



Chapter 6

Accessible Physical Structures and Features

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Orientation to Accessible Physical Structures and Features Chapter

This document is one chapter of a broader Implementation Guide on providing accessible healthcare to people with disabilities. The chapter will guide you through designing, constructing, and modifying facilities that are physically accessible to people with disabilities. 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 constructing a new or upgrading an existing physical structure or building 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 6.6: *Physical Structures Upgrade List* to identify minor accessibility upgrades that may be completed by facilities or maintenance staff without reviewing the other sections of the chapter.

Building accessible environments is just one part of crafting a healthcare setting that ensures patients with disabilities have equal access to care. An accessible space is one that considers wayfinding, sensory needs, medical diagnostic equipment, *and* the built environment. As such, we are creating three other chapters to support healthcare organizations in facilitating accessible environments and physical spaces:

1. **Chapter 5: Accessible Medical Diagnostic Equipment**
2. **Chapter 7: Wayfinding (Coming Soon)**
3. **Chapter 8: Sensory Friendly Environments & Experiences (Coming Soon)**

A note about terminology: The “[built environment](#)” generally refers to buildings, structures, or infrastructure made by people. This chapter discusses “**physical structures**” that make up the built environment in healthcare, including, but not limited to, buildings, suites, sidewalks, entryways, hallways, rooms, and spatial layouts. This chapter also discusses “**accessibility features**”, permanent environmental modifications available to all patients, such as ramps, grab bars, raised toilets, automatic door openers, and lever-style door knobs and faucets.

This chapter does not replace legal counsel. Work closely with your compliance, legal, risk, and buildings departments to ensure your specific legal obligations are met. For questions about your legal obligations under the ADA, please contact your regional ADA Center: <https://adata.org/find-your-region/>.⁷

Introduction to Accessible Physical Structures and Features

The built environment is governed by the ADA Standards for Accessible Design, which provides specific requirements to ensure every room, path, space, or area, indoors or outdoors, on an organization's property is equally accessible to people with disabilities as they are to those without. Some state building codes set a higher standard of accessibility.

A built environment that can be equally accessed means that any person with a disability, including patients, staff, and visitors, are able to park, travel from the public right of way, enter and navigate the building and/or clinic, access and use common areas like bathrooms and cafeterias, and receive the same quality of care received by someone without a disability.

Why are accessible built environments important?

Investing in the built environment is not only a legal obligation; the physical accessibility of a facility has implications for patient safety, quality, equity, and health outcomes. If a patient cannot reach or pass through an entrance, navigate within a facility, use the bathroom, or maneuver in an exam room, they are denied access to the healthcare available in that facility. These events can also discourage people with disabilities from seeking care until an emergency, contributing to worse health outcomes and higher healthcare costs for all.

Who benefits from accessible built environments?

Accessible built environments can improve navigation, safety, and healthcare experiences for *all* patients. In addition to patients with disabilities, older adults, pregnant patients, patients with strollers, those carrying medical equipment like oxygen, and more benefit from accessible, intuitive structures.

What are the legal requirements for building accessible facilities?

Organizations should refer to the [2010 ADA Standards for Accessible Design](#)[↗], including sections [223](#)[↗] and [805](#)[↗] pertaining to inpatient medical facilities, and [Chapter 2: Alterations and Additions](#)[↗]. [Appendix 0.3: Federal Requirements for Providing Accessible Care](#)[↗] in the General Resources section of this Guide summarizes applicable federal requirements. The U.S. Department of Justice guide, [Access to Medical Care for Individuals with Mobility Disabilities](#)[↗] is a helpful resource. If a state building code creates a standard of accessibility higher than the ADA, the higher standard should be followed.

What is the difference between accessibility features and accommodations?

Accessibility features differ from disability accommodations. Accessibility features do not need to be requested, nor are modifications to regular processes made for patients to access them. They are aspects of the built environment that are useable by everyone.

Disability accommodations, by contrast, are requested modifications tailored to meet an individual patient's needs. See [Chapter 3: Providing Accommodations](#)[↗] for more information about disability accommodations. [Appendix 0.7: Accessibility Screening Tool Template](#)[↗] in the General Resources section can help identify potential points of care and locations where accommodations or accessibility features should be available.

Steps to Create Accessible Physical Structures and Features

Step 1: Develop Leadership Support

When implementing any new accessibility initiative at your organization, gaining buy-in from leadership is essential. Building a new facility or re-modeling, designing, or configuring an existing one often requires significant capital costs compared to other initiatives. Leadership support at the organization and location levels are critical to secure necessary approvals.

Actions and Tasks

1. Identify what types of leadership support and buy-in you will need.
 - a. What type of buy-in from organization- or system-level leadership do you need?
 - b. Who will view plans or ultimately approve of your project at the clinic/department/facility level?
 - c. For organizations with multiple facilities, who might you need to secure buy-in from at each? For example, for large health systems, you may need to secure buy-in from each hospital's CEO.
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 prioritizing accessible built environments will fit within your organization's existing priorities and initiatives (e.g., accessibility program, health equity, quality and safety, patient experience goals, etc.).
4. Work with your legal team to identify which version of the ADA Standards apply to your facility(ies). Determine if your organization is involved in other relevant regulatory initiatives (e.g., Joint Commission accreditation, state-level requirements, etc.)
5. Identify potential concerns leadership may have (e.g., cost, construction, disruptions to operations) and possible solutions.
6. Identify upcoming departmental capital improvement or new construction projects. Locate internal funding request deadlines and create timelines to prepare for budget requests when needed.
7. Create necessary charters, strategic plans, and presentations to present to leadership to garner their support.

TIP: Prioritizing accessibility from the very beginning of a project will increase buy-in and the likelihood of success.

Materials and Resources

- [Appendix 0.3: Federal Requirements](#)↗
- [Appendix 0.10 Leadership Support: Key Individuals](#)↗
- [Appendix 6.5: Physical Structures Costs and Funding](#)
- [U.S. DOJ Access to Medical Care for Individuals with Mobility Disabilities](#)↗

**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 physical accessibility project(s). Your team *must* include people across different departments and units in order to secure necessary approvals—modifying the built environment will have clinical, operational, facilities, and compliance implications.

Actions and Tasks

1. Identify the implementation team for evaluating the accessibility of existing facilities, planning and executing barrier removal, installation of accessibility features, remodels, renovations, or new construction projects, and monitoring compliance over time.
 - a. Include people across different departments and units within your organization.
 - b. Include leadership and others who have the authority to make changes and approve expenditures.
 - c. Include staff working in these spaces; they know their clinic environment and how patients best move and navigate within the space.
 - d. Start with a team at a pilot site or single clinic to work through challenges before managing several projects at once.
2. Determine how you will include patient perspectives. People with disabilities will identify high-priority spaces with significant barriers beyond the ADA checklist.
 - 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 with accessibility questions?
 - d. Will you engage disability community organizations?
3. Determine the implementation team meeting structure.
 - a. How often will the team meet?
 - b. Is this a project that will be part of an existing capital planning, procurement, or facilities team? Or embedded within another team?
4. Identify champions for the project. Consider including clinical/non-clinical champions.
 - a. Are they able to implement changes?
 - b. Is there someone at the system level with whom you can partner? For example, a Disability Coordinator or your organization's ADA Coordinator is often already responsible for monitoring accessibility-related complaints and compliance.
5. Establish common goals for team.
 - a. Ensure that it fits within organizational goals and regulatory deadlines.
 - b. Use SMART Goals (Specific, Measurable, Attainable, Realistic, and Time-bound).

