - Can edit the disability fields
  - Can edit the accommodation fields

Auditing and Reporting for Operations, Quality Improvement, and to Support Research

Discrete data elements

- Included item on Daily Activity Report (DAR) or other similar reporting for staff to plan for patient accommodation needs
- Data to support reporting of process
  - #/% events asked, verified
    - Includes who entered the information
  - #/% accommodations provided
    - Includes the accommodations provided
    - Includes reason why accommodation was not provided
    - Clinic (Epic department) the patient was scheduled in

  - Should be templated reports
- Data to support reporting of disability accommodation needs by geographic region, by practice, etc.
  - Need to be able to pull at one point of time if a patient had a disability during that encounter (note: it should be the reported disability status/accommodation need during the date range, which may be different from patients' current status and needs)
  - Needs to be prospective and retrospective

Appendix 2.5

LOINC Codes

LOINC Number	Method and Type	Class	Question Description	Status	ACS[a]	WG[b]	PCDQ[c]	Disability Type
69860-5		SURVEY.HHS	Do you have difficulty dressing or bathing	ACTIVE	x		x	Activities of Daily Living
69858-9		SURVEY.HHS	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions	ACTIVE	x		x	Cognition
75254-3	HHS.ACA Section 4302.ONC	SURVEY.HHS	Do you have difficulty communicating, reading, or do you have limited proficiency in English [HHS.ACA Section 4302.ONC]	TRIAL				Communication
98068-0		SURVEY. GNHLTH	Difficulty communicating in usual language	ACTIVE			x	Communication
75255-0	HHS.ACA Section 4302.ONC	SURVEY.HHS	Assistance needed [HHS.ACA Section 4302.ONC]	TRIAL				General
98079-7		SURVEY. GNHLTH	Do you need any additional assistance or accommodations during your visit	ACTIVE			x	General
69856-3		SURVEY.HHS	Are you deaf or do you have serious difficulty hearing	ACTIVE	x		x	Hearing
75250-1	HHS.ACA Section 4302.ONC	SURVEY.HHS	Are you deaf or do you have difficulty hearing [HHS.ACA Section 4302.ONC]	TRIAL				Hearing
69861-3		SURVEY.HHS	Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a physician's office or shopping	ACTIVE	x		x	Instrumental Activities of Daily Living
75253-5	HHS.ACA Section 4302.ONC	SURVEY.HHS	Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office or shopping [HHS.ACA Section 4302.ONC]	TRIAL	x		x	Instrumental Activities of Daily Living
98078-9		SURVEY. GNHLTH	Difficulty reading or writing	ACTIVE			x	Learning
69859-7		SURVEY.HHS	Do you have serious difficulty walking or climbing stairs	ACTIVE	x	x	x	Mobility
75252-7	HHS.ACA Section 4302.ONC	SURVEY.HHS	Do you have difficulty walking or climbing stairs [HHS.ACA Section 4302.ONC]	TRIAL				Mobility
69919-9	HHS.ACA Section 4302	PANEL. SURVEY.HHS	Race, ethnicity, sex, primary language, disability - Health and Human Services (HHS) panel [HHS.ACA Section 4302]	TRIAL				Title of questionnaire
75256-8	HHS.ACA Section 4302.ONC	PANEL. SURVEY.HHS	Disability information and assistance needed panel [HHS.ACA Section 4302.ONC]	TRIAL				Title of questionnaire
98067-2		PANEL. SURVEY. GNHLTH	Patient-centered disability questionnaire	ACTIVE				Title of questionnaire

69857-1		SURVEY.HHS	Are you blind, or do you have serious difficulty seeing, even when wearing glasses	ACTIVE	x		x	Vision
75251-9	HHS.ACA Section 4302.ONC	SURVEY.HHS	Are you blind or do you have difficulty seeing [HHS.ACA Section 4302.ONC]	TRIAL				Vision

[a]American Community Survey Questions
[b]Washington Group Questions
[c]Patient-Centered Disability Questionnaire

Appendix 2.6

Documentation Barriers and Strategies

Below is a list of potential barriers that may be encountered when implementing documentation of disability status and accommodation needs. The far-right column lists implementation strategies to address the barriers. You could use one or a combination of the implementation strategies listed for each barrier.

Refer to [Expert Recommendations for Implementing Change (ERIC) Discrete Implementation Strategies Table] for descriptions of each strategy.

Category of Barrier	Barriers to Documenting Disability Status/ Accommodation Needs	Possible Implementation Strategies
Leadership, staff, and provider attitudes	Not seen as priority Not viewed as required Not viewed as valuable	• Designate a formal implementation team • Develop a formal implementation blueprint • Identify and prepare champions who can emphasize the necessity and importance of documentation with their colleagues • Promote adaptability: Identify how documentation may be tailored to meet individual clinic or unit needs • Provide ongoing consultation and check-ins via Disability Coordinator, legal team, or other champion • Educate/train on legal and regulatory requirements, implications for patient satisfaction, patient and workforce safety, etc. • Provide training • Use reminders (electronic health record (EHR) alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
	Insufficient buy-in and being "voluntold"	• Designate a formal implementation team • Develop a formal implementation blueprint • Promote adaptability • Identify and prepare champions • Provide resources (e.g., 3 types of accommodations) • Educate on implications for patient satisfaction, patient and workforce safety, etc. • Use reminders (EHR alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
Staff and provider knowledge and comfort	Discomfort asking about disability status	• Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training • Use reminders (EHR alerts, tents, signs) • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Relay clinical data (i.e., what percentage of patients who had disability status and/or accommodation needs documented were able to receive care) to responsible individuals/roles

		• Kudos to high performing staff/clinicians/sites • Patient-facing educational materials
	Lack of knowledge about disability competency, language, preferences	• Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training • Provide staff and providers with tools (scripts, cheat sheets, quick guides)
	Hesitance to ask because: 1. Don't know what to do if disability is reported (e.g., unsure if they should offer accommodations) 2. System/clinic might not have the needed accommodation	• Change record systems/EHR • Conduct a needs assessment that assesses for readiness and identifies local barriers • Workflow mapping • Identify and prepare champions • Provide ongoing consultation and check-ins • Establish centralized technical assistance (i.e., how and when to provide an accommodation when documented) • Provide resources • Provide training • Use reminders (EHR alerts, tents, signs) • Provide staff with tools (scripts, cheat sheets, quick guides) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites • Patient-facing educational materials
	Lack of awareness that disability status are in the EHR and can change over time	• Change record systems/EHR • Workflow mapping • Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training • Use reminders (EHR alerts, tents, signs)
Workflow and logistics	Challenges coordinating across departments and roles	• Change record systems/EHR • Designate a formal implementation team • Conduct a needs assessment • Develop a formal implementation blueprint • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Provide training • Relay clinical data to responsible individuals/roles • Review staff performance data (i.e., how often disability status questions were asked during registration) to inform changes • Promote network weaving by strengthening relationships and collaboration within and outside of the organization, departments, or units

	Limited time available	• Conduct needs assessment • Reexamine the implementation plan • Identify early adopters • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Provide resources • Use reminders (EHR alerts, tents, signs) • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Relay clinical data to responsible individuals/roles • Review staff performance data to inform changes • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
	Not assigned responsibility for tasks	• Change record systems/EHR • Designate a formal implementation team • Conduct a needs assessment • Develop a formal implementation blueprint • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Relay clinical data to responsible individuals/roles • Review performance data to inform changes • Audit and provide feedback
Patient-level challenges	Patients not comfortable with disclosing a disability and/or putting information into a trackable system	• Conduct a needs assessment • Promote adaptability • Establish centralized technical assistance • Patient-facing educational materials
	Patients have different levels of comfort regarding who and where to disclose a disability. Patients have different abilities to access systems to disclose a disability.	• Workflow mapping • Promote adaptability • Establish centralized technical assistance • Provide training • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Relay clinical data to responsible individuals/roles • Patient-facing educational materials • Prepare patients/consumers to be active participants • Obtain and use patients/consumer and family feedback

Appendix 2.7

Documentation Disability Questions

Currently, there are no standardized requirements for which disability status questions to use. We present three sets of disability status questions. Each question set has 6-8 questions. It is important to note that the categories of disability types in the question sets below do not represent or capture all disabilities. For example, the questions are not specific to Autism Spectrum Disorder or other social communication disabilities, intellectual and developmental disabilities, learning disabilities, and mental health disabilities. Your organization might decide to expand the disability questions, especially if your community has a high prevalence of disabilities not represented in these questions. We recommend including patient response options of “none”, “decline to answer,” and “other disability”. When an “other” disability is indicated, there should be an option for a comment field to write in the disability.

Three Sets of Questions

1. American Community Survey (ACS) Disability Questions
2. Washington Group Disability Questions (modified)
3. Patient-Centered Disability Questionnaire

Regardless of which question set is used, it is important to ask all questions listed within the set to fully capture the patient’s needs. Using the Patient-Centered Disability Questionnaire, our study team tested asking one screener question versus all six disability questions.[1] In the case of the screener question, if a patient answered the question affirmatively, then the staff was instructed to ask the full set of six questions. We found that staff were more likely to ask the screener question than the full set of six questions. We found no difference in the percentage of those who reported a disability between asking only the screener question or the full set. However, more research is needed to confirm whether a screener question truly includes all patients. Therefore, to be comprehensive, the full question set is recommended at this time.

NOTE: These question sets ask about an individual’s functional impairments rather than their disability identity. It can be useful to ask about both a patient’s functional impairment, which provides important information about the individual’s accommodation needs, as well as disability identity, which, similar to asking other demographics questions, provides data to measure outcomes for populations at risk of disparities. This is a rapidly evolving area; research is underway to develop a question set that captures both function and disability identity. For now, we highly recommend using one of the question sets below.

ACS Disability Questions

Following the passage of Section 4302 of the Patient Protection and Affordable Care Act (ACA), the Department of Health and Human Services (HHS) recommended the use of the American Community Survey (ACS) Disability Questions.[2] The original intent of the questions was to provide population-level prevalence estimates of disability in the United States.

Benefits of using these questions:
    - These are standard questions in disability population surveys in the United States. This allows for interoperability of data across the healthcare system and population surveys.
    - The questions are endorsed by HHS and are recommended by the Office for the National Coordinator for Health Information Technology, which sets federal standards for electronic health records (EHRs).
- Potential drawbacks:
    - The questions have only been tested in the United States.
    - Several of the questions have long preambles, which might make implementation more challenging.
    - The "doing errands" question will not assist in identifying patients' accommodation needs in the healthcare setting or the disability(ies) they might represent.
    - These questions do not allow for interoperability and sharing of the data between healthcare systems that use the Washington Group questions.
- These questions have not been tested in a healthcare setting.
    - The questions are not inclusive of all disability types, including communication disabilities.

Washington Group Questions (Modified)

The United Nations Washington Group on Disability Statistics developed a set of six disability status questions. The original intent of the questions was to provide population-level prevalence estimates of disability throughout the world. As such, these questions have been implemented in countries all over the world.[3] The original Washington Group questions have multiple response options to indicate the extent of the functional impairment, as opposed to a yes/no response. We recommend using a yes/no response for easiest implementation.

- Benefits of using these questions:
    - The questions have been internationally tested and implemented with linguistically and culturally diverse groups.
    - The questions include a communication disability question.
    - Several of the question wordings are more concise than the ACS questions.
- Potential drawbacks:
    - The questions differ slightly from the ACS questions, meaning they do not allow for interoperability and sharing of the data between healthcare systems and public health data.
    - The questions have not been tested in the healthcare setting.
    - The questions are not inclusive of all disability types.
    - The original questions have multiple response options.

Patient-Centered Disability Questionnaire

The Disability Equity Collaborative team embarked on a series of studies to identify disability status questions to be used in healthcare organizations for the purposes of identifying

patients who require disability accommodations and tracking quality of care at an organization-level.[4] These studies included a survey, qualitative focus groups and interviews, a national Delphi panel, and cognitive interviews.

- Benefits of using these questions:
  - The questions incorporate aspects of both the ACS and the Washington Group questions.
  - The questions have been tested in the healthcare setting.[1]
  - The questions include a communication disability question.
  - The question set includes a general disability question.
- Potential drawbacks:
  - Since the questions are not identical to either the ACS or Washington Group questions, it is not possible to compare the full disability question set to public health data gathered using either of the two other sets of questions.
  - The questions are not inclusive of all disability types.

Disability Category	ACS Questions	Washington Group Questions	Patient-Centered Disability Questionnaire
Hearing	Are you deaf or having serious difficulty hearing?	Do you have difficulty hearing, even if using a hearing aid(s)?	Are you deaf, or do you have serious difficulty hearing?
Vision	Are you blind or having serious difficulty seeing, even when wearing glasses?	Do you have difficulty seeing, even if wearing glasses?	Are you blind, or do you have serious difficulty seeing, even when wearing glasses?
Cognition	Because of a physical, mental, or emotional problem, do you have difficulty remembering, concentrating, or making decisions?	Do you have difficulty remembering or concentrating?	Do you have difficulty remembering or concentrating?
Mobility	Do you have serious difficulty walking or climbing stairs?	Do you have difficulty walking or climbing steps?	Do you have serious difficulty walking or climbing stairs?
Activities of Daily Living (ADL) /Fine Motor	Do you have difficulty bathing or dressing?	Do you have difficulty with self-care, such as washing all over or dressing?	Do you have difficulty dressing or bathing?
Instrumental Activities of Daily Living (IADL)	Because of a physical, mental, or emotional problem, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?		Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a physician's office or shopping?
Communication		In your usual language, do you have difficulty communicating, for example understanding or being understood?	Using your usual language, do you have difficulty communicating (for example, understanding or being understood)?
General			Due to a disability, do you need any additional assistance or accommodations during your visit?

References

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Appendix 2.8

Documentation Workflows

Below are workflows organized by outpatient, inpatient, and emergency department settings.

Outpatient

Disability status can change over time. In the outpatient setting, patients should be asked about their disability status and accommodation needs annually or every six months. There are six options for when to collect this information from patients:

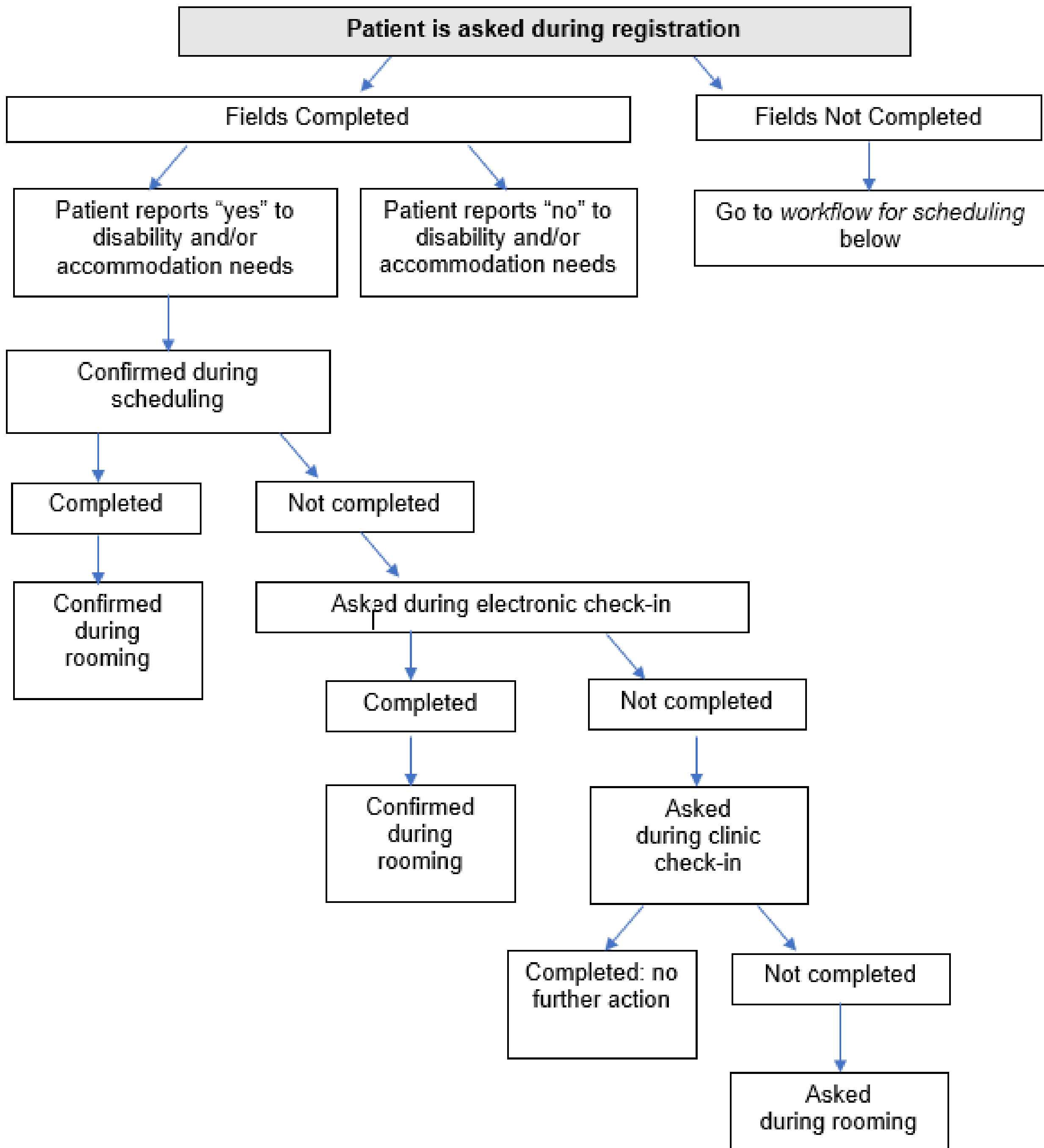
1. Registration
2. Scheduling
3. Electronic check-in
4. Clinic check-in
5. Rooming
6. Patient portal

The diagrams below demonstrate the different workflows for different time points.