Materials and Resources

- [Appendix 0.4: Disability Organizations](#) ↗
- [Appendix 0.6: Project Planning](#) ↗
- [Appendix 6.1: Physical Structures Implementation and Project Teams](#)
- [Appendix 6.3: Physical Structures Implementation Planning Worksheet](#)
- [Appendix 6.11: Physical Structures Barriers and Strategies](#)

**Appendices 0.4 and 0.6 can be accessed in the General Resources chapter.*

Step 3: Needs Assessment and Survey

Using Appendix 6.2: *Physical Structures Needs Assessment*, evaluate the current state of accessibility at your organization's buildings, structures, and facilities. Complete a comprehensive accessibility survey of your site(s).

TIP: For health systems with multiple facilities, consider hiring an external firm or consultant to survey your facilities. Firms that conduct accessibility surveys often have experts who will produce an objective evaluation of your organization's facilities.

Actions and Tasks

1. Locate existing barrier removal plans, deferred maintenance lists, accessibility complaints, grievances, patient experience surveys, or legal actions taken against your organization related to the construction, design, or navigation of a space. This will help you understand your organization's priorities and motivations.
2. Identify if there are any non-accessibility projects in the planning stages across your organization. There may be opportunities to leverage them for accessibility work and minimize disruptions to clinical operations.

TIP: For renovations or remodels of primary function areas at existing facilities that are not made for the express purpose of accessibility, the ADA requires up to 20% of the total project budget (or until compliance is met) be spent to make paths of travel accessible, including entrances, hallways, restrooms, water fountains, and more (see [Chapter 2: Alterations and Additions](#) of the Guide to the ADA Accessibility Standards).

3. Review your organization's capital project request policies. Identify internal project proposal deadlines and create timelines to prepare for budget requests when needed.
4. Use the [ADA Checklist for Existing Facilities](#) to identify accessibility barriers at each location. Before starting the survey, consider:
 - a. Will you hire an external firm or surveyor to evaluate your facility? If so, what is the budget?
 - b. If conducting the survey internally:
 - i. Who/what team(s) will be responsible?
 - ii. How many hours will be dedicated to conducting the survey(s)?
 - iii. What training or information is needed to conduct the survey accurately?
 - c. What supplies will you need?
 - d. How many of each feature included on the checklist, i.e., doors, parking spaces, bathrooms, exam rooms, waiting rooms, etc. are in your facility? How many must be accessible?
 - e. What is your data management plan? Is there an existing template you can adapt to track recorded measurements and other data? See Appendix 6.4: *Physical Structures Survey Data Template*.
 - f. What reports will you generate with the survey results, such as a Barrier Removal Plan (see Appendix 6.9: *Physical Structures Barrier Removal Guidance*)?

5. Engage with other healthcare organizations to understand their approaches to assessing built environments and making them accessible, 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 6.2: Physical Structures Needs Assessment](#)
- [Appendix 6.4: Physical Structures Survey Data Template](#)
- [Appendix 6.9: Physical Structures Barrier Removal Guidance](#)
- [Appendix 6.13: Physical Structures Training Resources](#)
- [ADA Checklist for Existing Facilities](#)⁷
- [Disability Equity Collaborative's Leaders workgroup](#)⁷

Step 4: Determine What, How, When, and Who Will Complete Projects

Determine what accessibility upgrades your organization will pursue, how and when they will be completed, and who will be responsible for them. Use Appendix 6.3: *Physical Structures Implementation Planning Worksheet* to specify site or clinic goals, strategies, timelines, milestones, and measures for implementation.

NOTE: Constructing or renovating a healthcare facility is a highly regulated process. It is beyond the scope of this chapter to address non-accessibility-related aspects of healthcare construction. For a breakdown of actions and tasks to complete in preparation for new construction, remodel, or renovation, see Appendix 6.8: *Physical Structures Project Best Practices and Timeline*.

Actions and Tasks

1. Use your completed accessibility survey to determine what projects your clinic or organization will pursue and where. Identify:
 - a. Modifications internal facilities management or maintenance staff can manage, including “readily achievable barrier removal,” such as lowering mirrors, replacing doorknobs, reconfiguring reach ranges for bathroom fixtures, etc.;
 - b. Structural upgrades or renovations your organization will pursue;
 - c. Accessibility features to purchase and install;
 - d. Changes that are “technically infeasible” due to structural or space constraints.

TIP: If not all elements identified in the survey can be made accessible in one project, select elements that (1) would provide the greatest benefit for patient access if made accessible, and (2) would not be unusually costly to modify.

2. Consider exposure to legal action for non-compliance. This will help you identify the barriers most likely to disrupt patients' access to care and result in a lawsuit and therefore determine which barriers to prioritize.
3. Identify the scope of the project(s). Are you pursuing multiple projects organization wide, or focusing on upgrades in a single clinic?

4. Identify your project(s) team. Determine whether you need to create/provide training or resources to educate project planning team members on accessibility in the healthcare context, or include members on the project team that already have accessibility expertise.
 - a. Peer to peer information can be more persuasive. For example, architects are more likely to listen to other architects with accessibility-specific knowledge.
5. Plan how construction contracts, accessibility features, and other suppliers will be purchased/paid for, including which budgets will fund them.
6. In consultation with your project and/or implementation team, develop a project timeline. Identify a target opening/reopening date for the facility, if applicable.
7. For existing facilities, work with clinic staff to understand how clinical operations will be disrupted by the project(s). Develop solutions and contingency plans.
 - a. Will the unit have to pause operations, or can the project be completed with minimal disruptions to clinical care?
 - b. How will you create and inform staff/patients about alternative accessible pathways during construction?
 - c. How will dust, debris, and other irritants from construction be managed in the clinical environment?
 - d. If clinical operations must be paused:
 - i. Will clinicians provide care at another location?
 - ii. Will appointments be rescheduled?
 - iii. Will patients be referred to another facility?
8. For existing facilities, work with facility leadership and/or finance departments to understand the indirect financial impacts of the project. How will you address concerns about lost revenue during the construction period?

TIP: For large, multi-site healthcare organizations tackling barrier removal system wide, consider creating an “Accessibility/Barrier Removal Masterplan” to help manage the impacts to patient care, finances, and coordination with other planned construction projects across the organization.

9. Be prepared for the project’s scope to expand. Consider the implications for the project’s budget and the project area itself.
 - a. For example, if your original plan is to install grab bars in a toilet room, you may discover the existing room is too small and must instead be taken down to the studs and reconfigured.
10. Following decisions made on processes, funding, 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 project should be included.