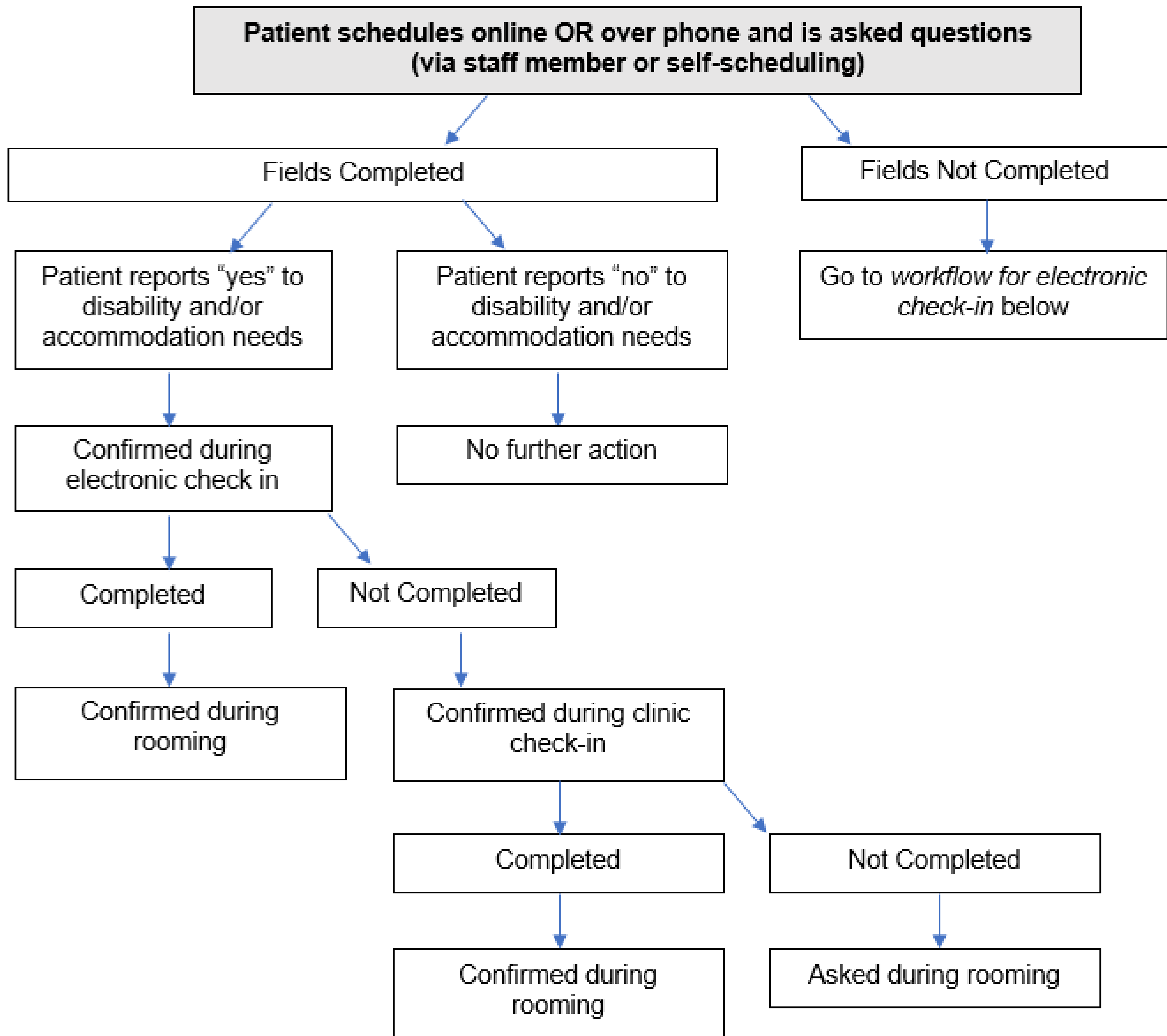
- If a patient reports a disability during registration or the patient portal, information should be confirmed during:
    1. Scheduling;
    2. Electronic check-in; or
    3. Clinic check-in.

If a patient reports a disability during check-in, information should be confirmed during rooming when the Medical Assistant ensures the patient has the accommodations they need.

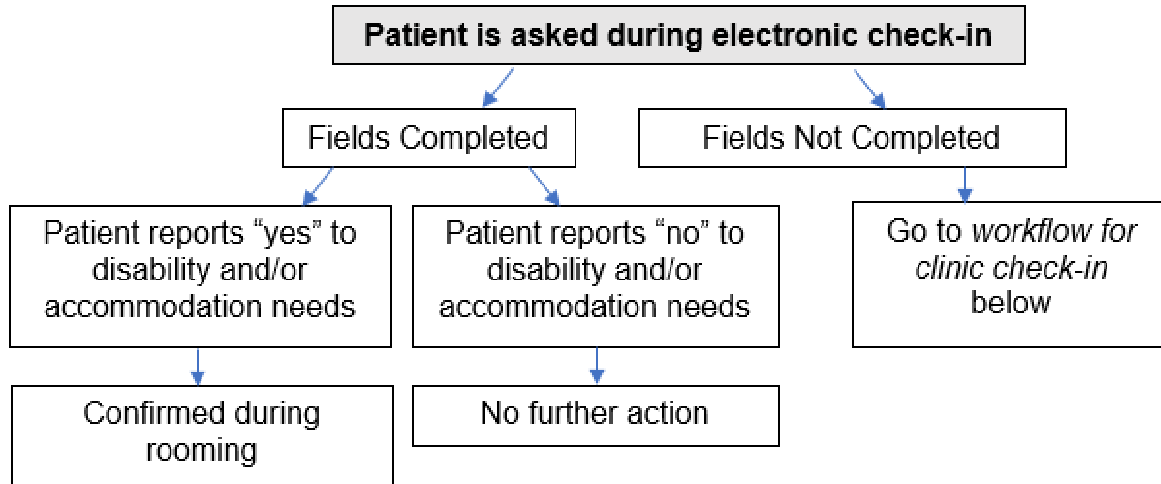
1. REGISTRATION



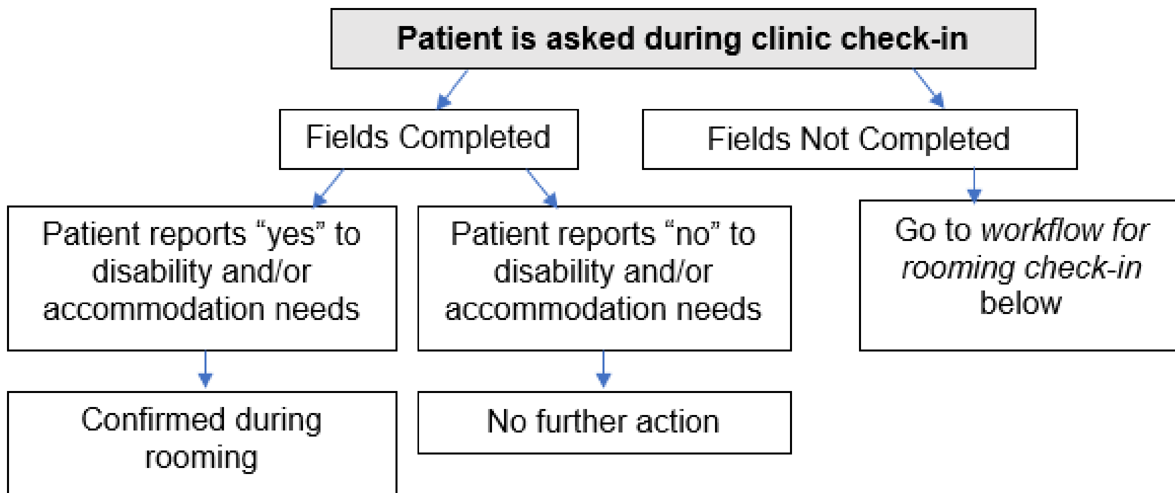
2. SCHEDULING



3. ELECTRONIC CHECK-IN



4. CLINIC CHECK-IN



5. ROOMING

Patient is asked during rooming

These tables list all options for who, when, what, and how to collect a patient's disability status and accommodation needs in the outpatient setting.

Pre-Appointment

WHO	WHEN	WHAT	HOW
Patient	Any time (at their leisure)	Invited to complete questionnaire	In patient portal
Patient	Scheduling appointment online	Asked disability status and accommodation questions	In patient portal
Patient	E-check-in	Asked disability status and accommodation questions	In patient portal
Scheduler	Scheduling appointment over phone	Asks disability status and accommodation questions	In EHR workflow
Registration staff	Registering patient over the phone	Asks disability status and accommodation questions	In EHR workflow

At Appointment

WHO	WHEN	WHAT	HOW
Front desk staff	In-person check-in	Asks disability status and accommodation questions and enters	In EHR workflow
Front desk staff	In-person check-in	Provides tablet/questionnaire to patient to complete pre-visit items including disability status and accommodation questions	Prompted in workflow
Medical assistant	Rooming	Asks disability status and accommodation questions and enters	In EHR workflow
Clinician	Encounter	Asks disability status and accommodation questions and enters	Ad hoc

After Appointment

WHO	WHEN	WHAT	HOW
Check-out staff	When scheduling next appointment at check-out	Asks disability status and accommodation questions and enters	In EHR workflow

Inpatient

You need to consider the pathway in which a patient is admitted and whether disability status was collected during admission. Disability status and accommodation needs should be asked during every admission. When selecting your process for documenting, consider whether a patient is admitted as an elective or planned admission, via the emergency department, or is transferred from another facility.

- **Patient is asked during patient registration**
  - Fields completed
    - Yes to disability and/or accommodation needs
      - Confirm during nurse intake
    - No to disability and/or accommodation needs
      - No further action
  - Fields not completed – *(go to workflow for nurse intake)*
- **Patient is asked during nurse intake process**

This table lists all options for who, when, what, and how to collect a patient's disability status and accommodation needs in the inpatient setting.

WHO	WHEN	WHAT	HOW
Registration	Registration	Asks disability status and accommodation questions and enters	In workflow
Intake nurse	During intake process	Asks disability status and accommodation questions and enters	In workflow
Bedside nurse	During any interaction	Asks disability status and accommodation questions and enters	Ad hoc
Clinician	During any interaction	Asks disability status and accommodation questions and enters	Ad hoc

Emergency Department

- **Patient is asked during registration**
    - Fields completed
        - Yes to disability and/or accommodation needs
            - Confirm during triage
        - No to disability and/or accommodation needs
            - No further action
    - Fields not completed – *(go to workflow for triage)*
- **Ask during nurse triage**

This table lists all options for who, when, what, and how to collect a patient's disability status and accommodation needs in the emergency department.

WHO	WHEN	WHAT	HOW
Registration	Registration	Asks disability status and accommodation questions and enters	In workflow
Triage	During triage	Asks disability status and accommodation questions and enters	In workflow
Bedside nurse	During any interaction	Asks disability status and accommodation questions and enters	Ad hoc
Clinician	During any interaction	Asks disability status and accommodation questions and enters	Ad hoc

Appendix 2.9

Documentation Frequently Asked Questions

Below is a list of frequently asked questions that staff or clinicians may present about the collection of patients' disability status and accommodation needs.

1. **Why is disability status and accommodation needs being collected?**
   To provide equitable, patient-centered care that responds to the needs of an organization's patient population, patients' disability status data needs to be consistently collected. Also, it's the law! Healthcare organizations must document patients' disability status to track the quality of care delivered to patients with disabilities and to identify patients who require healthcare accommodations.

2. **Why are these questions being collected by staff other than clinicians?**
   All healthcare team members need to be aware if a patient has a disability so that everyone from the scheduler to the clinician to the phlebotomist can accommodate patients with disabilities. Disability status and needs are patient reported and do not require clinical decision making to determine answers to the questions. Staff simply document what patients report to them in response to the questions.

3. **How do patients feel about being asked to disclose their disability status?**
   In surveys, 94% of patients with and without disabilities report being comfortable with healthcare organizations collecting their disability status information.

4. **How should I respond if someone refuses to answer the question?**
   Patients are not required to provide a response to the disability status questions. Staff should mark "Prefer not to answer" or "Declined to Answer" in the electronic health record if a patient does not want to answer.

5. **What do I do if a patient requests a specific accommodation and I'm not aware of whether we have it?**
   You could respond with: "Thank you for sharing your needs. At this time, we cannot guarantee that a specific clinic or facility will have the requested accommodation. However, I will make a note about this in your chart so that the clinic staff is aware of your needs."

6. **What if someone says they do not have a disability, but I think they might?**
   Disability status is a patient-reported field, just like race and ethnicity. Clinicians and staff should not assume or record a disability in the disability status field if the patient does not report having one.

Appendix 2.10

Documentation Who and When

Below are considerations when deciding by whom and when disability status and accommodation needs will be collected and documented.

General Considerations

- Prioritize collection during registration, scheduling, and e-check-in. Knowing about patients' accommodation needs early assists the team in preparing for the patient.
- Disability status and accommodation needs should be asked once and verified in subsequent visits. This minimizes the need to ask every time, while recognizing that disability status can change over time.
- Patients should indicate their disability status via the patient portal to minimize impact on staff and clinicians.
- The process for collection should be accessible to all patients with disabilities.
- Patients should have multiple opportunities to disclose disability status due to factors such as:
    - Different comfort levels with disclosing based on setting and collection method;
    - Disability needs that may affect the mode which they are able to disclose (e.g., if the patient portal is not accessible);
    - Disability needs that may vary from one appointment to the next, one healthcare setting to another, and may change over time.
- Considerations when developing a process for collecting disability status and accommodation needs:
    - What restrictions might be present in a clinic, site, or setting?
        - Do you have kiosks?
        - Is there a private location for patients to disclose in a waiting room?
        - Are there standard intake forms that the questions could be added to?
        - Even within the same organization, consider clinic-level differences (e.g., geriatric and family medicine clinic will have patients with different needs)
    - What might be patient restrictions?
        - Are there multiple manners or avenues for how a patient can disclose? Patients with cognitive or visual disabilities may not be able to or feel comfortable disclosing during e-check in or via portal.
        - Do few of your patients use the patient portal, or do patients lack the required technology to use the patient portal?
- Some patients might have non-apparent disabilities, and so it is important that all patients are asked about their disability status.
- Collection of disability status could be linked or grouped with collection of other demographic characteristics.
- Healthcare organizations are required to provide accommodations to caregivers who have disabilities. For example, if a caregiver is Deaf and their primary language is American Sign Language (ASL), healthcare organizations must provide an ASL interpreter for the caregiver. As such, you should collect disability status and accommodation needs from caregivers as well and store it in the patient's medical chart.

HOW: What methods should exist to collect information?

- There should be multiple ways to collect the information
    - Can be asked person-to-person during calls or encounters and entered by staff
    - Entered by patients in the portal
    - Entered by patients in tablets
    - Entered by patients using kiosks
    - Entered by patients using paper forms

WHEN: At what time points can information be collected?

- Ask regularly because disability status can change over time.
    - Repeated asks convey importance.
    - Could be collected initially and then verified prior to each subsequent visit (instead of asking the full set of questions at every visit).
- Before patient is seen by clinician
    - During registration
    - During pre-approval
    - During scheduling
    - During e-check-in
    - During in-person check-in
    - While in waiting room
- During clinical encounter
    - During rooming
    - While in exam room
- After patient is seen or at other incidental touchpoints
    - During check-out
    - During check-out when scheduling next appointment
    - Referrals from other physicians
    - Inpatient or Emergency Department encounter
    - Completing health insurance forms

WHO: What roles should collect and enter information?

- Overall considerations:
    - Multiple roles have this responsibility. It’s important to view it as everyone’s responsibility – though some may be the primary collectors or enterers of the information.
    - Completing the fields should be built into current workflows rather than a new field on a new page.
- Registration staff
- Scheduling staff
- Patient

PROCESS: How would the "what, when, by whom" actually happen?

- Electronic Health Record-supported:
  - incorporated into workflows
  - assigned to specific roles
  - possibility of pop-ups
  - hard or soft stops
  - interruptive best practice advisories
  - periodic reminders
- Consider how it will be integrated into telehealth encounters

Workflow Planning Tables

Pre-Appointment

WHO	WHEN	WHAT	HOW
Patient	Any time (at their leisure)	Invited to complete questionnaire	In patient portal
Patient	Scheduling appointment online	Asked disability status and accommodation questions	In patient portal
Patient	E-check-in	Asked disability status and accommodation questions	In patient portal
Scheduler	Scheduling appointment over phone	Asks disability status and accommodation questions	In EHR workflow
Registration staff	Registering patient over the phone	Asks disability status and accommodation questions	In EHR workflow
Pre-authorization staff	Pre-authorizing encounter	Contacts patient to ask disability status and accommodation questions	In EHR workflow
Triage nurse	Providing same-day appointment triage or advice	Asks disability status and accommodation questions	In EHR workflow
Receiver of referrals	Processing referral for patient to be seen at clinic	Requests disability status and need for accommodations from referring provider	In EHR workflow

At Appointment

WHO	WHEN	WHAT	HOW
Patient	Checking in on kiosk	Asked disability status and accommodation questions (& referred to front desk if affirmative?)	On kiosk
Patient	When front desk provides tablet at check-in	Asked disability status and accommodation questions (& referred to front desk if affirmative?)	On tablet
Front desk staff	In-person check-in when patient directed by kiosk or tablet	Asks disability status and accommodation questions and enters	In workflow
Front desk staff	In-person check-in	Asks disability status and accommodation questions and enters	In workflow
Front desk staff	In-person check-in	Provides tablet to patient to complete pre-visit items including disability status and accommodation questions	Prompted in workflow
Medical assistant	Rooming	Asks disability status and accommodation questions and enters	In workflow
Clinician	Encounter	Asks disability status and accommodation questions and enters	In workflow

After appointment and/or incidental contacts

WHO	WHEN	WHAT	HOW
Patient	After appointment	Patient post-appointment satisfaction questionnaire	Emailed link
Patient	After appointment	Patient post-appointment satisfaction questionnaire	In patient portal
Check-out staff	During check-out	Asks disability status and accommodation questions and enters	In workflow
Check-out staff	When scheduling next appointment at check-out	Asks disability status and accommodation questions and enters	In workflow
Billing staff	Any patient contact	Asks disability status and accommodation questions and enters	Prompted in workflow
Clinical staff	Any patient contact outside appointments	Asks disability status and accommodation questions and enters	In workflow

Appendix 2.11

Documentation Sample Script and Question Prompts

Sample Script*

Prompt: "The next set of questions asks about whether or not you have a disability. We are asking these questions to ensure we are helpful and meeting the needs of our patients."

1. Are you deaf or have serious difficulty hearing? (**deaf/hearing disability**)
2. Are you blind or do you have difficulty seeing, even when wearing glasses? (**blind/visually disability**)
3. Do you have serious difficulty walking or climbing stairs? (**mobility disability**)
4. Do you have difficulty remembering or concentrating? (**cognitive disability**)
5. Do you have difficulty dressing or bathing? (**manual dexterity disability or Activities of Daily Living disability**)
6. Using your usual language, do you have difficulty communicating (for example, understanding or being understood)? (**communication disability**)
7. Due to a disability, do you need any additional assistance or accommodations during your visit? **(other disability)**

A patient asks why this information is being collected or has concerns about answering the questions.

Q: **Why is this information being collected?**

> A: "We ask this question to patients at the clinic to learn more about our patient population and the accommodations that our patients with disabilities might need, such as large print documents for patients with visual disabilities, or height-adjustable exam tables for patients with mobility disabilities. This allows us to identify ways to best meet the needs of all of our patients. However, you can choose not to answer this question if you prefer."

*The above questions reference the Patient Centered Questionnaire. The script should be adapted depending on what questionnaire your clinic is using.

Appendix 2.12

Documentation Training Materials

What's Included:

1. Introduction to Training
2. Training Table: outlines who could be included in training, barriers that the training addresses, frequency of training, and format of training.
3. Table Tent: reminder template for staff who are collecting disability status
4. Clinic Signage Examples
5. Training slide deck an organization can use or modify to train their staff
    - Includes accompanying video demonstrations of clinic staff asking patients about their disability status and accommodation needs

Introduction to Training Resources

Who should be trained to ask the disability questions?

- Any staff member can ask the disability questions. These questions are not a clinical assessment and staff do not need any specialized clinical training. Staff should be trained on how to ask the questions and why the disability status questions are asked. Additionally, we suggest following basic disability language best practices so that staff know how to talk about disabilities in a patient-centered and respectful manner. Disability language best practices can be found in the General Resources chapter of the guide.

Training Table

Below is a table to help identify who will be trained and barriers that the training could address.

Who	Barrier the training could address	When	Format
Leadership	Not seen as a priority, required, or valuable Lack of disability competency - creating an affirming environment, making sure patients feel safe and welcome with needs met Lack of awareness of disability fields Lack of awareness of how to respond when there is a disability and accommodation need	• Annually • Ad hoc • Other	• Didactic • Other
Implementation team	Not seen as a priority, required, or valuable Lack of disability competency - creating an affirming environment, making sure pts feel safe and welcome with needs met Lack of awareness of disability fields in EHR Lack of awareness of how to respond when there is a disability and accommodation need and provide accommodations Challenge coordinating across departments and roles	• Orientation • Annually • Every two years • Every 6 months • Ad hoc • Other	• Didactic (could be in-person or online) • EHR tools (e.g., best practice advisories) • Laminated guides • Other
Clinician and staff (entering disability status and accommodation needs)	Not seen as a priority, required, or valuable Discomfort with asking questions – How to ask disability status in a respectful manner Lack of disability competency - creating an affirming environment, making sure pts feel safe and welcome with needs met Lack of awareness of fields Lack of awareness of how to respond when there is a disability and accommodation need and provide accommodations How to document disability status and accommodation needs in the EHR	• Orientation • Annually • Every two years • Every 6 months • Ad hoc • Other	• Didactic (could be in-person or online) • EHR tools (e.g., best practice advisories) • Laminated guides • Other

Table Tent

The next page is a resource that can be printed, folded, and placed on staff desks to serve as a reminder about what to say when asking about disability status and accommodation needs.

Prompt: "The next question asks about whether or not you have a disability, in order to help us train our staff and figure out how to be most helpful to our patients."

Screener: "Due to a disability, do you need any additional assistance or accommodations during your visit?"

If NO, do not ask any additional disability questions and move to next section.

Only if YES: "Thank you, now I'm going to ask you a few more questions about your needs."

1. Are you deaf or have serious difficulty hearing? (**deaf/hard of hearing**)
2. Are you blind or do you have difficulty seeing, even when wearing glasses? (**blind/visually impaired**)
3. Do you have serious difficulty walking or climbing stairs? (**mobility disability**)
4. Do you have difficulty remembering or concentrating? (**cognitive disability**)
5. Do you have difficulty dressing or bathing? (**manual dexterity disability**)
6. Using your usual language, do you have difficulty communicating (for example, understanding or being understood)? (**communication disability**)

Why is this information being collected?

A: We ask this question to patients at the clinic in order to learn more about our patient population and the accommodations that our patients with disabilities might need, such as large print documents for patients with visual disabilities, or height-adjustable exam tables for patients with mobility disabilities. This allows us to identify ways to best meet the needs of our patients.

Clinic Signage Examples

Why am I being asked if I have a disability?

We want to help.

We want to make sure all patients have what they need to participate in their visit. For example, you may require an adjustable exam table or large print materials. We want to have these accommodations available during your visit. This will help you get the most from your visit.

Not all visits are alike and people with disabilities are at higher risk for poor health and healthcare.

We want **ALL** our patients to have the same opportunity to be healthy.

For more info use the QR code for the Disability Equity Collaborative

[Insert clinic info and logo]

Training Slide Deck and Accompanying Videos

TRAINING SLIDE DECK LINKED HERE

The below videos accompany the slide deck during the indicated slide.

Registration Video: *slide 6*
Description: Patient calls in to schedule an appointment, registration staff register the patient, book appointment, and ask about disability status. (1 minute, 27 seconds)

Registration Video – Accommodation Requested: *slide 12*
Description: Patient calls in to schedule an appointment, registration staff register patients, book appointments, and ask about disability status. The patient is asking for accommodation regarding mobility. (3 minutes, 17 seconds)

Registration Video – Patient Declines to Answer Disability Questions: *slide 14*
Description: Patient calls in to schedule an appointment, registration staff registers patient, books appointment a patient and ask about disability status. Patient declines to answer question, scheduler validates patients right to decline. (1 minute, 12 seconds)

Registration Video – Accommodation Requested for Mobility and Service Animal: *slide 19*
Description: Patient calls in to schedule an appointment, registration staff registers patient, books appointment a patient and ask about disability status. Patient asks for accommodation regarding mobility and accommodating a service animal. (2 minutes, 28 seconds)

Registration Video – Patients with a Communication Disability: *slide 28*
Description: Patient calls in to schedule an appointment, registration staff registers patient, books appointment a patient and ask about disability status. Patient has a communication disability; registration staff provide additional time and notes in patient file. (3 minutes, 40 seconds)

Appendix 2.13

Documentation Monitoring Progress and Adaptations

Use this section to create a customized plan to track progress and adaptations made to your original implementation plan. In this plan, include a space to describe what changes or adaptations were made to the original implementation plan and the reason for the adjustment. Below are a few examples of adaptations that could be tracked.

HAVE practice leaders proactively removed organizational barriers to documenting disability status and accommodation needs?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT stage is the practice at in the process of documenting disability status and accommodation needs?

- Not started
- Just beginning
- Actively addressing
- Completed

HOW often are eligible patients screened (best estimate)?

- Never
- Up to 25% of time
- 26-50% of time
- 51-75% of time
- 76% of time or more

IS the practice collecting, reviewing, and reporting on disability status data and incorporating them into continuous quality improvement activities?

- Not started
- Just beginning
- Actively addressing
- Completed

IS the practice collecting, reviewing, and reporting on accommodation needs data and incorporating them into workflows to provide accommodations?

- Not started
- Just beginning
- Actively addressing
- Completed

ARE there standardized protocols within the practice workflow to conduct disability screening?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT modifications have been made to the original implementation plan across your organization and at each site?

- When?
- Why?
- Who requested the modification? Who executed the modification?
- How has this improved implementation?

Chapter 3

Providing Accommodations

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Orientation to Providing Accommodations Chapter

This document is one chapter of a broader Implementation Guide on providing accessible healthcare for people with disabilities. The chapter will guide you through providing accommodations at your clinic or organization. The information in this chapter is a synthesis of existing research and learnings from health systems across the country. It is intended to provide guidelines adaptable to your local context.

This chapter includes: 1) an introduction to the topic, 2) six steps for implementation, and 3) a variety of appendices. Under each step, the ***Actions and Tasks*** section outlines best practices and questions to consider while creating and implementing the provision of accommodations at your organization. The ***Materials and Resources*** section lists the relevant appendices, which include worksheets, templates, examples, and other resources to assist you in completing the ***Actions and Tasks*** of each implementation step.

Appendices can also be used independently as resources for providing accommodations. For example, you could use Appendix 3.4: *Accommodations Frequently Asked Questions* if you are only interested in sample responses to questions related to providing accommodations.

A note about terminology: Throughout this chapter, we refer to accommodations as any modification or adjustment made to standard processes in an organization to facilitate the full engagement of patients with disabilities in their healthcare. Healthcare organizations are legally required to make reasonable modifications of policies, practices, and procedures, ensure effective communication, and maintain accessible facilities for people with disabilities.[1-3] Healthcare organizations are also required to provide reasonable accommodations to their caregivers with disabilities.[4] In this guide, we refer to all such modifications as “accommodations”.

Accommodations can be requested by a patient to facilitate their participation in their care and should be documented in a patient’s chart (see *Chapter 2: Documenting Disability Status and Accommodation Needs*). In contrast, accessibility features such as accessible bathrooms and ramps should be available to all patients and do not need to be requested. Appendix 0.7: *Accessibility Screening Tool Template* in the General Resources chapter can help identify potential points of care and locations where accommodations or accessibility features should be available.

Introduction to Providing Accommodations

People with the same disabilities can benefit from a range of different accommodations. Patients should always be at the center of the conversation in determining which accommodations enable access to their care. It is also important to note that accommodations may be needed across a patient's healthcare journey beyond the clinical encounter – from registration to after-visit summaries. Accommodation needs might differ by setting and clinical encounter (e.g., a patient might need a different modification during an oncology appointment than at a blood draw appointment.)

Why is it important to provide accommodations?

A growing body of literature finds that people with disabilities experience disparities in health and healthcare outcomes.[5-7] For example, compared to non-disabled people, people with disabilities are more likely to have a greater number of chronic conditions and have higher rates of asthma, hypertension, emphysema, cardiovascular disease, diabetes, and arthritis.[5] People with disabilities are also more likely to rate the quality of their health as fair or poor.[8,9] Research has identified that a key factor in poor outcomes is the lack of provision of accommodations.[10-12]

What are the requirements for providing accommodations?

The Americans with Disabilities Act is a federal civil rights law that requires healthcare organizations to provide full and equal access to healthcare for people with disabilities.[1] It requires healthcare organizations to provide effective communication, establish accessibility standards, and make reasonable modifications to provide patients with disabilities access to the organizations' health programs and activities.

Additionally, healthcare organizations are required by Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act to provide disabled patients with accommodations, including auxiliary aids and services, to ensure access to care.[13] Healthcare organizations are also required to provide accommodations to disabled caregivers of patients.

Steps to Provide Accommodations

Step 1: Develop Leadership Support

When implementing any new accessibility initiative at your organization, earning buy-in from leadership is essential. Support from leadership will ensure you have the resources necessary to procure and successfully provide accommodations requested by patients with disabilities.

Actions and Tasks

1. Identify what types of leadership support and buy-in you will need.
2. Identify potential champions across your organization.
3. Identify how providing accommodations will fit within your organization's existing priorities and initiatives (e.g., health equity, quality and safety, patient experience goals, etc.).
4. Determine if your organization is involved in any regulatory initiatives that require providing accommodations (e.g., Joint Commission Excellent Health Outcomes for All Certification, U.S. Centers for Medicare and Medicaid (CMS) requirements, state-level requirements, etc.)

Materials and Resources

- Appendix 0.3: Federal Requirements
- Appendix 0.10 Leadership Support: Key Individuals

**Appendices 0.3 and 0.10 can be accessed in the General Resources chapter.*

Step 2: Identify Implementation and Leadership Team

The implementation team will be responsible for designing, leading, and monitoring the provision of accommodations across your organization.

Actions and Tasks

1. Identify the implementation team for providing accommodations.
    a. Consider including people across different departments and units within your organization.
    b. Include leadership and others who have the authority to make changes.
    c. Include staff who will be doing the work; they know their clinic workflows and will be helpful in implementing and piloting the project. This will also help with buy-in for the staff—who will more eagerly participate—and sustainability will be more attainable.
        i. It could be helpful to start with a pilot team to work through challenges before expanding to the entire clinic or healthcare system.
2. Determine the implementation team meeting structure.
    a. How often will the team meet?

   b. Is this a project that will be part of a quality improvement team or embedded within another team?
3. Identify champion(s) for the project
   a. Who is this person(s) going to be?
   b. Are they able to implement changes?
   c. Will they be a clinical champion or a non-clinical champion? Are both clinical and non-clinical needed?
   d. Is there someone at the *system level* with whom you can partner? For example, a Disability Coordinator or your organization's Section 1557 Coordinator might already be engaged in the delivery of accommodations.
4. Establish common goals for team.
   a. Ensure that it fits within organizational goals.
   b. Use SMART Goals (Specific, Measurable, Attainable, Realistic, and Time-bound)

Materials and Resources

- Appendix 0.6: Project Planning
- Appendix 3.1: Accommodations Implementation Team
- Appendix 3.5: Accommodations Barriers and Strategies

**Appendix 0.6 can be accessed in the General Resources chapter.*

Step 3: Needs Assessment

Identify the current state of documenting disability status and accommodation needs at your organization using Appendix 3.2: *Accommodations Needs Assessment*.

Actions and Tasks

1. Engage with other healthcare organizations to understand how they provide accommodations, including what is and isn't working for them. Consider joining the Disability Equity Collaborative's Leaders workgroup to create a peer network.
2. Determine how you will include patient perspectives.
   a. Will you include people with disabilities on your implementation team?
   b. Will you convene a patient advisory board?
   c. Will you conduct a patient experience survey?
   d. Will you engage disability community organizations?

Materials and Resources

- Appendix 0.7 Accessibility Screening Tool Template
- Appendix 0.8: Disability Accommodations Examples
- Appendix 0.9: Accommodations Inventory Table
- Appendix 3.2: Accommodations Needs Assessment
- Disability Equity Collaborative's Leaders workgroup

**Appendices 0.7 – 0.9 can be accessed in the General Resources chapter.*

Step 4: Determine What, How, When, and Who Will Provide Accommodations

In determining what accommodations your organization will provide, consider all essential activities required in a visit (e.g., scheduling, navigating within the facility, communication during and after the visit, etc.). Patients with disabilities should be able to access each of these essential activities. For example, if you provide after-visit summaries, plan accommodations so that patients with visual, cognitive, and communication disabilities can access these materials.

Actions and Tasks

1. Use your completed Appendix 0.7: *Accessibility Screening Tool Template* to determine what accommodations your clinic or organization will provide.
    a. Plan how equipment will be purchased, including which budgets will fund them.
    b. Identify the scope of the project. Consider if the accommodations will be available across the entire organization or a single clinic.
2. Decide how accommodations will be provided within a clinic. Aim to integrate the process into existing clinic and system-level workflows when possible. This step can include the following activities:
    a. Identify local barriers and facilitators to providing accommodations.
        i. For example, determine clinic level readiness and motivation for providing accommodations and potential pitfalls.
    b. Use the *Accommodations Implementation Planning* worksheet (Appendix 3.3) to specify site or clinic goals, strategies, timelines, milestones, and measures for providing accommodations.
    c. Create a workflow map, a visual representation of the actions, decisions, and tasks to be performed for successful provision of accommodations. Appendix 0.6: *Project Planning* includes example workflow maps. Consider the following details:
        i. Who will purchase the necessary equipment for disability accommodations?
        ii. How many of each accommodation will the clinic need?
        iii. Where will the accommodation be located?
        iv. How or when will new supplies be ordered?
        v. How will the accommodations be maintained?
        vi. What infection control issues need to be considered?
        vii. Who will schedule if the accommodation involves providing a service?
    d. Determine what can and cannot be adapted in the process for providing accommodations. For example, could there be different processes for different types of accommodations?
    e. Determine the resources needed to provide accommodations. For example, you will likely need to dedicate time for staff to complete trainings.
3. Following decisions made on workflows, processes, and roles, revisit the composition of the implementation team. Determine if additional individuals from departments or units that will be involved in any aspect of the process to provide accommodations should be included.

Materials and Resources

- Appendix 0.5: Policy Writing Guidance
- Appendix 0.6: Project Planning
- Appendix 0.7: Accessibility Screening Tool Template
- Appendix 0.8: Disability Accommodations Examples
- Appendix 3.2: Accommodations Needs Assessment
- Appendix 3.3: Accommodations Implementation Planning
- Appendix 3.5: Accommodations Barriers and Strategies

**Appendices 0.5 – 0.8 can be accessed in the General Resources chapter.*

Step 5: Pre-implementation

Ahead of implementation, consider the following actions to ensure staff, patients, and your organization's systems are prepared to provide and use accommodations.