Materials and Resources

- [Appendix 0.6: Project Planning](#) ↗
- [Appendix 6.1: Physical Structures Implementation and Project Teams](#)
- [Appendix 6.5: Physical Structures Costs and Funding](#)
- [Appendix 6.6: Physical Structures Upgrade List](#)
- [Appendix 6.7: Physical Structures Leased & Rented Space Frequently Asked Questions](#)

- [Appendix 6.8: Physical Structures Project Best Practices and Timeline](#)
- [Appendix 6.9: Physical Structures Barrier Removal Guidance](#)
- [Appendix 6.10: Physical Structures New Construction Guidance](#)

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

Step 5: Construction & Installation

Begin the construction/installation phase of the project. Consider the following actions to ensure staff, patients, and your organization's systems are prepared to resume care delivery following project completion.

Actions and Tasks

1. Identify who will design clinic workflows for a new facility, or redesign clinic workflows for the remodeled space. Will this be internal staff or an external consultant?
2. For barriers that are “technically infeasible” to remove, determine an alternative method to safely deliver care. See Appendix 6.6: *Physical Structures Upgrade List*.
3. Determine who will provide consultation to assist with training for providers and staff on how to use accessibility features/navigate the newly accessible facility.
 - 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.
4. Identify or create resources and trainings on how to use accessibility features/navigate the newly accessible facility.
 - a. Determine how trainings may differ depending on staff roles.
 - b. Determine frequency of training/re-training (e.g., one time, annual, etc.)
5. Identify or develop tools and reminders to encourage staff to maintain the accessible layout of a room.
 - a. Pictures and diagrams can be helpful. For example, post photos or diagrams in an exam room of its intended layout so that staff can maintain accessibility.
6. Decide how accessibility features will be maintained in the clinic or unit. Aim to integrate the process into existing clinic and system-level workflows when possible. Consider:
 - a. Who in the facility will be responsible for observing and tracking repair/replacement needs?
 - b. What is the process for clinic staff to request a repair/replacement?
 - c. What budgets will fund repairs/replacements?
7. Before the facility opens/reopens, conduct a final third-party accessibility survey of the space. Document and make any necessary changes.

TIP: If accessibility barriers remain following the final survey, it will be tempting to say the accessibility of the space is “good enough,” especially if the project is running up against the planned opening date. It is critical to have strong buy-in from leadership to back you in delaying the opening date to fix remaining barriers, if necessary.

8. Identify or develop patient-facing education materials to disseminate information on available accessibility features, rooms, etc.

9. Determine how success will be defined for building more accessible physical structures and environments.
 - a. Specify how you will monitor or assess patient experience, complaints, and outcomes.
 - b. Develop an evaluation plan to reflect your definition of success.

Materials and Resources

- [Appendix 6.3: Physical Structures Implementation Planning Worksheet](#)
- [Appendix 6.6: Physical Structures Upgrade List](#)
- [Appendix 6.11: Physical Structures Barriers and Strategies](#)
- [Appendix 6.12: Physical Structures Monitoring Progress and Adaptations](#)
- [Appendix 6.13: Physical Structures Training Resources](#)
- [ADA Checklists for Existing Facilities: Frequently Asked Questions](#)⁷

Step 6: Facility Opening/Reopening, Evaluation, and Monitoring

Open your new, reopen your existing, or resume normal operations at your facility. Monitor and regularly evaluate patient experience and any changes to outcomes related to the accessibility of the space.

Actions and Tasks

1. Conduct patient surveys to collect data on patients' experience in newly-accessible spaces.
2. Track any changes to patient outcomes (i.e., rates of missed appointments) or patient complaints. Communicate those to responsible individuals (e.g., clinic leadership, system leadership, staff working in these spaces) and the implementation team.
3. Make and document all needed adaptations.
4. Recognize high performing clinics or sites to celebrate improved patient navigability, experience, or outcomes.

Materials and Resources

- [Appendix 6.11: Physical Structures Barriers and Strategies](#)
- [Appendix 6.12: Physical Structures Monitoring Progress and Adaptations](#)
- [ADA Checklists for Existing Facilities: Frequently Asked Questions](#)⁷

Appendices Table

NAME	DESCRIPTION
Appendix 6.1: Physical Structures Implementation and Project Teams	A list of all the individuals who could participate on the implementation team. Also includes a list of staff, engineers, contractors, and consultants that might be necessary on a healthcare construction project team.
Appendix 6.2: Physical Structures Needs Assessment	A worksheet to review the current landscape of an organization, identify mission and priorities, gaps and strengths, and specific goals for implementing accessible environments and physical spaces.
Appendix 6.3: Physical Structures Implementation Planning Worksheet	A worksheet to identify the future direction and processes that will be followed for implementing accessible environments and physical spaces.
Appendix 6.4: Physical Structures Survey Data Template	A spreadsheet to help staff record and track measurements, photos, and observations of accessibility barriers identified in an accessibility survey.
Appendix 6.5: Physical Structures Costs and Funding	Lists example expected costs and potential funding sources for structural accessibility projects and features installation.
Appendix 6.6: Physical Structures Upgrade List	A list of accessibility features and modifications categorized by setting and staff that may be responsible for completing each upgrade. Discusses technical infeasibility and potential solutions.
Appendix 6.7: Physical Structures Leased & Rented Space Frequently Asked Questions	A list of frequently asked questions about accessibility and compliance in leased or rented spaces, including common areas.
Appendix 6.8: Physical Structures Project Best Practices & Timeline	Includes general best practices and a simplified sample timeline for any project related to accessible physical structures and features.
Appendix 6.9: Physical Structures Barrier Removal Guidance	Includes guidance and an example project for barrier removal in an existing leased facility.
Appendix 6.10: Physical Structures New Construction Guidance	Includes guidance and an example project for new construction.
Appendix 6.11: Physical Structures Barriers and Strategies	A list of potential implementation barriers to completing structural accessibility projects and possible strategies to address those barriers. Barriers are organized categorically.
Appendix 6.12: Physical Structures Monitoring Progress and Adaptations	A worksheet to track progress and adaptations to the implementation plan.
Appendix 6.13: Physical Structures Training Resources	Guidance for developing trainings and external resources for the implementation team, leadership, clinicians, and staff.



Appendix 6.1

Physical Structures Implementation and Project Teams

Consider including these individuals on the team implementing projects related to building or remodeling physical structures and installing accessibility features across your organization.

1. Clinic/unit manager
2. Operations team member
3. Procurement team member
4. Patient safety officer
5. Clinical engineering team member
6. Compliance or regulatory department representative
7. Disability coordinator
8. Diversity, Equity and Inclusion leader
9. Executive or chief officers
10. Facilities management or representative from the organization's architectural group
11. Materials management
12. Family and patient experience liaison
13. Patient(s) with disabilities or patient advisory board
14. Infection control
15. Nurses
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. Valet/Parking team
21. Security staff

External Hires

After building your initial implementation team, you may want to contract external staff to assist with surveying your facility, planning your project, and/or for construction/installation. Below are sample roles. Many architectural firms or general contractors will have these kinds of roles on their teams. If you are part of a large health system, be sure you don't already have in-house staff before exploring external options.