Actions and Tasks

1. Identify, purchase, or develop necessary resources and accommodations.
    a. Establish relationships with service providers.
    b. Create policy adaptation documents (see Appendix 0.5: *Policy Writing Guidance*).
2. Ensure that identified accommodations can be documented in the electronic health record (EHR). (See Chapter 2: *Documenting Disability Status and Accommodation Needs* for additional information.)
3. Determine who will provide consultation to assist with training for staff and providers on use of accommodations.
    a. This person will offer expert guidance, feedback, and problem-solving to a site longitudinally.
    b. This can be a practice facilitator or similar role.
4. Determine who will provide technical assistance for both providing accommodations generally and the use of each accommodation.
5. Determine how accommodations will be maintained.
6. Create resources and trainings on how to use accommodations for staff and providers (see Appendix 3.7: *Accommodations Training Table*).
7. Identify or develop tools and reminders to encourage use of accommodations (see Appendix 3.4: *Accommodations Frequently Asked Questions*).
8. Identify or develop patient-facing education materials to disseminate information on available accommodations to patients.
9. Determine how success will be defined for providing accommodations, including appropriate metrics (e.g. were requested accommodations provided; patient, staff, and clinician satisfaction with the process, etc.).
    a. Specify how you will monitor or assess whether patients are receiving requested accommodations.
    b. Develop an evaluation plan to reflect your definition of success.

Materials and Resources

- Appendix 0.5: Policy Writing Guidance
- Appendix 3.3: Accommodations Implementation Planning
- Appendix 3.4: Accommodations Frequently Asked Questions
- Appendix 3.6: Accommodations Monitoring Progress and Adaptations
- Appendix 3.7: Accommodations Training Table

**Appendix 0.5 can be accessed in the General Resources chapter.*

Step 6: Implementation, Evaluation, and Monitoring

Roll out the implementation plan developed in previous steps to provide accommodations.

Actions and Tasks

1. Track and communicate rates of providing accommodations to responsible individuals (e.g., clinic leadership, those providing accommodations) and the implementation team.
2. Review site-level data on provision rates and determine if changes in workflow or strategies are needed.
3. Review site-level data to determine if additional accommodations are needed.
4. Make and document all needed adaptations.
5. Conduct Audit and Feedback, an implementation strategy that includes providing site-level staff, provider, or team-level data on providing accommodations to those assigned to perform tasks.
    a. For example, create a progress chart to display in a staff breakroom.
    b. This Audit and Feedback article details how to employ the strategy.
6. Recognize high performing staff, clinicians, or specific clinics or sites to recognize and celebrate high provision rates.

Materials and Resources

- Appendix 3.4: Accommodations Frequently Asked Questions
- Appendix 3.5: Accommodations Barriers and Strategies
- Appendix 3.6: Accommodations Monitoring Progress and Adaptations

Appendices Table

NAME	DESCRIPTION
Appendix 3.1: Accommodations Implementation Team	A list of all the individuals who could participate on the implementation team.
Appendix 3.2: Accommodations Needs Assessment	A worksheet to review the current landscape of an organization, identify mission, priorities, gaps, strengths, and specific goals for providing accommodations.
Appendix 3.3: Accommodations Implementation Planning	A worksheet to identify the future direction and processes that will be followed for implementing accommodations.
Appendix 3.4: Accommodations Frequently Asked Questions	A Frequently Asked Questions (FAQ) document for staff about providing accommodations.
Appendix 3.5: Accommodations Barriers and Strategies	A list of potential barriers to provide accommodations and possible strategies to address the barriers. Barriers are organized categorically.
Appendix 3.6: Accommodations Monitoring Progress and Adaptations	A worksheet to track progress and adaptations to the implementation plan.
Appendix 3.7: Accommodations Training Table	A training table that outlines who may be trained, what challenges, topics, or attitudes training could address, when to conduct training, and how.

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Appendix 3.1

Accommodations Implementation Team

Consider including these individuals on the team implementing accommodations within your organization.

1. Clinic manager(s)
2. Compliance or regulatory department representative
3. Directors of departments or groups who will be affected
    a. Scheduling director
    b. Registration director
    c. Medical Assistant director
    d. Nursing director
    e. Patient and Family Experience/Patient Relations
4. Disability coordinator(s)
5. Diversity, Equity and Inclusion leader
6. Executive or chief officers
7. Facilities management or representative from the organization's architectural group
8. Family and patient experience liaison
9. Patient(s) with disabilities or patient advisory board
10. Infection control
11. Interpreter service lead
12. Medical Assistant
13. Nurses
14. Operational and electronic health record analysts
15. Patient navigators
16. Project managers and/or quality improvement specialists
17. Purchasing department representative
18. Workforce safety/Safe patient handling
19. Inpatient or outpatient operation leads and project managers
20. Social workers or case managers
21. Child Life Specialist
22. Workflow consultants

Appendix 3.2

Accommodations Needs Assessment

Instructions:

- This assessment can be completed by anyone at any point in developing systems and processes for providing any type of accommodation. Questions that are not applicable to your organization or clinic can be skipped.
- Please note that Needs Assessments are long processes that require input and commitment from multiple partners within the organization and community to develop a robust and sustainable plan.

Current State of Providing Accommodations

This section will help you capture the current state of providing accommodations at your organization or clinic. The questions will work to identify existing resources, opportunities, and current processes.

Background

1. What is the motivation driving the development of systems and processes for providing accommodations?
    a. Are there specific populations you are focused on (e.g., people with physical disabilities, intellectual or developmental disabilities, etc.)? If so, why?
    b. Are there certain settings you are focused on (e.g., scheduling, specific specialty appointments, etc.)? If so, why?
2. What is the specific goal or desired outcome of developing processes to provide disability accommodations?
3. How does providing accommodations align with current organizational priorities (e.g. quality and safety; health equity; Diversity, Equity, and Inclusion)?
4. What, if any, leadership support is there for providing accommodations? What levels of support do you need (C-Suite, Director(s), Manager(s), etc.)?
5. What, if any, regulatory requirements are there for providing accommodations (e.g., Joint Commission Excellent Health Outcomes for All Certification, CMS requirements, state-level requirements etc.)

Accommodations

*Reminder: Questions that are not applicable can be skipped.

1. What accommodations are currently provided?

    a. Consider accommodations in the following categories (See *Appendix 0.8* in the General Resources chapter for a list of accommodations):
        i. Adapting a policy or process (e.g., allow patient to wait in private room)
        ii. Provide a “thing” (e.g., assistive listening devices)
        iii. Provide a service (e.g., sign language interpretation)
        iv. Scheduling a patient where an accommodation is located (e.g., exam room with a Hoyer lift)
        v. Change in clinician/staff interaction style (e.g., ask the patient how best to verbally communicate with them)
        vi. Staff provide assistance (e.g., assistance with transferring)
        vii. Modify the environment (e.g., low light)

    b. In which clinics or units are the accommodations available?

2. Are there any specific individuals, groups, or departments within your organization who are excelling at providing accommodations to patients?

    a. What types of disability do available accommodations support?

    b. Are existing accommodations available to caregivers with disabilities?

3. Is there a budget to provide disability accommodations?

    a. What types of budgets exist?

    b. Whose budget is used for the accommodations?

    c. What types of initiatives or supplies are covered by that budget?

4. Is there a list of the accommodations available across the healthcare system (clinics/units)?

   a. Is this posted internally?

   b. Is this posted externally so patients can view the list?

   c. Who maintains the list, and when has it last been updated?

5. How are available accommodations tracked in the organization?

6. What accommodations are listed in your electronic health record as options for patients?

7. What is the process for a patient to request an accommodation?

8. What is the process for a caregiver with a disability to request an accommodation?

9. What trainings are available for staff and clinicians on available accommodations and/or how to use the accommodations?

People

1. Who oversees what accommodations are prioritized and/or purchased?

2. Who oversees the provision of accommodations?

   a. How might this differ by type of accommodation?

   b. How might this differ by clinic?

3. Who might be your champions?
   a. Disability Coordinator (could be: “ADA Coordinator”, “Section 1557 Coordinator” or “Disability Accessibility Coordinator”)
   b. Clinician champion(s)?
   c. Practice managers?

d. If not, do you have someone who is willing to lead this work?

4. Who in your organization might have expertise on accommodations?

    a. Interpreter services?

    b. Rehabilitation departments?

Institutional Support:

1. What initiatives exist for providing access to care for patients with disabilities?

Identify Gaps and Struggles

This section will help you identify existing gaps and opportunities for future initiatives.

Based on the above information, describe your organization's:

1. Strengths: What internal factors exist that could facilitate providing accommodations in your organization?

2. Weaknesses: What internal barriers exist that inhibit providing accommodations at your organization?

3. Opportunities: What favorable external factors exist that could promote providing accommodations at your organization?

4. Threats: What external factors exist that have the potential to inhibit the success of providing accommodations at your organization?

Materials and Resources

1. Appendix 0.8: Disability Accommodations Examples
2. Appendix 0.9: Accommodations Inventory Table
3. Appendix 3.1: Accommodations Implementation Team
4. Appendix 3.7: Accommodations Training Table

**Appendices 0.8 and 0.9 can be accessed in the General Resources chapter.*

Appendix 3.3

Accommodations Implementation Planning

The following plan will help guide your work to provide accommodations at your organization.

INSTRUCTIONS: Use this worksheet to guide your overall organizational/clinic plan for providing accommodations. For each of the questions below, select or complete all that may apply. The following could serve as a practical worksheet or a thought exercise for your implementation team.

GOALS FOR THIS PLAN:

____

(Examples: “We plan to focus on federally mandated equipment.”; “We plan to focus on communication accommodations in the inpatient setting.”)

Team

WHO will be on the team to implement provision of disability accommodations?

WHO will be on the team to monitor and evaluate provision of disability accommodations?

WHO will coordinate provision of disability accommodations in the clinics, units, etc.?

WHAT other institutional partners will you need to engage?

Types of Accommodations

WHICH accommodations are you currently providing that you will continue to provide?

WHAT new accommodations will you offer? See Appendix 0.8 in the General Resources chapter for a list of examples.

WHAT accommodations will be available to patients across the entire organization?

If different from those listed above, WHAT accommodations will be available to caregivers across the entire organization?

WHAT accommodations will be available only to specific clinics? Which clinics?

WHAT accommodations are already listed in the electronic health record (EHR)?

WHAT accommodations will be newly listed in the EHR?

WHICH populations could benefit from the accommodations you will be providing?

WHAT gaps in patients' needs will the accommodations address?

Methods for Providing

Note: This step will likely be an involved process to map out your process for providing each accommodation.

WHAT is the workflow for providing each accommodation (or accommodation category), including who, what, and when?

WHAT is the workflow for maintaining accommodations (or accommodation category) including who, what, and when?

WHO designs and updates workflows? (See Appendix 0.6: *Project Planning* in the General Resources Chapter for workflow examples.)

Training and Buy-In

HOW will you inform staff and clinicians that your organization is providing accommodations?

- Newsletters
- Presentations at staff meetings
- Email announcements
- Other:____

HOW will you engage staff and clinicians and increase buy-in for providing accommodations?

- Training
- Kudos
- Other:____

WHAT tools will you use to promote providing accommodations?

- EHR tools (e.g., hard stop or yield signs)
- Email reminders
- Reminders at staff meetings
- Other:____

HOW will you train staff and clinicians on what accommodations are available?

HOW will you train staff and clinicians on how to use the accommodations?

WHERE will training materials be located?

- Internal website
- Other:____

HOW often will you provide training?

- New employee orientation
- Yearly
- Other:____

WHO will be trained/educated in providing accommodations?

WHO is trained for assistance with *particular* accommodations, such as helping with transfers?

- All staff
- Medical assistants
- Office manager
- Other:____

HOW will you inform patients and caregivers with disabilities of what accommodations are available?

- Notice by placards/flyers at front desk, waiting room, exam rooms
- Communication during appointment scheduling
- Medical staff will communicate during visit

Other:____

Planning for Implementation and Evaluation

WHAT is your timeline for implementing the provision of accommodations?

HOW will you monitor what accommodations are available and used within your organization?

WHAT process will you use to ensure that accommodations requests are fulfilled?

HOW will you monitor when to procure or implement a new accommodation that you currently do not have available?

HOW will you monitor the maintenance of accommodations?

HOW often will you monitor your progress to fulfill accommodations requests?

- Weekly
- Monthly
- Quarterly
- Other:____

HOW will you monitor whether your processes align with federal, state, accreditation, or other standards?

- Work with your Disability Coordinator
- Work with your compliance office
- Other:____

HOW will you continue to engage leadership in this work?

- Regular reporting of data
- Highlight positive patient stories
- Other:____

Resources

WHAT resources will you need? Reference your completed Needs Assessment.

- FAQ pages
- Training materials
- Scripts
- Other:____

WHERE will you identify resources needed?

- Within your clinic/department
    - Team meetings
- Other departments/clinics
- External to your organization
- Other:____

WHAT is the budget source for each accommodation (if needed)?

WHAT central resources (lists of accommodations, tip sheets, etc.) are available for the accommodations?

Materials and Resources

1. Appendix 0.6: Project Planning
2. Appendix 0.8: Disability Accommodations Examples
3. Appendix 0.9: Accommodations Inventory Table
4. Appendix 3.1: Accommodations Implementation Team
5. Appendix 3.2: Accommodations Needs Assessment

*Appendices 0.6, 0.8, and 0.9 can be accessed in the General Resources chapter.

Appendix 3.4

Accommodations Frequently Asked Questions

Below is a list of frequently asked questions that staff or clinicians may ask about providing accommodations.

1. **Are we required to provide accommodations?**
   Healthcare organizations are legally required to provide accommodations to patients with disabilities and their caregivers with disabilities to ensure equitable access to care. Providing accommodations supports timely, safe, and effective care for people with disabilities.

2. **What accommodations are we required to provide?**
   While there is no required list of disability accommodations, you are required to provide accommodations that enable patients with disabilities to access the same services and quality of care patients without disabilities receive. For example, you must have accessible medical equipment to ensure that all patients can be examined on a table, such as a Hoyer lift or adjustable height exam table. See Appendix 0.8: Disability Accommodations Examples for a list of sample accommodations. This list is not exhaustive and should be tailored for your site.

3. **What if a patient requests an accommodation that our organization doesn't have?**
   First, acknowledge their request and your intention to ensure that they can access their care. Apologize that the specific accommodation they've requested is not available, and tell them which accommodations you have that might meet their needs. Communicate with the patient to learn the supports they need and identify reasonable alternative accommodation(s).

   Remember that healthcare organizations are required to provide reasonable accommodations. Note the accommodation request and let the appropriate people in your organization (e.g., program managers, disability coordinator, quality, safety, patient relations, facilities) know of the request.

4. **What if a patient requests an accommodation, but it doesn't seem like they really need it?**
   As a healthcare provider or staff member, your role is to support access to healthcare for people with disabilities. The patient with a disability is the authority on their need for supports. You still need to provide the accommodation(s) the patient has requested. People can have disabilities that are not apparent.

Appendix 3.5

Accommodations Barriers and Strategies

Below is a list of potential barriers that may be encountered when implementing a plan for providing accommodations. The far-right column lists implementation strategies to address the barriers. You could use one or a combination of the implementation strategies listed for each barrier.

Refer to the Expert Recommendations for Implementing Change (ERIC) Discrete Implementation Strategies Table for descriptions of each strategy.

Category of Barrier	Barriers to Providing Accommodations	Possible Implementation Strategies
Leadership, staff, and provider attitudes	Not seen as priority Not viewed as required Not viewed as valuable	• Identify and prepare champions who can emphasize the necessity of providing accommodations with their colleagues • Promote adaptability: Identify ways the process of providing accommodations can be tailored to meet individual clinic or unit needs • Provide ongoing consultation and check-ins via Disability Coordinator, legal team, or other champion • Educate/train on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. • Use reminders (electronic health record alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
	Insufficient buy-in or being “voluntold”	• Identify and prepare champions • Promote adaptability • Educate/train on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. • Use reminders (electronic health record alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
Staff and provider knowledge and comfort	Discomfort asking about disability status	• Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training on use of accommodations • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Use reminders (electronic health record alerts, tents, signs) • Collect data (via patient experience surveys) related to provision of accommodations and relay to responsible individuals/roles • Kudos to high performing staff/clinicians/sites • Identify and celebrate early adopters
	Lack of knowledge about disability competency, language, preferences	• Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training • Provide staff and providers with tools (scripts, cheat sheets, quick guides)

	Hesitance to ask because do not know to provide Or System/clinic might not have the needed accommodation	• Assess staff readiness for providing accommodations and identify local barriers/factors contributing to hesitancy • Workflow mapping • Identify and prepare champions • Provide ongoing consultation and check-ins • Establish centralized technical assistance (i.e., how to use an accommodation) • Educate staff on available accommodations and processes for requesting one in their unit • Provide staff and providers with tools (e.g., scripts, cheat sheets, quick guides) • Use reminders (electronic health record alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites • Patient-facing educational materials listing which accommodations are available • Identify early adopters
	Lack of awareness that patients need accommodations or that the team is required to provide accommodations	• Workflow mapping • Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training on use of accommodations • Educate staff on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. • Use reminders (EHR alerts, tents, signs)
	Lack of knowledge about how to use the accommodation, including how to keep staff and clinicians up to date with knowledge about accommodations	• Establish centralized technical assistance • Provide training on use of accommodations • Use train-the-trainer strategies • Provide ongoing consultation and check-ins • Identify and prepare champions • Identify early adopters • Audit and provide feedback • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Use reminders (EHR alerts, tents, signs)
Workflow and logistics	Challenges coordinating across departments and roles	• Change record systems/EHR • Designate a formal implementation team • Conduct a needs assessment • Develop a formal implementation blueprint • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Provide training • Relay clinical data to responsible individuals/roles • Review staff performance data (i.e., how often disability status questions were asked during registration) to inform changes • Promote network weaving by strengthening relationships and collaboration within and outside of the organization, departments, or units

	Limited time, budget and resources available	• Conduct needs assessment • Reexamine the implementation plan • Identify early adopters • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Provide resources • Use reminders (EHR alerts, tents, signs) • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Relay clinical data to responsible individuals/roles • Review staff performance data to inform changes • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
	Competing demands and can put additional burden on the organization	• Change record systems/EHR • Designate a formal implementation team • Conduct a needs assessment • Develop a formal implementation blueprint • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Relay clinical data to responsible individuals/roles • Review performance data to inform changes • Audit and provide feedback
	Not assigned responsibility for tasks	• Change record systems/EHR • Designate a formal implementation team • Conduct a needs assessment • Develop a formal implementation blueprint • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Relay clinical data to responsible individuals/roles • Review performance data to inform changes • Audit and provide feedback

<table>
<tr><td rowspan="4">Patient-level challenges</td><td>Patients are unaware that they have the right to accommodations</td><td rowspan="4">Workflow mapping
Use reminders (EHR alerts, tents, signs)
Promote adaptability
Establish centralized technical assistance
Provide training to staff on what accommodations are available in the organization and how to share with patients
Provide staff and providers with tools (scripts, cheat sheets, quick guides)
Relay clinical data to responsible individuals/roles
Patient-facing educational materials
Prepare patients/consumers to be active participants
Obtain and use patients/consumers and family feedback</td></tr>
<tr><td>Patients are unsure of what accommodations are available</td></tr>
<tr><td>Patients are unsure of what accommodations they would benefit from</td></tr>
<tr><td>Patients don’t know how to request accommodations</td></tr>
</table>

Appendix 3.6

Accommodations Monitoring Progress and Adaptations

Use this section to create a customized plan to track progress and adaptations made to your original implementation plan. In this plan, include a space to describe what changes or adaptations were made to the original implementation plan and the reason for the adjustment. Below are a few examples of adaptations that could be tracked.