1. Accessibility consultants
2. Accessibility surveyor
3. Architects
4. Mechanical engineers
5. Electrical engineers
6. Plumbing engineers
7. Fire protection engineers
8. Geotechnical engineer
9. Civil engineer
10. Traffic consultant
11. General contractor
12. Medical equipment consultant

13. Healthcare operational and workflow consultant (for designing facility layouts)
14. Laboratory planning consultant
15. Infection control consultant
16. Food service consultant
17. Environmental/hazardous materials consultant
18. Elevator vendor
19. Lighting designer and supplier
20. Signage designer and vendor (including someone who can review Braille signage)



Appendix 6.2

Physical Structures Needs Assessment

Instructions:

- This assessment can be completed by anyone at any point in designing or constructing accessible physical structures. 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 Structural Accessibility

This section will help you capture the current structural accessibility of your organization or clinic.

Background

1. What is the motivation driving the desire to improve the accessibility of your organization's physical space(s)?
 - Legal compliance
 - Lawsuit
 - Patient complaint
 - Adherence to accreditation standards
 - Improve quality of care and patient experience for people with disabilities
 - Other:
 - a. Are there specific populations you are focused on (e.g., people with physical disabilities, visual disabilities)? If so, why?
 - b. Are there certain settings you are focused on (e.g., public spaces such as lobbies and cafeterias, private spaces such as exam rooms)? If so, why?
 - c. Are you focused on new construction, modifying existing facilities, or both? Why?
2. What is the desired outcome of improving the accessibility of the environment and physical space?
3. How does constructing a more accessible space align with current organizational priorities and initiatives (e.g. quality and safety; upcoming building expansion)?
4. What, if any, leadership support is there for environment and physical space improvements at your organization? What levels of support do you need (C-Suite, Director(s), Manager(s), etc.)?

5. What, if any, regulatory requirements are there for the accessibility of the environment and physical space (e.g., ADA Standards, Joint Commission Excellent Health Outcomes for All Certification, CMS requirements, state-level requirements etc.)?

Accessibility Survey

1. Has your facility(ies) been surveyed for compliance with ADA Standards? If so:
 - a. When was the survey conducted?
 - b. Who completed the survey?
 - Internal staff (specify individual or department)
 - External firm or consultant (specify who)
 - Other:
 - c. What survey was used?
 - [ADA Checklist for Existing Facilities](#) (2010 Standards)[↗]
 - [Checklist for Readily Achievable Barrier Removal](#) (1991 Standards)[↗]
 - State-specific checklist
 - Other:
2. Has a barrier removal plan or deferred maintenance list been created for your facility(ies)?
3. What year was your facility built? This will determine which version of the ADA Standards applies.
 - Pre-1990? (likely a need for significant upgrades)
 - 1991-2012? (likely a need for moderate upgrades)
 - 2012 – present? (likely only needs minor upgrades)
4. What service lines are housed in your facility(ies)? Certain medical specialties have needs that exceed code minimums, such as:
 - Rehabilitation
 - Physical therapy
 - Orthotics/Prosthetics
 - Geriatrics
5. Is there a budget for conducting code compliance surveys?
 - a. What types of budgets exist?
 - b. Whose budget is used?

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

Existing Facilities

1. Describe the general quality and value of the facility(ies). For example, are there problems with the building beyond accessibility (i.e., layout does not support modern medical equipment, mold, HVAC issues, etc.)? If yes, consider:
 - a. Pursuing a “real-estate solution” (selling the building, moving out and leasing a newer, code-compliant building).
 - b. Demolishing and building new, rather than investing in extensive accessibility upgrades for a building near the end of its useful life.
2. Are there any specific departments, spaces, facilities, or rooms within your organization that were intentionally designed with accessibility in mind and can be a model for your organization?
 - a. What types of disability do these spaces support?
3. Is the structural design of the existing clinic/floor/department/exam rooms “functionally” accessible? For example:
 - a. How far is the waiting room from where patients are called back for their appointment?
 - b. In exam rooms, is there space for a caregiver? Is there space for a clinician to face the patient during the appointment to facilitate communication?
4. Are there any non-accessibility construction projects for this facility(ies) currently happening or in the planning stages that can be leveraged for increasing accessibility? Examples include:
 - Radiology upgrades
 - Change of medical group or specialty
 - New Parking Lots / Upgrades
 - Energy/sustainability upgrades
 - Other:
 - Are the teams responsible for these projects aware of the ADA’s requirements for additions and alterations to primary function areas in existing facilities? (See [Chapter 2: Alterations and Additions](#)⁷ of the Guide to the ADA Accessibility Standards.)
5. Are there non-structural accessibility initiatives that can be completed or planned for during the project period?

- a. [See Chapter 3: Providing Accommodations](#)⁷ for guidance on operationalizing reasonable accommodations policies.
 - b. See [Chapter 5: Accessible Medical Diagnostic Equipment](#)⁷ for guidance on auditing, procuring, and implementing accessible MDE in a facility/clinic/unit.
6. Is the clinic/unit/facility due for upgrades that are not accessibility related? An accessibility project may present the opportunity to address other updates, including replacing defrayed carpeting and cabinetry, check-in counters, outdated furniture, etc.)
7. In addition to federal ADA Standards, what accessibility-related state and/or local building codes apply to your organization? (*NOTE: Some states have their own accessibility codes. When state and local building codes differ, the standard with the highest level of accessibility applies.*)
 - a. Is there an internal standard or process for incorporating accessibility requirements into all remodels, renovations, or structural upgrades?
8. What are the known accessibility barriers in your facility(ies)? Examples include (see Appendix 6.9: *Physical Structures Barrier Removal Guidance* for more):
 - o Force required to open doors
 - o Inadequate parking
 - o Undersized exam/treatment rooms, e.g., insufficient space to maneuver, house accessible medical diagnostic equipment, or transfer to that equipment
 - o Steep sidewalks or other exterior areas
 - o Lack of access to amenities such as cafeteria or meditation gardens, etc.
 - o Other:
 - a. How was your organization made aware of these barriers?
 - o Accessibility survey results
 - o Patient complaints
 - o Staff observations
 - o Other:
9. Is there a budget for readily achievable barrier removal?
 - a. What types of budgets exist?
 - b. Whose budget is used?
 - c. What types of initiatives or supplies are covered by that budget?
10. Does your organization have internal funding request or capital project proposal deadlines?