HAVE practice leaders proactively removed organizational barriers to providing accommodations?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT stage is the practice at in the process of providing accommodations?

- Not started
- Just beginning
- Actively addressing
- Completed

HOW often are patients provided the accommodations they request (best estimate)?

- Never
- Up to 25% of time
- 26-50% of time
- 51-75% of time
- 76% of time or more

ARE there standardized protocols within the practice workflow to provide accommodations?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT modifications have been made to the original implementation plan across your organization and at each site?

- When?
- Why?
- Who requested the modification? Who executed the modification?
- How has this improved implementation?

Appendix 3.7

Accommodations Training Table

Below is a table with examples for who may need to be trained, what challenges, topics, or attitudes training could address, when to conduct training, and how to conduct the trainings. This should be used as a starting point to develop a customized training plan for your organization.

<table>
<tr><th>Who</th><th>What</th><th>When</th><th>How</th></tr>
<tr><td rowspan="5">Leadership</td><td>Not seen as a priority, required, or valuable</td><td rowspan="5">• Annually
• Ad hoc</td><td rowspan="5">• Didactic</td></tr>
<tr><td>Lack of disability competency - creating an affirming environment, making sure patients feel safe and welcome with needs met</td></tr>
<tr><td>Lack of awareness of laws and requirements related to providing accommodations</td></tr>
<tr><td>Lack of awareness of evidence-based accommodations</td></tr>
<tr><td>Lack of awareness of how to respond when there is a disability and accommodation need</td></tr>
<tr><td rowspan="7">Implementation team</td><td>Not seen as a priority, required, or valuable</td><td rowspan="7">• Orientation
• Annually
• Every two years
• Every 6 months
• Ad hoc</td><td rowspan="7">• Didactic (could be in-person or online)
• EHR tools (e.g., best practice advisories)
• Laminated guides</td></tr>
<tr><td>Lack of disability competency - creating an affirming environment, making sure patients feel safe and welcome with needs met</td></tr>
<tr><td>Lack of awareness of laws and requirements related to providing accommodations</td></tr>
<tr><td>Lack of awareness of potential or available accommodations</td></tr>
<tr><td>Lack of awareness of how to respond when there is a disability and accommodation need</td></tr>
<tr><td>Lack of awareness of how to find and provide accommodations</td></tr>
<tr><td>Challenge coordinating across departments and roles</td></tr>
<tr><td rowspan="6">Clinician and staff</td><td>Not seen as a priority, required, or valuable</td><td rowspan="6">• Orientation
• Annually
• Every two years
• Every 6 months
• Ad hoc</td><td rowspan="6">• Didactic (could be in-person or online)
• EHR tools (e.g., best practice advisories)
• Laminated guides</td></tr>
<tr><td>Lack of disability competency - creating an affirming environment, making sure patients feel safe and welcome with needs met</td></tr>
<tr><td>Lack of awareness of available accommodations</td></tr>
<tr><td>Lack of awareness of how to respond when there is a disability and accommodation need</td></tr>
<tr><td>Lack of awareness on how to find and provide accommodations</td></tr>
<tr><td>How to use a given accommodation</td></tr>
</table>

Chapter 4

Effective Communication

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Orientation to Effective Communication Chapter

This document is one chapter of a broader Implementation Guide on providing accessible healthcare for people with disabilities. The chapter will guide you through how to implement effective communication initiatives at your organization. The information in this chapter is a synthesis of existing research and learnings from health systems across the country. It is intended to provide guidelines which are adaptable to your local context.

This chapter includes: 1) an introduction to the topic, 2) six steps for implementation, and 3) a variety of appendices. Under each step, the ***Actions and Tasks*** section outlines best practices and questions to consider while implementing effective communication at your organization. The ***Materials and Resources*** section lists the relevant appendices, which include worksheets, templates, examples, and other resources to assist you in completing the ***Actions and Tasks*** of each implementation step.

Appendices can also be used independently as resources for documenting disability status and accommodation needs. For example, you could use Appendix 4.7: *Verbal Communication Guidance* if you are only interested in learning strategies staff can use when communicating with people with communication disabilities.

In this chapter, we divide implementation of effective communication into establishing **policies and procedures** and providing **auxiliary aids and services (accommodations).** The terms “auxiliary aids and services” and “accommodations” are used interchangeably. For more information on providing accommodations, refer to *Chapter 3: Providing Accommodations.*

Introduction to Effective Communication

What is effective communication?

Effective communication is when communication with people with disabilities is just as effective as communication with people without disabilities.[1] According to the American Speech-Language-Hearing Association, effective communication happens when everyone can clearly and accurately exchange information in the ways that work best for them.[2]

Who are people with communication disabilities?

Patients with communication disabilities comprise over 14% of adults in the U.S.[3] Communication disabilities include speech, language, hearing, voice, and cognitive difficulties. They include persons with difficulty understanding others or expressing oneself through speaking, reading, or writing due to health conditions.

Why is it important to provide effective communication during healthcare delivery?

People with communication disabilities are more likely to experience poorer health and healthcare outcomes compared to their peers without these disabilities. Examples of these disparities include being more likely to report poor or fair health, delaying or forgoing preventive healthcare, and being more likely to seek care in the emergency department in the past year.[6-9] When hospitalized, people with communication disabilities experience three times more adverse events than adults without these disabilities.[10]

Effective communication, including the use of auxiliary aids and services, is integral to safe and high-quality care, shared decision making, and patients' feelings of trust and respect towards their healthcare team.

What are the requirements for effective communication in healthcare?

The Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act require that communication with people with disabilities be as effective as communication with people without disabilities, including by providing auxiliary aids and services when necessary.[11-14] Those auxiliary aids and services must be provided free of charge, in accessible formats, in a timely manner, and in a way that protects patient privacy.

Healthcare organizations must implement written procedures describing the process for ensuring effective communication for individuals with disabilities, including how to access appropriate auxiliary aids and services.[15]

Steps for Implementing Effective Communication

Step 1: Develop Leadership Support

When implementing any new accessibility initiative at your organization, earning buy-in from leadership is essential. Support from leadership will ensure you have the resources necessary to successfully create and implement effective communication policies and procedures.

Actions and Tasks

1. Identify what types of leadership support and buy-in you will need.
2. Identify potential champions across your organization.
3. Identify how providing effective communication will fit within your organization's existing priorities and initiatives.
4. Determine if your organization is involved in regulatory initiatives that require effective communication (e.g., Joint Commission Excellent Health Outcomes for All Certificate, state-level requirements, etc.)

Materials and Resources

- Appendix 0.3: Federal Requirements
- Appendix 0.10: Leadership Support: Key Individuals

**Appendices 0.3 and 0.10 can be accessed in the General Resources chapter.*

Step 2: Identify Implementation and Leadership Team

Effective communication is a shared organizational responsibility that must be embedded into routine clinical workflows, rather than delivered only through consultative or specialty services. Consider including people across different departments and units within your organization on your implementation and leadership team(s).

Actions and Tasks

1. Identify the implementation team for providing effective communication.
    a. Include leadership and others who have the authority to make changes.
    b. It could be helpful to start with a pilot or testing team to work through challenges before expanding to the entire clinic or healthcare system.
2. Determine the implementation team meeting structure.
    a. How often will the team meet?
    b. Is this a project that will be part of a quality improvement team or embedded within another team?
3. Identify champions for the project.
    a. Select person(s) to lead and champion the implementation team.
    b. Are they able to implement changes?

c. Consider the role of the champion(s): will they be a clinical champion or a non-clinical team member? Are both clinical and non-clinical needed? Will you include multidisciplinary champion(s) to support system-wide implementation? Is there someone at the *system level* who has been assigned this task that can help? For example, a Disability Coordinator?

Materials and Resources

- Appendix 4.1: Effective Communication Implementation Team

Step 3: Needs Assessment

Identify the current state of patient-facing communications at your organization using Appendix 4.2: *Effective Communication Needs Assessment*.

Actions and Tasks

1. Identify if and where effective communication policies and procedures are currently happening, including who is leading the work and the department or unit the work is happening in.
2. Engage with other healthcare organizations to understand their effective communication procedures, including what is and isn't working for them. Consider joining the Disability Equity Collaborative's Leaders workgroup to create a peer network.
3. Determine how you will include patient perspectives.
   a. Will you include people with disabilities on your implementation team?
   b. Will you convene a patient advisory board?
   c. Will you conduct a patient experience survey?
   d. Will you engage disability community organizations?

Materials and Resources

- Appendix 4.2: Effective Communication Needs Assessment
- Appendix 4.6: Effective Communication Accommodations Examples
- Disability Equity Collaborative's Leaders workgroup

Step 4: Determine What, When, and Who Will Provide Effective Communication

Part A: Policy Writing

When composing your effective communication policy, consider all essential activities required in a visit (e.g., scheduling, navigating within the facility, communication during and after the visit, etc.). Patients with disabilities should be able to access each of these essential activities. For example, if you provide after-visit summaries, ensure patients with visual, cognitive, and communication disabilities can access the materials.

Actions and Tasks

1. Establish the team responsible for developing or modifying your organization's effective communication policy.
    a. Will this team be different than your implementation team?
    b. Identify who will review drafts and ultimately approve your policy.
        i. Is there a department typically responsible for administrative policies?
        ii. Do other policies (i.e., nondiscrimination, grievance procedures) already exist? If so, who drafted them?
2. Identify the scope of the project. Consider if this policy will apply organization-wide or to a single clinic.
3. Review legal, regulatory, and accreditation requirements to determine what must be included in your policy.
4. Draft the policy in accordance with your organization's mission and values.
5. Engage the disability community and patients' perspectives for feedback.

Materials and Resources

- Appendix 0.4: Disability Organizations
- Appendix 4.1: Effective Communication Implementation Team
- Appendix 4.3: Effective Communication Implementation Planning
- Appendix 4.4: Effective Communication Policy Planning Guidance

**Appendix 0.4 can be accessed in the General Resources chapter.*

Part B: Communication Auxiliary Aids and Services (Accommodations)

Use the completed "Communication Auxiliary Aids and Services (Accommodations)" section of your Needs Assessment (Appendix 4.2: *Effective Communication Needs Assessment)* and reference Appendix 4.5: *Effective Communication Accommodations Examples* to determine what accommodations your clinic or organization will provide.

Actions and Tasks

1. Select the auxiliary aids and services your organization will provide.
2. Plan how equipment will be purchased, including which budget(s) will fund them.
3. Determine what staff (i.e., interpreters) your organization must hire, including what department will house them.
4. Identify the scope of the project. Consider if the accommodations will be available across the entire organization or a single clinic.
5. When procuring auxiliary aids and services, consider:
    a. Who will purchase the necessary equipment?
    b. How many of each accommodation will the clinic need?
    c. Where will accommodation(s) be located?
    d. How will clinicians and staff be made aware of where accommodation(s) are located and how to access them in real time?
    e. How or when will new supplies be ordered?
    f. How will accommodation(s) be maintained?
    g. What infection control issues need to be considered?

6. Using Appendix 0.9: *Disability Accommodations Inventory Table* in the General Resources chapter, decide how auxiliary aids and services will be provided within a clinic. Aim to integrate the process into existing clinic and system-level workflows when possible.
    a. Identify how patients will be asked about their preferred communication strategies and accommodation needs.
    b. Identify local barriers and facilitators to providing auxiliary aids and services.
        i. For example, determine clinic level readiness and motivation for utilizing aids with patients, such as communication boards.
    c. Use the *Effective Communication Implementation Planning* worksheet (Appendix 4.3) to specify site or clinic goals, strategies, timelines, milestones, and measures for implementing effective communication.
    d. Create a workflow map, a visual representation of the actions, decisions, and tasks to be performed to successfully provide accommodations. See Appendix 4.11: *Effective Communication Process Map* for a sample map of this process during a medical encounter.
        i. For example, identify someone responsible for scheduling interpreter services.
    e. Determine what can and cannot be adapted in the standard process for providing an auxiliary aid or service.
        i. For example, there will likely be different processes for providing Communication Access Real Time Translation (CART) during the medical encounter versus providing pre-visit paperwork during registration.
    f. Determine the resources needed to provide accommodations.
        i. For example, you will need to dedicate time for staff to complete trainings.
7. Revisit the composition of the implementation team. Determine if additional individuals from departments or units that will be involved in any aspect of the workflow/process to provide an accommodation should be included.

Materials and Resources

- Appendix 0.9: Disability Accommodations Inventory Table
- Appendix 4.2: Effective Communication Needs Assessment
- Appendix 4.3: Effective Communication Implementation Planning
- Appendix 4.4: Effective Communication Policy Planning Guidance
- Appendix 4.5: Effective Communication Accommodations Examples
- Appendix 4.11: Effective Communication Process Map

**Appendix 0.9 can be accessed in the General Resources chapter.*

Part C: Training

All patient-facing staff, clinicians, and interpreters should be trained on your effective communication policy and procedures to support successful implementation.

Actions and Tasks

1. Determine who will provide consultation to assist with training for staff and providers on your effective communication policy, the use of effective communication strategies, and providing auxiliary aids and services.
    a. This person (or people) will offer expert guidance, feedback, and problem-solving to a site longitudinally.
    b. This can be a practice facilitator or similar role.
2. Identify or create resources and trainings on effective communication strategies for staff and providers.
3. Identify or create resources and trainings on how to use auxiliary aids and services for staff and providers.

Materials and Resources

- Appendix 4.6: Effective Communication Training Resources
- Appendix 4.7: Verbal Communication Guidance
- Appendix 4.8: Written Communication Guidance
- Appendix 4.9: Deafness and Sign Language Guidance

Step 5: Pre-implementation

Prior to implementation, consider the following actions to ensure staff, patients, and your organization's systems are prepared to successfully implement effective communication.

Actions and Tasks

1. Determine who will provide technical assistance for both utilizing effective communication strategies, providing auxiliary services, and using auxiliary aids.
    a. Is this a speech-language pathologist? Interpreter?
2. Determine how auxiliary aid and service equipment will be maintained.
3. Identify or develop tools that will encourage staff to utilize effective communication strategies.
4. Identify or develop patient-facing education materials to inform patients of the new effective communication policy.
5. Determine how success will be defined for effective communication, including appropriate metrics (e.g. were requested aids and services provided; patient, staff, and clinician satisfaction with the process, etc.).
    a. Specify how you will monitor or assess whether patients are receiving requested aids and services.
    b. Develop an evaluation plan to reflect your definition of success.

Materials and Resources

- Appendix 4.4: Effective Communication Policy Planning Guidance
- Appendix 4.10: Effective Communication Frequently Asked Questions
- Appendix 4.12: Effective Communication Barriers and Strategies

Step 6: Implementation, Evaluation, and Monitoring

Roll out the implementation plan developed in previous steps to implement effective communication procedures.

Actions and Tasks

1. Track and communicate rates of compliance with effective communication policies, use of services, and provision of auxiliary aids and services to responsible individuals (e.g., leadership, those providing services or accommodations) and implementation teams.
2. Review site-level data on provision rates and determine if changes in workflow or strategies are needed. Determine if additional staff, services, or aids are needed.
3. Make and document all needed adaptations.
4. Conduct Audit and Feedback, an implementation strategy that includes providing site-level staff, provider, or team-level data on effective communication to those assigned to perform tasks.
    a. For example, create a progress chart to display in a staff breakroom.
    b. Audit and Feedback article that details how to employ the strategy.
5. Recognize high performing staff, clinicians, or specific clinics or sites to recognize and celebrate high completion rates.
6. Continue to solicit patient feedback and make adjustments to your implementation plan as necessary.

Materials and Resources

- Appendix 4.10: Effective Communication Frequently Asked Questions
- Appendix 4.12: Effective Communication Barriers and Strategies
- Appendix 4.13: Effective Communication Monitoring Progress and Adaptations

Appendices Table

NAME	DESCRIPTION
Appendix 4.1: Effective Communication Implementation Team	A list of all the individuals who could participate on the implementation team.
Appendix 4.2: Effective Communication Needs Assessment	A worksheet to review the current landscape of an organization, identify mission and priorities, gaps and strengths, and specific goals for implementing effective communication.
Appendix 4.3: Effective Communication Implementation Planning	A worksheet to identify the future direction and processes that will be followed for implementing accommodations.
Appendix 4.4: Effective Communication Policy Planning Guidance	Guidance, a checklist, and sample template to use when creating an effective communication policy.
Appendix 4.5: Effective Communication Accommodations Examples	A list of sample communication auxiliary aids and services (accommodations).
Appendix 4.6: Effective Communication Training Resources	A list of resources and a table that outlines who may be trained, what challenges, topics, or attitudes training could address, when to conduct training, and how.
Appendix 4.7: Verbal Communication Guidance	Provides examples, resources, and tools for effective verbal communication.
Appendix 4.8: Written Communication Guidance	Provides tips and resources for effective written communication.
Appendix 4.9: Deafness and Sign Language Guidance	Provides guidance for effective communication with patients who are deaf and use sign language as their main form of communication.
Appendix 4.10: Effective Communication Frequently Asked Questions	A Frequently Asked Questions (FAQ) document for health system staff about effective communication.
Appendix 4.11: Effective Communication Process Map	An example process map for providing auxiliary aids and services (accommodations).
Appendix 4.12: Effective Communication Barriers and Strategies	A list of potential barriers to implementing effective communication and possible strategies to address them. Barriers are organized categorically.
Appendix 4.13: Effective Communication Monitoring Progress and Adaptations	A worksheet to track progress and adaptations to the implementation plan.

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Appendix 4.1

Effective Communication Implementation Team

Below is a list of example roles and departments that include people who could participate on an effective communication implementation team.

1. Speech-language pathologists
2. Audiologists
3. Child life specialists
4. Occupational therapists
5. Health literacy specialists
6. Social workers and case managers
7. Interpreter services
8. Patient experience
9. Security
10. Nursing
11. Registration
12. Patient(s) with disabilities or patient advisory board
13. Families of patients with disabilities
14. Health IT
15. Compliance/Legal staff
16. Chaplain services

Appendix 4.2

Effective Communication Needs Assessment

Instructions:

- This assessment can be completed by anyone at any point in implementing effective communication. Questions that are not applicable can be skipped.
- Please note that Needs Assessments are long processes that require input and commitments from multiple partners within the organization and community to develop a robust and sustainable plan.

Current State of Accessibility

This section will help you capture a snapshot of the current landscape of effective communication at your organization or clinic. These questions will work to identify existing resources, existing opportunities, and describe the current processes.

Background

1. What is the motivation driving the development of systems and processes for implementing effective communication?
    a. Are there specific populations you are focused on (e.g., people with visual disabilities, hearing disabilities, or intellectual or developmental disabilities)?
    b. Are there certain settings you are focused on (e.g., scheduling, radiology appointments, etc.)
    c. Are there specific modalities of communication you are focused on (e.g., written, verbal, and/or electronic)?

2. What is the specific goal or desired outcome of implementing effective communication?

3. How does implementing effective communication align with any current organizational priorities (e.g., quality and safety; health equity; language interpretation)?

4. What, if any, leadership support is there for implementing effective communication?

5. What, if any, regulatory requirements are there for implementing effective communication (e.g., Joint Commission Certificates, U.S. Centers for Medicare and Medicaid requirements, state-level requirements, etc.)?

Policy and Procedures

1. What, if any, effective communication policies does your organization have?

2. Does your policy apply organization-wide or within certain clinics or units? If it is within specific clinics or units, list them.

3. What types of disability experiences do effective communication policies support?

4. How do you evaluate compliance with the policy?

Processes

1. What is the process for patients to request a preferred communication strategy or auxiliary aid or service? What is the process for caregivers with disabilities?

2. At what point(s) of care are communication-related needs questions asked of patients? Select all that apply.
   - During scheduling/registration
   - Electronic check-in
   - In-person check-in
   - Exam room
   - Patient portal
   - Other:____

3. What aids and services are listed in your electronic health record as options for patients?

   - Are these fields required, optional, or free-text?

4. What question(s), if any, about preferred communication strategies are systematically asked to patients?

Communication Auxiliary Aids and Services (Accommodations)

1. What communication auxiliary aids and services are currently available? See Appendix 4.5 for a list of examples.

2. In which clinics or units are these auxiliary aids and services available?

3. How are staff made aware of where auxiliary aids and services are located and how to access them at the point of care?

    a. INPATIENT ONLY: How will staff access auxiliary aids and services after hours?

4. What types of disabilities do your auxiliary aids and services support?

5. Are there any specific individuals, groups, or departments within your organization who are excelling at providing auxiliary aids and services?

6. Are existing aids and services available to caregivers with disabilities?

7. Is there a budget to implement effective communication across written/digital, verbal, and non-verbal communication modalities?

    a. What types of budgets exist?

    b. Whose budget is used for staff training vs. auxiliary aids and services?

    c. What types of initiatives or supplies are covered by that budget?

8. Is there a list of auxiliary aids and services available across the healthcare system?

    a. Is this posted internally?

    b. Is this posted externally so patients can view the list?

    c. Who maintains the list, and when has it last been updated?

    d. How are available communication accommodations tracked in the organization?

People

1. Who oversees how effective communication policies and procedures are implemented?
    a. How might this differ by clinic/department?
    b. How might this differ by communication strategies and services?
2. Who oversees how aids and communication equipment are prioritized/purchased?
    a. How might this differ by clinic/department?
    b. How might this differ by type of accommodation?
3. Who might be your champions? They could include:
    a. Disability Coordinator (i.e., “ADA Coordinator”, “Section 504 Officer”, “Section 1557 Coordinator”, “Disability Accessibility Coordinator”.)
    b. Clinicians
    c. Practice managers
    d. Interpreter services
    e. Other:____
4. Who in your organization might have expertise in effective communication and/or auxiliary aids and services?
    a. Interpreter services
    b. Rehabilitation departments
    c. Speech-language pathologists
    d. Audiologists
    e. Other:____

Training

1. What effective communication training do you currently provide to staff and clinicians?
    - ○ Policy procedures
    - ○ Communication strategies
    - ○ Providing/using auxiliary aids and services
    - ○ Other:____

2. How do you provide training?
   - Online modules
   - Simulations
   - Seminars/webinars
   - Other:____

3. Is there someone responsible for creating, updating, or facilitating training for staff and providers on effective communication policies?

Institutional Support

1. What initiatives exist for communicating effectively with all patients, potentially including patients with disabilities?

Identify Gaps and Strengths

This section will help you to identify gaps and opportunities for future initiatives.

Based on the above information, describe your organization's:

1. Strengths: What internal factors exist that could facilitate providing effective communication in your organization?

2. Weaknesses: What internal barriers exist that inhibit providing effective communication at your organization?

3. Opportunities: What favorable external factors exist that could promote providing effective communication at your organization?

4. Threats: What external factors exist that have the potential to inhibit the success of providing effective communication at your organization?

Materials and Resources

- Appendix 0.9: Disability Accommodations Inventory Table
- Appendix 4.1: Effective Communication Implementation Team
- Appendix 4.5: Effective Communication Accommodations Examples
- Appendix 4.12: Effective Communication Barriers & Strategies

Appendix 0.9 can be accessed in the General Resources chapter.

Appendix 4.3

Effective Communication Implementation Planning

The following plan will help guide your work in implementing effective communication into patient-facing interactions and written materials.

INSTRUCTIONS: Use this worksheet to guide your overall organizational/clinic plan for providing effective communication. For each of the questions below, complete all that may apply. Questions that are not applicable may be skipped. The following could serve as a practical worksheet or a thought exercise for your implementation team.

GOALS FOR THIS PLAN:

____

(*Example*: "We plan to focus on modifying our organization's effective communication policy.")

TEAM

WHO will be on the team to implement effective communication policies and the provision of communication auxiliary aids and services?

WHO will be on the team to monitor and evaluate implementation of effective communication policies and the provision of auxiliary aids and services?

WHO will coordinate the provision of auxiliary aids and services?

WHO will facilitate trainings for staff on your effective communication policies and procedures, including how to provide/use auxiliary aids and services?

WHAT other institutional partners will you need to engage?

POLICY WRITING

WHICH procedures in current effective communication policies will you keep in your new policy?

WHAT new effective communication procedures will you include in your policy?

WHO will review policy drafts? Who will ultimately approve your policy? Is this the same or different people?

HOW will you engage the disability community to incorporate patient and community perspectives in your policy? Select all that apply.

- Convene an advisory board of patients with disabilities
- Conduct patient experience surveys
- Review patient complaints about provider, staff, and organization communications
- Engage disability employee resource or affinity group
- Other:____

COMMUNICATION AUXILIARY AIDS AND SERVICES (ACCOMMODATIONS)

WHAT effective communication aids and services will be available to patients across the entire organization?

WHAT effective communication aids and services will be available only to specific clinics? Which clinics?

HOW will staff be made aware of where auxiliary aids and services are housed and how to access them at the point of care, including after hours?

WHAT effective communication aids and services are already or will be listed in the electronic health record?

WHICH populations, if not all, could benefit from the effective communication aids and services you will be providing?

WHAT gaps in patients' needs will the aids and services address?

METHODS FOR IMPLEMENTING EFFECTIVE COMMUNICATION

Note: This step will likely be an involved process to map out your process for each point of communication.

HOW will patients be asked about their preferred communication strategies and need for accommodation(s)? When?

HOW will caregivers be asked about their own preferred communication strategies and need for accommodation(s)? When?

HOW will communication needs and accommodation(s) be communicated across visits, care teams, and transitions of care?

WHAT is the workflow for implementing effective communication procedures and/or providing auxiliary aids and services, including who, what, and when?

WHAT is the workflow for maintaining effective communication procedures in each setting, including who, what, and when?

WHAT is the escalation pathway if requested accommodation(s) cannot be provided in real time?

WHO designs and updates workflows? (See Appendix 0.6: *Project Planning* in the General Resources Chapter for Workflow examples.)

Materials and Resources

- Appendix 4.12: Effective Communication Process Map

TRAINING AND BUY-IN

HOW will you inform staff and clinicians that your organization is prioritizing effective communication?

- Newsletters
- Presentations at staff meetings
- Email announcements
- Other:____

HOW will you increase buy-in with clinicians and staff for utilizing effective communication?

- Training
- Kudos
- Other:____

WHAT tools will you use to promote utilizing effective communication?

- EHR tools (e.g., hard stop or yield signs in)
- Email reminders

- Reminders at staff meetings
- Other:____

HOW will you train staff and clinicians on your effective communication policy and procedures, and what communication accommodations are available?

HOW will you train staff and clinicians on what auxiliary aids and services are available?

HOW will you train staff and clinicians on how to provide and/or use auxiliary aids and services? How will this differ depending on the aid or service?

HOW will you train staff and clinicians on how to use effective communication strategies?

WHERE will training materials be located?

- Internal website
- Other:____

HOW often will you provide effective communication training?

- New employee onboarding
- Annually
- Semi-annually
- Other:____

WHICH roles will be trained in effective communication strategies or to assist with auxiliary aids and services (all staff, clinicians, medical assistants, reception, etc.)?

HOW will you inform patients of your effective communication policies? Choose one or more.

- Notice by placards/flyers at front desk, waiting room, exam rooms
- Communication during appointment scheduling
- Medical staff will communicate during visit
- Other:____

EQUITY AND QUALITY

HOW will you ensure that the process of asking patients' preferred communication methods and does not reinforce stigma and discrimination?

- Training staff and clinicians
- Monitor patient complaints
- Other:____

HOW will you integrate effective communication into your quality and safety priorities and initiatives?

PLANNING FOR IMPLEMENTATION AND EVALUATION

WHAT is your timeline for implementing an effective communication policy, procedures, and providing auxiliary aids and services?

HOW will you monitor staff and clinician progress to follow effective communication procedures?

HOW will you monitor staff and clinician progress to use requested communication strategies?

HOW will you monitor progress in providing requested accommodations?

WHAT process will you use to ensure that staff and clinicians use requested communication strategies and provide requested accommodations (if different than process listed above)?

HOW will you elicit patient feedback on your delivery of effective communication?

HOW often will you monitor your progress?

HOW will you monitor whether your processes align with federal, state, accreditation, etc. standards?

- Work with your organization's Disability Coordinator
- Work with your compliance office
- Other:____

HOW will you continue to engage leadership support in this work?

- Regular reporting of data
- Highlight positive patient stories
- Other:____

RESOURCES

WHAT resources will you need? Select all that apply.

- Patient-facing education materials (FAQ pages, policy statements, signs, etc.)
- Training materials
- Scripts
- Communication toolkits
- Other:____

WHERE will you identify resources needed?

- Within your clinic/department
    - Team meetings
- Other departments/clinics
- External to your organization
- Other:____

WHAT central resources (e.g., lists of accommodations, tip sheets, etc.) are available for effective communication?

Appendix 4.4

Effective Communication Policy Writing Guidance

The Patient Protect and Affordable Care Act (ACA) requires healthcare organizations to create and implement an effective communication policy. The regulation states:

> "***Effective communication procedures.*** A covered entity must implement written effective communication procedures in its health programs and activities describing the covered entity's process for ensuring effective communication for individuals with disabilities when required under §92.202. At a minimum, a covered entity's effective communication procedures must include current contact information for the Section 1557 Coordinator (if applicable); how an employee obtains the services of qualified interpreters the covered entity uses to communicate with individuals with disabilities, including the names of any qualified interpreter staff members; and how to access appropriate auxiliary aids and services."[1]

Below, we included a brief checklist to consider when developing your effective communication policy. This is not an exhaustive list. Always coordinate with your compliance and/or legal department to ensure your policy complies with applicable laws and regulations.

Effective Communication Policy Checklist

The Health Resources and Services Administration recommends including the following in your effective communication policy:[2,3]

- Contact information for your Section 1557/Disability Coordinator
- Definition of who is entitled to auxiliary aids and services (i.e., people who are deaf, visually impaired, companions with disabilities, etc.)
- Examples of auxiliary aids and services that your organization has available
- How to respond to a request for services
- How long it should take to respond to requests
- Where devices (assistive listening systems, video remote interpreting (VRI) equipment, etc.) are stored
- Names of subcontractors that provide auxiliary services (interpreters, CART, Braille, etc.)
- Hours of when auxiliary services are provided
- Procedures for obtaining services last minute or during an emergency
- When it is appropriate to exchange written notes and when to call an interpreter
- Who is considered a qualified interpreter
- Language about friends, family, and third parties being unqualified to interpret
- Appropriate times and settings to use VRI

You may also consider including:

- Procedures for providing requests for auxiliary aids or services from companions or caregivers with disabilities
- How and how often the policy will be reviewed and updated for compliance

Public Notice of Effective Communication Policy

In settlement agreements,[4-6] the Office for Civil Rights at the U.S. Department of Health and Human Services—the office responsible for enforcing compliance with effective communication requirements—has required healthcare organizations to post effective communication policy statements that notify patients of the availability of free auxiliary aids and services and other information.

Effective communication policy statements should be posted in both staff and patient areas. Posted notices should be in plain language, multiple languages, and accessible formats. In a model policy,[7] the National Association of the Deaf (NAD) recommends including the following in your statement:

- Notice that your organization provides auxiliary aids and services to ensure effective communication for free;
- Examples of auxiliary aids and services available; and
- Contact information for your Section 1557/Disability Coordinator.

This statement should be posted:

- On signs, designed in accordance with the ADA Standards for Accessible Design,[8] at:
  - Admitting stations;
  - Emergency departments;
  - Nurses stations;
  - Patient and visitor elevator lobby; and/or
  - Wherever a Patient's Bill of Rights is required to be posted.
- In all printings of a patient handbook or similar publication;
- On internet and intranet websites; and to
- Distribute the policy to all patient-facing staff upon their employment and on an annual basis thereafter.

NAD Model Policy (PDF): **https://www.nad.org/wp-content/uploads/2020/04/Model-Hospital-Policy.pdf**

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Appendix 4.5

Effective Communication Accommodations Examples

The following is a list of examples of effective communication accommodations a healthcare system, hospital, or clinic could provide. The list is categorized by "auxiliary aids" and "services". See Appendix 0.8: *Disability Accommodations Examples* in the General Resources chapter for additional disability accommodations.

Auxiliary aids and services on this list that are similar or serve the same communication needs (i.e., visual, auditory, expressive communication, cognitive support, sensory support) are not necessarily substitutes for one another. Patients with disabilities request certain auxiliary aids and services based on their specific needs and preferred communication methods. Patients with disabilities may also need multiple aids and services to effectively accommodate their communication needs. Healthcare organizations should therefore have more than one accommodation available for any given communication need.

REMINDER: Under the Americans with Disabilities Act, patients with disabilities and their companions or caregivers with disabilities cannot be required to provide or cover the cost of the disability accommodations (auxiliary aids and services) they need. It is your organization's responsibility to provide reasonable accommodations to ensure equal access to care and offered services.