11. Are people with disabilities and/or accessibility experts consulted when designing/planning structural projects?

New Construction

1. In addition to federal ADA Standards, what accessibility-related state and/or local building codes apply to your organization?
 - a. Is there an internal standard or process for incorporating accessibility requirements into all new construction projects?
2. Does your organization have customized design standards for common spaces? If so, was accessibility considered when designing those standards?
3. What service lines will be housed in the facility(ies)? Certain medical specialties have needs that exceed code minimums, such as:
 - Rehabilitation
 - Physical therapy
 - Orthotics/Prosthetics
 - Geriatrics
4. Is there a budget for new capital projects?
 - a. Is there a campus masterplan that can provide guidance/funding sources?
 - b. What types of budgets exist?
 - c. Whose budget is used?
 - d. What types of initiatives or supplies are covered by that budget?
5. Are people with disabilities and/or accessibility experts consulted when designing/planning structural projects?

Maintenance

1. Is there a process to follow-up after new construction, renovation, or remodeling to confirm that the building does indeed meet the applicable ADA Standards?
2. Is there a process or workflow for monitoring the facility for accessibility-related repairs?

- a. Who is responsible for identifying repairs?
 - Front desk staff
 - Practice manager
 - Other:
- b. Who is responsible for completing repairs?
 - Maintenance
 - Facilities management
 - Other:
3. Is there a process for patients to provide feedback on the accessibility of a facility?
4. Is there a budget for maintenance and management of accessibility features?
 - a. What types of budgets exist?
 - b. Whose budget is used?
 - c. What types of initiatives or supplies are covered by that budget?
5. Are there hours or days that a building is unoccupied?
 - a. If yes, could this time be used to complete construction, installation, or maintenance?

Training

1. What trainings are available for staff on the accessibility of the built environment and its physical structures?
2. What trainings are available to promote staff and clinicians awareness of and how to use (if applicable) accessibility features?
3. What trainings are available for staff to maintain the accessible environment?
 - a. What do trainings cover?
 - b. Do trainings differ by role?
 - c. How often are trainings conducted?

People

1. Who might be your champions?
 - Disability Coordinator (could be: “ADA Coordinator”, “Section 1557 Coordinator” or “Disability Accessibility Coordinator”)
 - Clinician champion(s)
 - Practice managers
 - Facilities staff
 - a. If not, do you have someone who is willing to lead this work?
2. Who in your organization might have expertise on or have already been involved in a project to improve the structural accessibility of a space, such as a Rehabilitation department?
3. Is there a department typically responsible for capital projects, including architecture, engineering (e.g., structural, mechanical, plumbing, fire protection), accessibility specialists, or construction?
4. Is there a department typically responsible for facility maintenance and repairs?
 - a. How does this differ in each setting, including parking, entryways, lobbies, hallways, toilet rooms, exam rooms, elevators, and public spaces?

Institutional Support

1. What initiatives exist for improving patient mobility and access within your facility(ies), potentially including 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 accessibility-related structural improvements at your organization?
2. Weaknesses: What internal barriers exist that inhibit accessibility-related structural improvements at your organization?
3. Opportunities: What favorable external factors exist that could promote accessibility-related structural improvements at your organization?
4. Threats: What external factors exist that have the potential to inhibit the success of accessibility-related structural improvements at your organization?



Appendix 6.3

Physical Structures Implementation Planning Worksheet

The following plan will help guide your work to implement projects related to the structural accessibility of space(s) at your organization.

INSTRUCTIONS: Use this worksheet to guide your overall organizational/clinic plan for accessibility improvements to physical structures. 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 complete barrier removal at our outpatient clinics”: “We plan to lease a new floor in a medical office building for physical therapy.”

Leadership Support and Buy-In

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

WHAT charters, strategic plans, presentations, etc. do you need to create?

WHAT regulatory requirements must your environments and physical spaces meet?

WHO are your clinical champions?

WHAT internal funding/project proposal deadline are you targeting?

HOW will you integrate physical access into your organization’s quality and safety priorities and initiatives?

Team

See Appendix 6.1 for examples of roles to include on your implementation team.

WHO will be on the implementation team to identify, design, and monitor accessibility projects?

WHO will be on the team overseeing each project, if managing multiple?

WHO will be responsible for surveying your facility(ies) for compliance with ADA Standards?

WHO will analyze survey results and determine the appropriate scope of construction work?

WHO will be responsible for building/remodeling/installing accessibility features in your facility?

WHO will be on the team to evaluate the accessibility of these spaces following project completion?

WHO will coordinate maintenance of the accessibility design, feature(s), item(s), equipment, etc. in the clinics/units?

WHAT other institutional partners will you need to engage?

WHAT external staff/professionals/consultants/service contractors will you need to hire? Will these hires work organization-wide or project-specific?

HOW will you include people with disabilities on your team(s)?

- Employee Resource Group
- Patient Advisory Committee
- Other:

HOW often will these teams meet?

Resources

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

- A centralized budget
- Project-specific budgets
- Budget to cover service contracts
- Other:

WHAT sources are funding the project(s)?

- Internal, centralized budget
- Internal grant
- External grant
- Other:

WHAT is the budget source for each aspect of the project, i.e., for compliance survey, construction, building management, etc.?

WHAT supplies, materials, equipment, etc. will you need? Reference your completed Needs Assessment.

HOW will you identify resources needed?

- Internal
- External
- Other:

HOW will you elicit feedback from your patients with disabilities on the accessibility of your facility(ies)? WHO will you invite to these activities?

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

Existing Facilities

WHAT version of the ADA Standards originally applied to your existing building(s)?

WHAT gaps in patients and visitors with disabilities' needs will building modifications address?

IS the space leased, rented, or owned by your organization?

IS the space public or private (i.e., a cafeteria or exam room)?

WHAT planned construction projects will be leveraged for accessibility work?

- Radiology upgrades
- Change of medical group or specialty
- New parking lot/upgrades
- Energy/sustainability upgrades
- Other:
- Is this space a “primary function area” that would trigger path of travel requirements?

WHAT aspects of the project may require building permits?

WHAT aspects of the project do not require a permit, and can be completed by internal maintenance/facilities staff? See Appendix 6.6: *Accessible Physical Structures Upgrade List* for examples.

- Grab bars
- Handrails
- Sign installation
- Other:

WHAT, if any, accessibility features/structures/designs/layouts are currently in place that you will keep?

WHAT rooms/areas will be renovated?

WHAT new accessibility features will you build/install?

WHAT, if any, barriers are technically infeasible to modify or remove?

WHAT is the alternative method to deliver equal access to care?

WHAT accessible medical diagnostic equipment will be housed in the facility? Where? See [Chapter 5: Accessible Medical Diagnostic Equipment](#)⁷ for guidance.

HOW will you account for the size of accessible medical diagnostic equipment in exam rooms, including sufficient space to maneuver around and transfer to the equipment?

WHAT is the process to follow-up after construction to confirm that modifications meet applicable standards?

New Construction

WHAT is the scope of the project and the nature of the building(s)? For example, are you building a new accessible exam room, or an entire clinic?

IS this a completely new building, a renovation, or a new addition to an existing building?

WHAT services will be housed in this building?

HOW will you account for the size of accessible medical diagnostic equipment in exam rooms, including sufficient space to maneuver around and transfer to the equipment?

WHAT aspects of the project may not require a permit, and can be completed by internal maintenance/facilities staff?

HOW will clinical operations be impacted by construction?

HOW might construction affect access to care for patients with disabilities?

WHO will assess completed projects for compliance?

Training and Staff Buy-In

HOW will you inform staff and clinicians that your organization completed an accessibility-related construction project or modification?

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

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

- Training
- Kudos
- Other:

WHAT is the process or workflow to monitoring the facility for accessibility-related repairs?

WHO will be responsible for identifying repairs? If multiple facilities, consider who for each.

WHO will be responsible for completing repairs? If multiple facilities, consider who for each.

HOW will you train staff and clinicians on how to maintain a space's accessibility and prevent barriers?

WHERE will training materials be located?

- Internal website
- Other:

HOW often will you provide training?

- New employee orientation
- Yearly
- Other:

WHAT are the indirect financial impacts of the project? HOW will this be managed?

HOW will you continue to engage leadership in this work?

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

Planning for Implementation and Evaluation

WHAT is your construction project timeline? WHAT is your target opening or reopening date?

HOW will you monitor your progress towards completion?

WHAT is the process and WHO is responsible for monitoring ADA compliance throughout construction?

- Work with your Disability Coordinator
- Work with your Compliance office
- Other:

HOW often will you monitor your progress?

- Weekly
- Monthly
- Quarterly
- Other:

HOW will clinical operations be disrupted?

WHAT is the contingency plan to maintain clinical operations and access to care during the construction period?

HOW will dust, debris, and other irritants from construction be managed in the clinical environment?

HOW will you inform patients of barrier removal/new construction?

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

HOW will you inform patients of temporary accessible routes during construction?

- Notice by placards/flyers at front desk, waiting room, exam rooms
- Communication during appointment scheduling
- Website blog posts
- Notification through the patient portal
- Other:

WHO will design clinic workflows in new or remodeled facilities? WHAT is the workflow(s)?

HOW will you monitor or assess changes in patient experience, complaints, and outcomes?



Appendix 6.4

Physical Structures Survey Data Template

The Excel linked below is a sample template to record and organize information collected during an accessibility survey, including measurements, photos, and observations of identified accessibility barriers.

[DOWNLOAD SURVEY DATA TEMPLATE HERE \(EXCEL\)](#)[↗]



Appendix 6.5

Physical Structures Costs and Funding

Costs

This section lists potential costs associated with constructing or modifying physical structures to be accessible. This is not an exhaustive list.

- Service contracts
 - Audit/survey
 - Architect design
 - Engineer
 - Accessibility consultant
 - General contractor
 - Maintenance service
 - Elevators
 - Electricians/Plumbers/HVAC Technicians
- Building materials
- Permits and fees
 - Building permit
 - Inspection fees
 - Zoning fees
 - Expediting fees, if applicable
- Insurance
- Demolition/removal of noncompliant items/materials/features
- Accessibility features, such as:
 - Grab bars
 - Handrails
 - Lever door handles
 - Automatic door opener kits
- Dust/debris control
- Disruptions to revenue
- Staff training on use of accessibility features and maintenance of space
- Compensation for disability partners: interns, advisory committee members

Funding

This section lists potential funding sources for structural projects that are accessibility related.

- Central health system budget
- Procurement or Supply Chain budget
- Other departmental budget
- Project budget
- Internal health system grants
- External grants, such as federal capital improvement grants or foundation grants
- Donations
- [Disabled Access Credit](#)
 - For HCOs who earned ≥\$1,000,000 or had ≥30 full time employees in the previous year
 - Up to \$5,000 per year for access expenses
- [Barrier Removal Tax Deduction](#)
 - Claim up to \$15,000 per year for qualified expenses
- [Community Development Block Grants](#): Federal funding distributed by states/cities that may be used to remove architectural barriers.
- State Incentives: Many states offer their own tax incentives for accessibility upgrades. [Contact your regional ADA Center to learn more.](#)
- [Provider Accessibility Initiative: Barrier Removal Fund](#): Since 2018, the Barrier Removal Fund has provided over \$2.9 M in grants to fund accessibility improvements at 298 healthcare providers in sixteen states (Delaware, Hawaii, Louisiana, Iowa, California, Florida, Georgia, Illinois, Indiana, Kansas, Michigan, Nebraska, Ohio, Pennsylvania, New Mexico, and Texas).



Appendix 6.6

Physical Structures Upgrade List

Chapter 6: Accessible Physical Structures and Features

This chart provides examples of structural accessibility upgrades and accessibility features, organized by setting and the staff responsible for building/installing that upgrade.

This chart is also intended to give you a sense of what tasks may require hiring an external contractor/consultant, and those that can be completed by maintenance or facilities staff.*

Setting	Upgrade/Feature	Example Staff Responsibility
Parking, Driveways, Route to Entrance	Signage installation	Internal facilities/maintenance
	Parking striping and access aisles	Specialized contractor
	Curb ramps	General contractor
	Detectable warning surfaces	Specialized contractor
	Accessible route to facility entrance	General contractor
	Sidewalk repair or widening	Specialized contractor
Entrances	Automatic doors	Specialized contractor
	Automatic door buttons	Skilled trade/specialized contractor
	Door force	Internal facilities/maintenance or Specialized contractor
	Doorknob replacement**	Internal facilities/maintenance
	Entryway widening	General contractor
	Signage installation	Internal facilities/maintenance
	Handrail installation	Internal facilities/maintenance
	Ramps	General contractor
Lobby/Waiting Areas	Lower check-in counters	General contractor
	Furniture layout:** - Wheelchair-accessible seating - Clear circulation routes - Access to outlets	Any staff
	Door force	Internal facilities/maintenance or Specialized contractor
	Lower water fountains	Internal facilities/maintenance

Chapter 6: Accessible Physical Structures and Features

Hallways/Passageways	Signage installation	Internal facilities/maintenance
	Braille/tactile text room identification signs	Internal facilities/maintenance
	Door force	Internal facilities/maintenance or Specialized contractor
	Hallway widening	General contractor
	Carpet/flooring leveling/replacement	General contractor
	Handrails	Internal facilities/maintenance
	Clear pathways (remove trash cans, plants, décor, etc.)**	Any staff
Toilet and Shower Rooms	Grab bars	Internal facilities/maintenance
	Room layout redesign	Architect; General contractor
	Toilet height	Internal facilities/maintenance
	Shower seat (folding, wall-mounted, transfer, L-shaped, etc.)	Internal facilities/maintenance
	Accessible sink	Internal facilities/maintenance
	Accessory relocation (soap, towel, dispensers)**	Internal facilities/maintenance
	Accessible stalls	General contractor
	Lower mirrors**	Internal facilities/maintenance
	Baby changing table	Internal facilities/maintenance
	Adult changing table	Internal facilities/maintenance
Exam/Imaging/Treatment Rooms	Room layout/floor space	Architect & General contractor or accessibility consultant
	Accessible medical diagnostic equipment - Height-adjustable exam table - Wheelchair-accessible weight scale	Internal facilities/clinical engineering