Auxiliary Aids

- **Sound signalers**: Flashes a light when there is a loud noise or a knock on the door.
- **Auditory or adaptive pill bottles**: A technology that reads prescription labels aloud.
- **Signature guides**: A tool that helps someone with a visual or fine motor impairment accurately sign documents. It is typically a sturdy piece of plastic or metal with one or more openings through which a person can trace or place their signature.
- **Communication boards**: A sheet or board with pictures, words, and symbols that the user can point to to communicate.
- **White board and dry-erase marker**
- **Text-to-speech apps and Speech-to-text apps**
- **Communication toolkits**: A prepared box or bag with common communication aids, including communication boards, dry-erase boards, sound amplifiers, and sensory fidgets. They are typically located in central locations such as nurses' stations.
- **Picture schedules and social stories**: Pictures that illustrate a medical test, procedure, or next steps in care.
- **Sound amplification device**: A device that amplifies sound for the listener.
- **Voice amplifier**: A device that amplifies a speaker's voice.
- **Portable hearing loops**: A device that wirelessly transmits sound directly into hearing aids or cochlear implants. It consists of a microphone, an amplifier, and a loop of wire that emits a magnetic field picked up by the telecoil in compatible devices, enabling clearer hearing in noisy environments.

- **Clear masks**
- **Video phone**
- **Print or written materials in alternative formats**, such as:
  - Pictures
  - Plain language
  - Audio recordings
  - Large print
  - Braille
- **Magnifiers**, including full page magnifiers
- **Screen readers**: software that allows blind or visually impaired users to read and use a computer screen with a speech synthesizer or braille display.
- **Audio description of video informational materials**
- **Audio treatment summary and instructions**
- **Noise cancelling headphones**
- **Sensory fidgets**
- **Sunglasses**
- **Accessible telehealth platforms with captioning and chat functions**

Services

- **American Sign Language or other sign language interpretation**
- **Communication Access Real Time Translation (CART):** Instant translation of spoken language through a transcriptionist who types on a notebook computer and uses real-time software.
- **Certified deaf interpreter**: Deaf or hard-of-hearing individual who is a native sign language user. They interpret sign language and incorporate gestures, miming, props, and other tools to provide detailed Deaf communication.
- **Cued speech interpreter**: Individuals who are trained to use a system of visual cues (hand shapes and positions) to make spoken language more accessible to individuals who are deaf or hard-of-hearing.
- **Speech to speech interpreter:** person trained to recognize unclear speech and repeat it clearly
- **Qualified note takers**: An individual knowledgeable on medical vocabulary and terminology who takes accurate notes
- **Document reader**: Someone available to read documents aloud.
- **Relay telephone calls**
- **Qualified reader:** An individual knowledgeable on medical vocabulary and terminology who can read written material verbally
- **Written or electronic appointment reminders and communication**

Appendix 4.6

Effective Communication Training Resources

To successfully implement effective communication under the Americans with Disabilities Act (ADA), the U.S. Department of Justice states, “Covered entities should teach staff about the ADA’s requirements for communicating effectively with people who have communication disabilities.”[1]

If staff are not aware of effective communication policies, effective communication strategies, and the availability of auxiliary aids and services, communication with people with disabilities will not be as effective as communication with those without. All patient-facing staff, clinicians, and interpreters should be trained in effective communication.

Training Resources

Healthcare organizations often purchase or create online modules, videos, resources, and materials for effective communication training. Below are some resources to get you started.

General

- Communicating with Patients with Disabilities | University of Illinois Chicago
- Effective Communication for Health Care Providers (PDF)
- ASHA Communication Access Resources: Education, Training, and Implementation
- ADA Healthcare Webinar Series: Effective Communication: Leveraging Alternate Formats in Healthcare
- NH Disability and Health Program Health Professional Training, Module 2: Accessible and Adaptive Communication

Critical Care Setting

- SPEACS-2 Communication skills training for providers caring for patients who are intubated

Aphasia

- Communication Tools: Communicative Access & Supported Conversation for Adults With Aphasia (SCA™)

Intellectual and Developmental Disabilities (I/DD)

- The National Roadmap for Disability-Inclusive Healthcare
- Webinar on Plain Language: Plain Language and Beyond: Developing Health Resources for People with Intellectual and Developmental Disabilities
- Just include Me

Training Table

Below is a table to help identify who may need to be trained, topics, when to conduct training, and how. Be sure that your trainings include role-specific responsibilities (e.g., who identifies a patient's need, who retrieves aids or requests services, who documents the request and its provision) to ensure each staff member clearly understands their role and responsibility for the implementation of effective communication.

<table>
<tr><th>Who</th><th>What</th><th>When</th><th>How</th></tr>
<tr><td rowspan="5">Leadership</td><td>Disability competency: creating an affirming environment; language to use with people with disabilities</td><td rowspan="5">Annually
Ad hoc</td><td rowspan="5">Didactic</td></tr>
<tr><td>Effective communication overview: what is effective communication; examples of communication disabilities; why effective communication is important</td></tr>
<tr><td>Laws and regulations related to effective communication</td></tr>
<tr><td>Language to use when speaking with people with disabilities</td></tr>
<tr><td>Staff responsibilities when a disabled person needs an auxiliary aid or service, including which roles/departments must be involved</td></tr>
<tr><td rowspan="7">Implementation team</td><td>Disability competency: creating an affirming environment; language to use with people with disabilities</td><td rowspan="7">Annually
Every two years
Every 6 months
Ad hoc</td><td rowspan="7">Didactic (could be in-person or online)
Laminated guides</td></tr>
<tr><td>Laws and regulations related to effective communication, including which patients are covered</td></tr>
<tr><td>Existing effective communication policy and involved departments (if applicable)</td></tr>
<tr><td>Effective communication strategies and accommodations (auxiliary aids and services) - what they are, how to use and how to find in organization</td></tr>
<tr><td>Disability competency: creating an affirming environment; language to use with people with disabilities</td></tr>
<tr><td>Laws and regulations related to effective communication, including which patients are covered</td></tr>
<tr><td>Existing effective communication policy and involved departments (if applicable)</td></tr>
<tr><td rowspan="6">Clinician and staff</td><td>Disability competency: - creating an affirming environment, language to use when speaking with people with disabilities</td><td rowspan="6">Orientation
Annually
Every two years
Every 6 months
Ad hoc</td><td rowspan="6">Didactic (could be in-person or online)
EHR tools (e.g., best practice advisories)
Laminated guides</td></tr>
<tr><td>Laws and regulations related to effective communication, including how they apply to staff and what patients are covered</td></tr>
<tr><td>Effective communication strategies and accommodations (auxiliary aids and services)</td></tr>
<tr><td>How to respond when there is a communication disability and accommodation need, including where aids and services are located and who is responsible for them</td></tr>
<tr><td>How to use communication auxiliary aids or services</td></tr>
<tr><td>Organization's effective communication policy</td></tr>
</table>

Reference

1. ADA Requirements: Effective Communication. Civil Rights Division, U.S. Department of Justice. Updated February 28, 2020. Accessed October 31, 2025. https://www.ada.gov/resources/effective-communication/.

Appendix 4.7

Verbal Communication Guidance

Effective communication involves all staff on the frontlines of patient care, from registration to physicians. Verbal communication takes place in person, over the phone, during virtual appointments, and more. This document provides examples and resources for verbal communication.

NOTE: This document is not comprehensive. It provides a high-level overview of example verbal communication strategies and tools. Keep in mind that effective verbal communication strategies *supplement* necessary auxiliary aids and services—they do not replace them. Work with an expert, such as an advisory committee or accessibility professional, to evaluate whether these examples meet the needs of your patients with disabilities.

Disabilities

Effective communication is essential and legally required for patients with any disability that can affect how they communicate, such as:

- **Hearing disabilities**: Deafness, hearing loss
- **Visual disabilities**: Blind, low vision
- **Cognitive and learning disabilities**: Intellectual and developmental disability, dementia, dyslexia
- **Speech disabilities:** Stuttering or dysarthria or apraxia due to conditions such as Cerebral Palsy, stroke, or ALS
- **Language disabilities:** Aphasia, developmental language delays, Autism
- **Mental health disabilities:** Anxiety, post-traumatic stress disorder

Verbal Communication Strategies

There are many strategies, approaches, and tips for effectively communicating with people with disabilities. The following are a few example strategies staff can use when interacting with patients with disabilities.

Interact Tool

The research team behind the Patient-Centered Outcomes Research Institute (PCORI)-funded Interact Trial developed a communication tool that patients with communication disabilities can use with their clinicians. Access a free, publicly available version of the tool here.[1] The following are communication strategies that patients may benefit from. It is important to remember that every patient has different preferences and needs for the strategies. A team member should always ask the patient first about their preferences.

➢ ***When Speaking***

- Look at the patient.
- Use age-appropriate language.
- Speak in short phrases and sentences.
- Ask yes or no questions.
- Speak at a clear, medium pace.

- Frequently check that the patient understands what you said.
- If a patient does not understand, rephrase what you said – do not repeat.
- Let the patient know when you are switching topics.
- Use printed words or pictures for the patient to point to when answering questions.
- Write keywords while you are talking where the patient can see them.
- Use meaningful gestures, i.e., point to your stomach when asking if their stomach hurts.

➢ ***When Listening***

- Look at the patient.
- Provide the patient extra time to process what you said.
- Provide the patient extra time to speak.
- Avoid interrupting or guessing what the patient is saying, even if they are struggling.
- Ask permission to guess if the patient is frustrated.
- Let the patient know when you don't understand and ask them to explain.

For Patients Who are Blind or Low Vision

- Identify yourself clearly when entering the room or starting a conversation.
- Explain procedures and examinations before performing them. Announce what you're going to do before touching the patient.
- Describe surroundings and obstacles in the patient's path to help them navigate the space. Use distances and clock faces to describe positioning.
  - "There is a table in the middle of the room, about six feet in front of you."
  - "From where you are facing, the weight scale is at the 3 o'clock position about 3 feet in front of you."
- Offer assistance in navigating a space. Ask the patient if they would like help before providing it or touching the patient.
- Describe any visual elements, gestures, or non-verbal cues that are important to the conversation.
- Offer alternative options to access written materials (See Appendix 4.8: *Written Communication Guidance*).

Verbal Communication Tools

The following are a few examples of communication tools developed by DEC and other organizations to help facilitate effective verbal communication between patients and providers.

Communication Passports

Communication passports are worksheets or workbooks containing information about a patient's demographic and medical information, preferred methods of communication, and other care needs. Communication passports can be an efficient method for people with disabilities to share their care and communication needs with their providers before an exam, treatment, or other form of care occurs. Below are a few examples:

- The Les Turner ALS Foundation: ALS Communication Passport
- Hearing Loss Association of America (HLAA): Communication Access Plan (PDF)

Resource Kits

Several other organizations have compiled or developed communication resources for providers:

- Academic Autism Spectrum Partnership in Research and Education (AASPIRE): Healthcare Toolkit
- HLAA: Resources for Providers

PACE

The acronym PACE can help staff and providers remember commonly requested strategies. Slow down the PACE of speech.

- **P**: Use **P**LAIN language
  - Use common, familiar words.
  - Avoid jargon.
  - Keep sentences short.
  - Use an active voice. Focus on who is doing the action: "You may need a test rather than a test may be needed."
- **A: A**sk about and adapt to communication preferences
  - "What are ways I can support your communication?"
  - "How do you communicate best?"
- **C:** "**See**" the patient. Address the patient first and look at them when speaking
- **E:** Assess the **E**nvironment. Minimize background noise and stimuli.

Reference

1. Hickey E, Man B, Helm KVT, Lockhart S, Duffecy J, Morris MA. Preferred Communication Strategies for People with Communication Disabilities in Health Care Encounters: a Qualitative Study. *J Gen Intern Med*. Apr 2024;39(5):790-797. doi:10.1007/s11606-023-08526-4

Appendix 4.8

Written Communication Guidance

Effective communication involves all aspects of patient care. This document provides examples and resources for effective communication in written materials.

NOTE: This document is not comprehensive. It provides a high-level overview of considerations for ensuring written communications are accessible. Keep in mind that effective written communications and materials *supplement* necessary auxiliary aids and services—they do not replace them. Work with an expert, such as an advisory committee or accessibility professional, to evaluate whether your materials are accessible.

Disabilities

Accessible written communication materials should be considered for individuals with the following disabilities:

- **Hearing disabilities**: Deafness, hearing loss
- **Visual disabilities**: Blind, low vision
- **Physical disabilities**: Upper extremity weakness from a high-level spinal cord injury, ALS, Parkinson's Disease, Multiple Sclerosis (MS)
- **Cognitive and learning disabilities**: Intellectual and developmental disability, dementia, dyslexia
- **Language disabilities:** Aphasia, developmental language delays, Autism

Examples of Written Communication

Written communication can be found throughout the healthcare encounter. Consider both patient reading and patient writing. The following are a few examples of where written communication can appear in a patient's healthcare experience:

- After-visit summaries
- Consent forms
- Medication or treatment instructions
- Notices for upcoming appointments
- Notification of policies and patient rights
- Billing statements
- Signs throughout a facility

Visual Accessibility Suggestions for Print Materials

There are a range of guidelines and suggestions for ensuring print materials are visually accessible. We highly recommend consulting with your organization's design team, an accessibility professional, and/or an advisory committee. Below are a few tips for accessible print materials:

- Use sans serif font (Arial, Helvetica, or Verdana)
- Avoid bold or italics

- Use font that is at least 14 point
- Use 1.5 or more line spacing
- High contrast colors (Black writing on white paper)
- Don't rely on color alone to convey meaning

It is not enough to simply enlarge documents. When a document's font is enlarged, the formatting must still be readable and comprehensive.

Here are a few other resources for creating accessible print materials:

- Section 508 Compliance Guidance: Accessible Fonts and Typography
- National Disability Rights Network: Accessibility Guidelines
- American Council of the Blind: Large Print Guidelines

Visual Accessibility Accommodations

In addition to ensuring print materials are written in accessible fonts, sizing, and contrasts, patients with visual disabilities may need accommodations to access your written communications. Consider having common documents, such as HIPAA forms, readily available in large print and other accessible formats.

Patients with visual disabilities may require print or written materials in:

- Large print versions
- Recorded spoken audio versions
- Braille versions
- Electronic versions

The following are additional accommodations that can support patients with visual disabilities:

- Auditory pill bottles
- Signature guides
- Magnifiers, including full page magnifiers
- Staff to orient blind or low vision patient to the room
- Staff to assist with navigating to and within a facility
- Staff to read written information aloud in private rooms
- Light dimmers/brighteners

Accessible or Plain Language

People with cognitive, communication, and/or learning disabilities often benefit from accessible or plain language documents. The following are some tips for creating accessible or plain language documents:

- Aim for materials to be at 3rd-5th grade reading level
- Use active voice
- Keep language simple and direct
- Limit one sentence to one idea
- Use bullet points or simplified tables
- Avoid jargon or acronyms
  - **NOTE**: While you may remove medical jargon, using plain language does not mean leaving out medical content or the meaning of the information. Technical terms are replaced with everyday words, communicating the same information in clear, digestible language.

For some patients, consider adding graphics or pictures to illustrate written information. For example, when providing a patient with directions for a new medication, include a picture of the bottle and pills, as well as graphics indicating when to take the medication.

To learn more about accessible and plain language document recommendations, navigate to the UCEDD Resource Center.

Web and Electronic Communication Accessibility

Communication in healthcare happens virtually via websites, patient portals, emails, and telehealth. Healthcare organizations are required to ensure all communication platforms are accessible, including items such as images and test results that are uploaded to a patient's chart. All patients should have equitable access to these virtual options via accessibility features like Alt text, screen reader compatible PDF documents, captioned videos, and more. Additionally, it is important to provide patients choices. For example, patients should not be required to only communicate with their provider's office via the patient portal.

It is beyond the scope of this chapter to provide comprehensive guidance on how to ensure that your electronic communication channels and platforms are accessible. As these technologies evolve, so do the standards. We recommend reviewing the latest Web Content Accessibility Guidelines (WCAG) standards for websites and web-based content from the World Wide Web Consortium (W3C), and work closely with your organization's IT team(s).

Appendix 4.9

Deafness and Sign Language Guidance

The following is an overview of recommendations/guidelines for providing accessible communication to patients who are Deaf/deaf and use sign language as their main form of communication. We recommend working with your organization's interpreter services team to develop guidelines and processes for providing timely and effective sign language interpretation. If someone uses sign language and requests a qualified sign language interpreter, **you are required to provide one**.

American Sign Language (ASL) is a distinct language that is grammatically different from English. It is also important to remember that not everyone who uses sign language is fluent in ASL; there are different types of sign language. For example, Signed Exact English is used in some English-speaking countries.

Virtual Remote Interpreting (VRI) Requirements

For patients who are deaf and use sign language, it is best to use an in-person sign language interpreter. If this is not possible, you may provide video remote interpreting (VRI) services to virtually connect the patient with a qualified interpreter. Remember, federal law mandates that staff who use or set up VRI must be adequately trained, and VRI must display:[1-3]

- Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth connection with high-quality video images that do not lag or produce choppy, blurry, or grainy images or irregular pauses in communication;
- A sharp image that is large enough to display both the interpreter and the patient's face, arms, hands, and fingers, regardless of body position; and
- A clear, audible transmission of voices.

To meet these requirements, consider the technological standards outlined by the National Association of the Deaf (NAD) under "Minimum Requirements for VRI Technology and Equipment" here.

Interpreters and Effective Communication Policies

Additionally, your organization's effective communication policy should contain the following information regarding interpreter services:

- When it is appropriate to exchange written notes and when to call an interpreter
- Who is considered a qualified interpreter
- Language about friends, family, and third parties being unqualified to interpret
- Appropriate times and settings to use VRI

Written Notes

For patients who use sign language, it is **NEVER** appropriate to exchange written notes alone. Written notes do not provide equivalent access to information or interaction. Additionally, as noted above, ASL is a distinct language that is grammatically different from

English. Written communication can therefore be an ineffective method for communicating to and with a sign language user.

A qualified sign language interpreter must be called for all patients that use sign language to communicate. If a patient who is deaf or hard of hearing does not use sign language, ask them their preferred communication strategy. For some, written notes could be a preferred method of communication.