	Accessible family/caregiver/visitor seating**	Internal facilities
	Accessible dressing/changing space	General contractor
	Low coat hooks**	Internal facilities/maintenance
Elevators	Braille/tactile signage	Elevator vendor/contractor
	Audible floor indicators	Elevator vendor/contractor
	Visual floor indicators	Elevator vendor/contractor
	Call button	Elevator vendor/contractor
Cafeteria/Dining Areas	Low dining tables/counters	General contractor
	Low service counters	General contractor
	Low self-service stations	General contractor

**Low-cost modifications that can be completed immediately.

Technical Infeasibility

In some cases, accessibility upgrades may be “**technically infeasible**” to make, particularly in older facilities or those located in historic buildings. Under the ADA, “technically infeasible” is defined as:

“Something that has little likelihood of being accomplished because existing structural conditions would require removing or altering a load-bearing member that is an essential part of the structural frame; or because other existing physical or site constraints prohibit modification or addition of elements, spaces, or features that are in full and strict compliance with the minimum requirements.”¹

Upgrades that will be costly or inconvenient are NOT considered technically infeasible. When a certain upgrade *is* technically infeasible, compliance is still required to the maximum extent technically feasible—your organization must determine alternative methods to ensure equal access to people with disabilities. The following table lists examples of those circumstances and potential solutions. This is not an exhaustive list.

Technical Infeasibility Table*

Accessibility Upgrade/Feature	Technical Infeasibility Conditions	Solutions
Accessible route to entrance	• Steep grade changes • Retaining walls • Drainage • Underground utilities	• Route with clear directional signage to alternate entrance • Install handrails • Incorporate flat resting areas • Staff assistance programs/policies
Code-compliant elevators	• Building too small for elevator shaft and equipment • Solid core shafts	• Install platform lift(s) where permitted • Relocate key services to accessible floor within building with clear directional signage
Entrance ramps	• Steep grade changes • Limited horizontal space on building's property	• Install limited-use lift • Create alternate accessible entrance with clear signage
Widening doors, hallways, entrances, etc.	• Requires removing load bearing walls or core building frame • Would damage historic features	• Alternate accessible entrance with clear signage • Prioritize wayfinding improvements
Accessible room layouts	• Load bearing walls	• Offer appointments & services in accessible rooms nearby
Walk- or roll-in showers	• Fixed plumbing/utility lines under existing bathroom	• Portable transfer benches • Install wall-mounted shower chair • Install handheld showerhead
General structural accessibility	• Irregular floor heights • Low floor-to-floor clearances	• Vertical platform lifts • Limited-use elevator • Reroute ramps

Reference

1. U.S. Department of Justice. Definitions. 36 CFR Appendix-B-to-Part-1191 106.5. 2010. [https://www.ecfr.gov/current/title-36/part-1191#p-Appendix-B-to-Part-1191\(106\)\(106.5\)](https://www.ecfr.gov/current/title-36/part-1191#p-Appendix-B-to-Part-1191(106)(106.5))

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Appendix 6.7

*Physical
Structures
Leased/Rented
Space
Frequently Asked
Questions*

Below is a list of frequently asked questions about the unique considerations for accessibility in leased or rented spaces. This document does not replace legal counsel. Work closely with your compliance, legal, risk, and buildings departments to ensure your specific legal obligations are met. For questions about your legal obligations under the Americans with Disabilities Act (ADA), please contact your regional ADA Center: <https://adata.org/find-your-region/>.⁷

1. Who is responsible for accessibility upgrades in leased or rented spaces?

Generally speaking, the legal responsibility is shared between the tenant and landlord. It is a common belief that the tenant or landlord can assign legal responsibility for ADA compliance to the other party in the lease. This is largely not true. Contracts between landlord and tenant may establish responsibility for who will *pay* for construction upgrades and maintenance, but regardless of what the contract says, one cannot contract out their responsibility for providing accessible physical structures.

2. Who is responsible for creating and maintaining accessible physical structures and features in common spaces?

The landlord and tenant share responsibility for the accessibility of common areas such as elevators, parking lots, public toilet rooms, common entry areas, and other shared facilities. Generally, a tenant's decision to continue leasing a space carries an obligation to address any existing non-compliance in common areas. In cases where a landlord is unwilling to provide accessibility upgrades that are required by law, the tenant may need to either pay for the upgrades themselves, or pursue other properties.

3. How does a tenant address inaccessibility in common spaces?

Ideally, addressing non-compliance is a collaborative effort between tenant and landlord. Some steps a tenant may take could include:

1. Reach out to the landlord to determine if they are aware of deficiencies
2. Negotiate a landlord/tenant split on corrective work
3. Survey and evaluate existing conditions
4. Develop budgets
5. Perform barrier removal

4. What should be considered when searching for a new space to lease?

When considering new leased space, consider performing an accessibility survey of the property, whether vacant, currently occupied, or brand new. The survey may be brief and will inform real estate/buildings/facilities leadership about corrections that must be made prior to occupying the building.



Appendix 6.8

Physical Structures Project Best Practices and Timeline

This document includes best practices and a simplified sample timeline to help organizations plan structural accessibility projects.