Qualified Interpreter

A "qualified interpreter" is, "someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary."[4] Qualified interpreters, "adhere to generally accepted interpreter ethics principles including client confidentiality."[5]

State law may require interpreters to be certified; we strongly recommend working closely with your organization's legal team to ensure compliance with all federal, state, and local laws and regulations.

Friends, Family, and Third-Party Interpreters

Healthcare organizations cannot require patients to bring their own interpreter or rely on an adult accompanying a patient to interpret for them, except:

- In an emergency when a qualified interpreter is not available; or
- When a patient requests the accompanying adult interpret for them, the accompanying adult agrees, and it is appropriate under the circumstances.

However, even when requested by the patient, healthcare organizations cannot rely on the accompanying adult, "when there is reason to doubt the person's impartiality or effectiveness," such as when they have a personal stake in the outcome of their care.[4] In other words, **friends and family members cannot be relied on to interpret for a patient and a qualified interpreter must be called.**

Minor children cannot interpret for a patient, even when requested by the patient, except in an emergency when a qualified interpreter is not available.[4,6-8]

Appropriate Times and Settings to Use VRI

According to NAD, VRI should be used as a last resort when an in-person qualified interpreter is not available. When crafting your policy, consider allowing providers to use VRI only:[9]

- While waiting for an in-person interpreter to arrive, which should be no more than two hours from the time requested for unscheduled medical events;
- If the patient is staying for less than two hours;
- If you need to communicate with a patient outside of the time an interpreter was scheduled; or

- If the patient has not expressed preference for an in-person interpreter or it was determined that VRI complies with minimum standards to result in effective communication.

Communicating Through an Interpreter

When communicating with a patient through a sign language interpreter, consider the following guidance:

- Speak directly to the patient, not the interpreter
- Use first person, i.e., “How are *you* feeling?”
- Pause as needed to allow full interpretation
- Whether in-person or VRI, ensure the interpreter is positioned clearly in the patient’s visual field

References

1. Specific Requirements; Auxiliary aids and services; Video remote interpreting (VRI) services. 28 CFR §36.303(f) (2016). Accessed April 2, 2026. https://www.ecfr.gov/current/title-28/part-36/section-36.303#p-36.303(f)
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4. ADA Requirements: Effective Communication. Civil Rights Division, U.S. Department of Justice. Updated February 28, 2020. Accessed October 31, 2025. https://www.ada.gov/resources/effective-communication/.
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9. National Association of the Deaf. Minimum Standards for Video Remote Interpreting Services in Medical Settings. Accessed November 4, 2025, https://www.nad.org/about-us/position-statements/minimum-standards-for-video-remote-interpreting-services-in-medical-settings/

Appendix 4.10

Effective Communication Frequently Asked Questions

These are examples of commonly asked questions by staff and clinicians when implementing effective communication. Example answers are provided for each question, which should be adapted to local context.

Which patients do effective communication laws cover?

These laws apply to **all** patients with disabilities, including but not limited to those with hearing, speech and language, cognitive, motor, developmental, and visual disabilities.

How do I effectively communicate during an appointment when I have such limited time with patients?

Clinician time constraints are a concern for both clinicians and patients, so you can be upfront about the amount of time available. However, remember that federal law requires any patient communications, even when limited, to be just as effective for patients with disabilities as it is for patients without disabilities.

There are effective communication strategies that do not add time to an encounter, such as looking directly at the patient and speaking in short phrases and sentences. Even when pressed for time, do not interrupt the patient. If necessary, ask for permission to guess what they are saying. These strategies can make communication more efficient as they decrease miscommunications and the need to repeat oneself.

Patients' communication and accommodation needs should be asked ahead of the visit to prepare (i.e., a patient that needs extra time to talk could be scheduled for two time slots or given the last appointment of the day). While it's mandated that all after-visit summaries, notes, and follow-up communications be accessible to all patients, this is especially important when there is limited time to discuss their care during the visit.

What if a patient requests a communication aid or service (accommodation) that our organization doesn't have?

First, acknowledge their request and your intention to ensure they can access information about their care. Apologize that the specific accommodation is not available and tell them which accommodations you have that might meet their needs. Let the appropriate staff at your organization know of the request so clear procedures can be established to better accommodate the need in the future.

Remember that healthcare organizations are required to ensure communication with people with disabilities is just as effective as communication with people without disabilities, including by providing *reasonable* auxiliary aids and services when necessary. With the exception of providing qualified interpreters for sign language users, there is no required list of specific communication accommodations.

Do sign language interpreters need to be certified?

No. However, the interpreter must be "qualified," meaning they can interpret effectively, accurately, and without bias, using any necessary specialized vocabulary. Certification is not

required for someone to be qualified. In fact, certified interpreters might not always be qualified for certain situations, especially if they are unfamiliar with medical terminology.

Should qualified interpreters be available outside of regular hours?

Yes.

Who decides what communication accommodation is the right one?

Always ask the patient if they have a preferred communication strategy and/or accommodation—they know their needs best. While the healthcare team is ultimately responsible for deciding what reasonable accommodation is provided, the U.S. Department of Justice (DOJ) expects organizations to consult with the patient and consider their preferred communication methods. The accommodation provided, if not the one requested by the patient, must enable equally as effective communication.

What happens when a patient does not report their communication needs ahead of an appointment, and I am not prepared?

The DOJ states that "walk-in" requests should be honored to the extent possible. Healthcare organizations can require *reasonable* advance notice of a need for aids or services based on the length of time needed to acquire that aid or service, but such notice requirements must not be "excessive".

Can I rely on a patient's family member or friend to interpret for them?

No. Healthcare organizations cannot require patients to bring their own interpreter or rely on an adult accompanying a patient to interpret for them, except:

- In an emergency when a qualified interpreter is not available; or
- When a patient requests the accompanying adult interpret for them, the accompanying adult agrees, and it is appropriate under the circumstances.

However, even when requested by the patient, healthcare organizations cannot rely on the accompanying adult, "when there is reason to doubt the person's impartiality or effectiveness," such as when they have a personal stake in the outcome of their care. In other words, **friends and family members cannot be relied on to interpret for a patient. A qualified interpreter must be called.**

Minor children also cannot interpret for a patient, even when requested by the patient, except in an emergency when a qualified interpreter is not available.

Can I charge my patients for use of an interpreter, or when I provide them with an aid such as a hearing amplifier?

No. Under the ADA, healthcare organizations are obligated to provide disability accommodations at no cost to the patient, including communication aids and services.

Do I need to provide a sign-language interpreter for *all* staff and clinician interactions with Deaf patients who use sign-language?

It depends. Ideally, an interpreter is present for all staff and clinician interactions. In practice, the level of accommodation depends on the patient and circumstances—or, per ADA

guidance, "the complexity and nature of communications required." For example, if a patient stops at the volunteer desk to ask for directions to a clinic, the volunteer could initiate the process to arrange a sign language interpreter at the clinic while, in the meantime, using a combination of writing, showing, or walking the patient to the clinic, depending on the complexity of the directions.

Once more complex discussions related to the patient’s participation in their care begin—such as with clinicians regarding the patient's health—a sign language interpreter must be present. Even in seemingly non-complex situations, such as checking in or scheduling an appointment, some patients may require an interpreter to fully participate in the activity as patients without disabilities do.

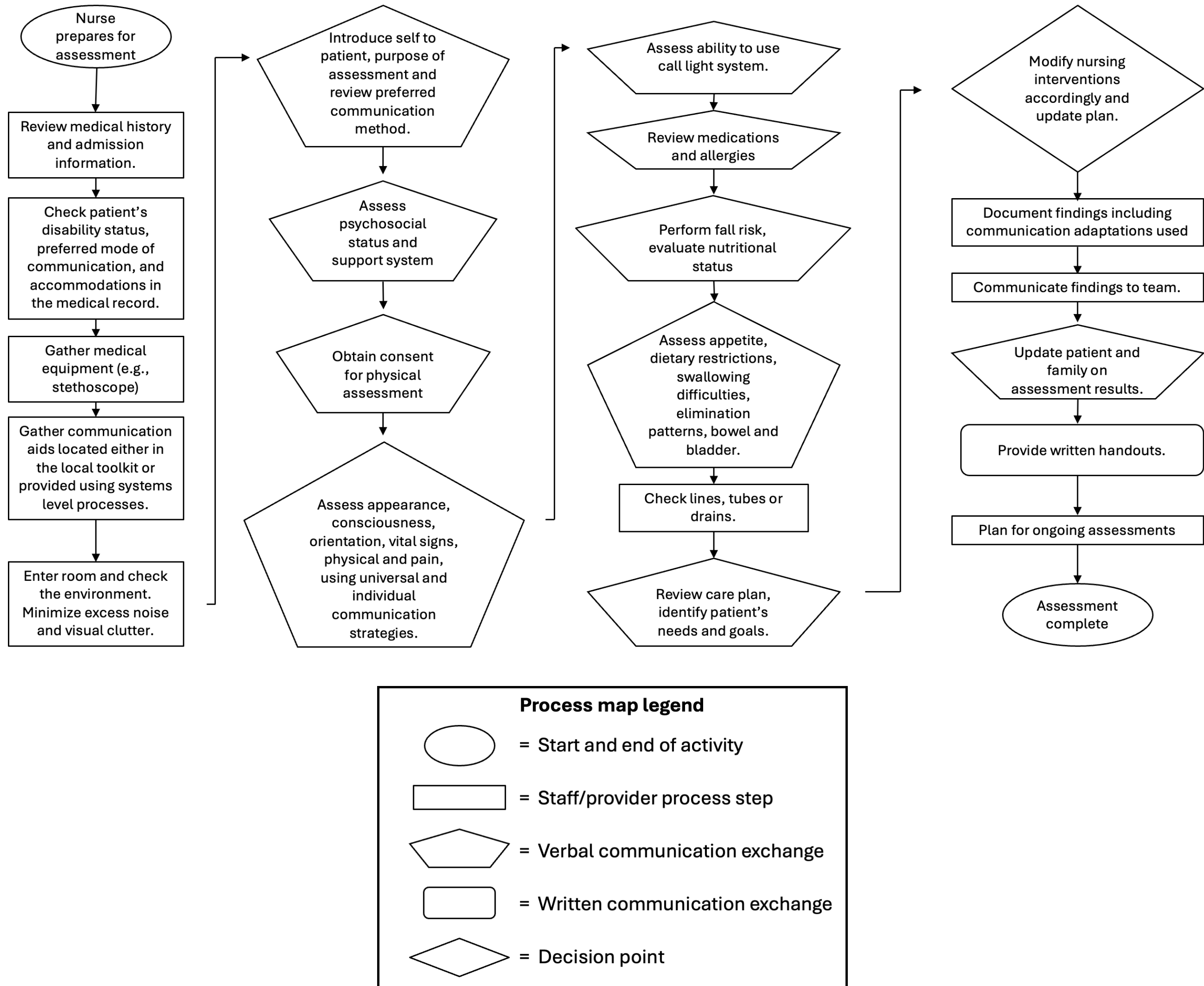
Do caregivers with disabilities also have the right to accommodations?

Yes. Effective communication laws apply to caregivers with disabilities when they are involved in a patient’s care or decision-making.

Appendix 4.11

Effective Communication Process Map

Figure 1. Example of a process map for an inpatient nursing assessment with verbal and written communication exchanges specified



Appendix 4.12

Effective Communication Barriers and Strategies

Below is a list of potential barriers that might be encountered when implementing effective communication. The far-right column lists implementation strategies to address the barriers. You could use one or a combination of the implementation strategies listed for each barrier.

Refer to the Expert Recommendations for Implementing Change (ERIC) Discrete Implementation Strategies Table for descriptions of each strategy.

Category of Barrier	Barriers to Effective Communication	Possible Implementation Strategies
Leadership, staff, and provider attitudes, knowledge and comfort.	Not seen as priority Not viewed as required Not viewed as valuable	• Identify and prepare champions who advocate for providing effective communication accommodations within their teams • Promote adaptability: Identify ways the process of providing communication accommodations can be tailored to meet individual clinic or unit needs • Provide ongoing consultation and check-ins via Disability Coordinator, legal team, or other champions • Educate/train on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. • Use reminders (electronic health record alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
	Insufficient buy-in or being "voluntold"	• Identify and prepare champions • Promote adaptability • Educate/train on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. • Use reminders (electronic health record alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites
	Discomfort with providing accommodations	• Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training on use of communication accommodations • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Use reminders (electronic health record alerts, tents, signs) • Collect data (via patient experience surveys) related to provision of effective communication accommodations and relay to responsible individuals/roles • Kudos to high performing staff/clinicians/sites • Identify and celebrate early adopters
	Lack of knowledge about disability competency, language, preferences	• Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training • Provide staff and providers with tools (scripts, cheat sheets, quick guides)

Staff and provider knowledge and comfort: Workflow and logistics	Hesitance to ask because do not know how to provide Or System/clinic might not have the needed accommodation	• Assess staff readiness for providing communication accommodations and identify local barriers/factors contributing to hesitancy • Workflow mapping • Identify and prepare champions • Provide ongoing consultation and check-ins • Establish centralized technical assistance (i.e., how to use an accommodation) • Educate staff on available communication accommodations and processes for requesting one in their unit • Provide staff and providers with tools (e.g., scripts, cheat sheets, quick guides) • Use reminders (electronic health record alerts, tents, signs) • Audit and provide feedback • Kudos to high performing staff/clinicians/sites • Patient-facing educational materials listing which communication accommodations are available • Identify early adopters
	Lack of awareness that patients need accommodations or that the team is required to provide accommodations	• Identify and prepare champions • Provide ongoing consultation and check-ins • Provide training on use of communication accommodations • Educate staff on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. • Use reminders (EHR alerts, tents, signs)
	Lack of knowledge about how to use the accommodation, including how to keep staff and clinicians up to date with knowledge about accommodations	• Establish centralized technical assistance • Provide training on use of communication accommodation • Use train-the-trainer strategies • Provide ongoing consultation and check-ins • Identify and prepare champions • Identify early adopters • Audit and provide feedback • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Use reminders (EHR alerts, tents, signs)
	Challenges coordinating across departments and roles	• Change record systems/EHR • Designate a formal implementation team • Conduct a needs assessment that assesses readiness and identifies local barriers to providing communication accommodations • Develop a formal implementation blueprint • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Provide training • Relay clinical data (i.e., what percentage of patients who received a communication accommodation were able to access care) to responsible individuals/roles • Review staff performance data (i.e., how often a requested accommodation was provided) to inform changes

		• Promote network weaving by strengthening relationships and collaboration within and outside of the organization, departments, or units
Workflow and logistics	Limited time, budget and resources available	• Conduct a needs assessment • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Audit and provide feedback • Reexamine the implementation plan • Identify early adopters • Reallocate resources or advocate to reallocate resources with leadership • Access new funding (e.g., identify internal and external grant opportunities for larger items) • Use data to document need (see Chapter 2: Documenting Disability Status and Accommodation Needs)
	Competing demands and can put additional burden on the organization	• Conduct a local needs assessment • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Use reminders (electronic health record alerts, tents, signs) • Relay clinical data to responsible individuals/roles • Review performance data to inform changes • Audit and provide feedback • Kudos to high performing staff/clinicians/sites • Identify early adopters
	Not assigned responsibility for tasks	• Change record systems/EHR • Designate a formal implementation team • Conduct a needs assessment • Develop a formal implementation blueprint • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Relay clinical data to responsible individuals/roles • Review performance data to inform changes • Audit and provide feedback

Patient-level challenges	Patients are unaware that they have the right to accommodations	Implementation strategies directed at clinicians and clinics: • Use reminders (EHR alerts, tents, signs) • Establish centralized technical assistance • Provide training to staff on patients' rights to accommodations, accommodations available in the organization, and how to share with patients • Provide staff and providers with tools (scripts, cheat sheets, quick guides) addressing patients' rights • Create and distribute patient-facing educational materials • Prepare patients/consumers to be active participants • Obtain and use patients/consumers and family feedback
	Patients are unsure of what communication accommodations are available	• Provide centralized technical assistance on available accommodations. • Create and distribute patient-facing educational materials
	Patients are unsure of what communication accommodations they would benefit from	• Provide staff and providers with tools (e.g., scripts, cheat sheets, quick guides) to educate patients • Create and distribute patient-facing educational materials

Appendix 4.13

Effective Communication Monitoring Progress and Adaptations

DISABILITY EQUITY COLLABORATIVE

Use this section to create a customized plan to track progress and adaptations made to your original implementation plan. In this plan, include a space to describe what changes or adaptations were made to the original implementation plan and the reason for the adjustment. Below are a few examples of adaptations that could be tracked.

WHO is responsible for reviewing this monitoring plan and HOW often will it be reviewed?

HAVE practice leaders proactively remove organizational barriers to implementing effective communication procedures?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT stage is the practice at in adopting an effective communication policy?

- Not started
- Just beginning
- Actively addressing
- Completed

HOW often are patients provided the communication accommodations they request (best estimate)?

- Never
- Up to 25% of the time
- 26-50% of the time
- 51-75% of the time
- 76% of the time or more

HOW soon are accommodations provided after a patient's request?

- Minutes:
- Hours:
- Days:
- Other:____

When the requested accommodations are not provided or there are significant delays in providing them, what are the most common reasons?

- Lack of awareness
- Workflow barriers
- Staffing limitations
- Technology issues
- Budget constraints
- Other:____

ARE there standardized protocols within the practice workflow to provide communication accommodations?

- Not started
- Just beginning
- Actively addressing
- Completed

IS the practice asking patients their preferred communication strategies and utilizing effective communication strategies?

- Not started
- Just beginning
- Actively addressing
- Completed

WHAT modifications have been made to the original implementation plan across your organization and at each site?

- When?
- Why?
- Who requested the modification? Who executed the modification?
- How has this improved implementation?