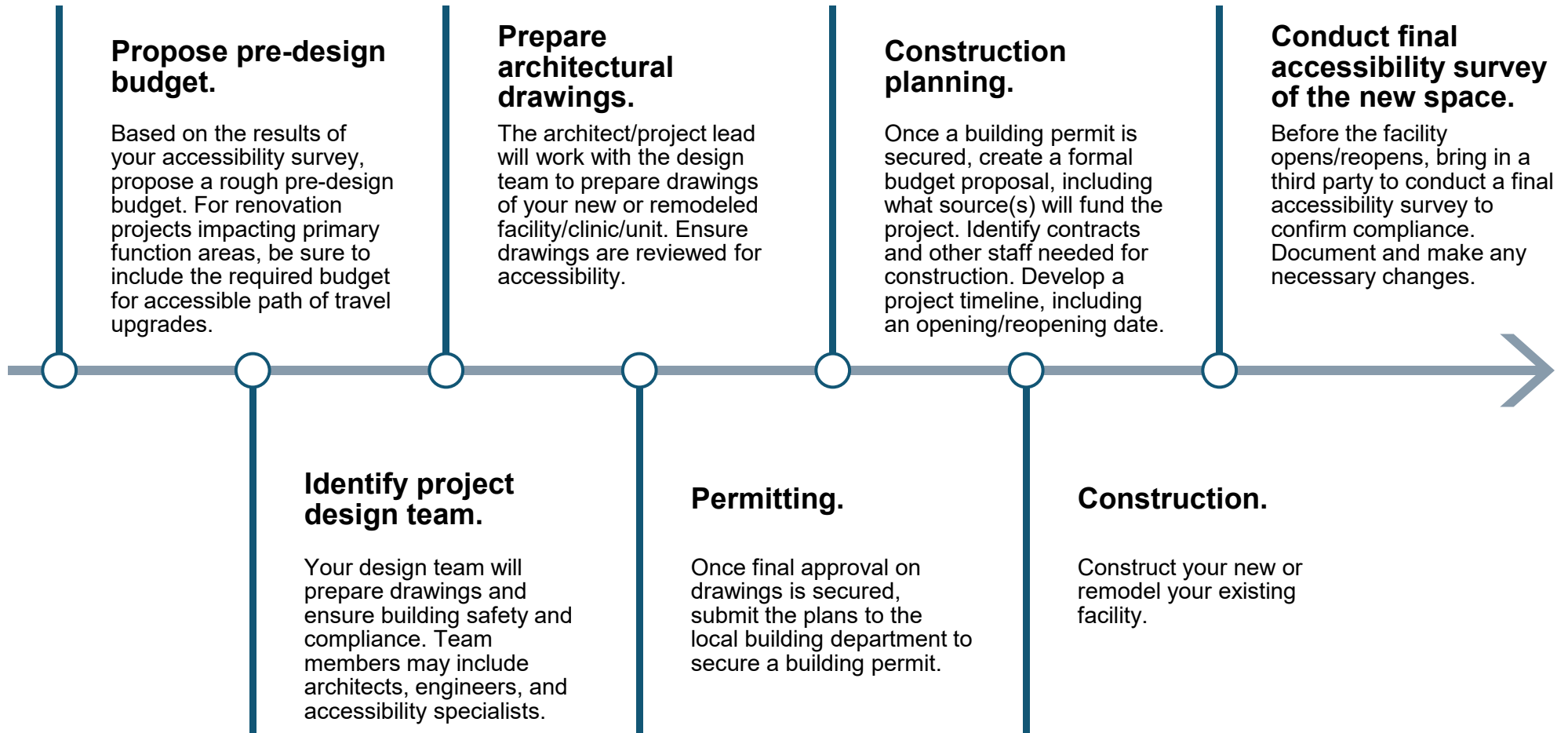
Best Practices

Generally, for both new construction and remodels of existing facilities, accurately identifying accessibility barriers, monitoring progress towards compliance throughout the project, and ultimately confirming that the finished product meets intended accessibility standards is essential for success.

Whether you are constructing a new building or are remodeling an existing one, the following four tips will help keep the project on track:

1. **Hire an access consultant.** Surprisingly, licensed architects, conscientious contractors, and qualified building inspectors may not be enough to ensure compliance with the complex and detailed world of accessibility. Accessibility is a separate specialty within these various fields. An accessibility consultant reviews the architect's drawings, advises on any issues that arise, and checks the contractor's work for compliance.
2. **Design to exceed code minimums.** This will maximize accessibility for your patients and visitors and leave a margin of error for contractors during the construction phase. Designing to exceed standards will ensure that all features are accessible, even where contractors aren't exact.
3. **Prioritize features that often receive patient complaints.** Prioritizing barrier removal and feature installation based on the patient experience ensures you are addressing patients' most pressing needs. The force needed to open doors, for example, is an often-forgotten barrier for people with disabilities. In this example, install automatic doors opener in key locations.
4. **Inspect construction work at the 90% completion stage.** This will ensure any accessibility errors are identified and addressed before a grand opening date.

Sample Construction Timeline





Appendix 6.9

Physical Structures Barrier Removal Guidance

Existing Facility – Barrier Removal

Unlike new construction projects, existing buildings often have significant accessibility shortcomings. These are defined as “barriers” to persons with disabilities. For renovations and remodeling projects, the intent of the Americans with Disabilities Act (ADA) and many state building code requirements is that all elements within the renovated area are brought up to the current accessibility standards where “readily achievable.”

Barrier removal requires thoughtful analysis, a detailed plan of action, and a construction budget for remodeling. The complexity and difficulty level of correcting older, existing buildings goes up exponentially with building age, too.

When considering how to make an existing facility accessible, your project team will face numerous challenges, including:

1. A building that is occupied during construction is **difficult to remodel** and **disruptive to patient care**.
2. **Non-compliance may be everywhere you look** (exit stairs, elevators, toilet rooms, exam and treatment rooms, doors, signage, drinking fountains, phones, width of corridors, light switch heights, cafeteria food service height, etc.).
3. **The applicable standards may be unclear**. Depending on date of construction and previous remodeling, the applicable standards may be different than expected.

Ultimately, barrier removal work requires expert-level oversight. Involving an access specialist early in the process will help determine best steps forward and ensure that the end result will be compliant with applicable standards.

Example Project

In 2025, a healthcare organization surveys the accessibility of an existing three-story medical office building they lease. The building was constructed in 1985 and contains the following suites:

- Urgent Care Clinic
- Outpatient Radiology
- Laboratory Services
- Pediatrics
- Adult Medicine
- Cardiac Care
- Dermatology
- Outpatient Surgery

During the assessment phase, the access specialist performs a detailed inspection and issues a 350-page report listing 127 elements that are not compliant with the 2010 ADA Standards. It was noted that the 1991 ADA Standards could also be applied, but are less favorable.

Following the assessment, the architect, access specialist, contractor, and representatives for the building's owner meet over a period of four months to determine the best path forward for remodeling and removing barriers. The original budget estimate triples over the course of these discussions. The team decides to upgrade the following elements in *each* of the suites, where applicable:

- Patient Toilet Rooms: Undersized, accessories to be relocated, door clearances inadequate
- Public Toilet Rooms: Undersized, accessories to be relocated, door clearances inadequate
- Exam and Treatment Rooms: Door clearances not provided, turning circle not provided
- Exit Stair Handrails: Incorrectly configured, must be removed and replaced
- Dermatology Phototherapy Booth: Inaccessible to wheelchair users; possibly requires an alternative method for treatment, or a larger booth
- Radiology Dressing Rooms: Undersized
- Signage: Total overhaul required (lack of visual contrast and placement irregularities)
- Elevator: Control panel needs to be overhauled
- Fire Alarm Strobes: Not provided
- Check-in Counters: Too high
- Entry Doors: Require too much force to open
- Doorknobs: Replace with lever handles throughout
- Drinking Fountains: Need high-low
- Accessible Phone: Not provided
- Accessible Parking Stalls: Over slope
- Curb Ramps: Not provided

After identifying barriers, the architect develops a set of drawings to “remove barriers” throughout the building. The architect confirms with the healthcare organization that the result would meet each individual medical unit's needs. The project team develops a barrier removal plan, a phased approach to organize barrier removal in priority order (priority order identified in the [ADA Checklist for Existing Facilities](#)⁷. Consider the sample priority ratings in Appendix 6.4: *Physical Structures Survey Data Template*).

During the building permit phase, several more accessibility issues are identified in the drawings and noted as non-compliant. The architect makes corrections, and the designs are ultimately approved.

During the construction phase, the architect, building inspector, and access specialist are responsible for walking the project periodically to confirm that the construction indeed matches the paper version of the building that was permitted.

- It's during this phase that problems are most likely to fall through the cracks. There's often pressure to overlook "minor" issues for fear of inconveniencing the medical practices again to make corrections. However, not doing so may result in unequal access for your patients with disabilities, patient safety issues, legal challenges, and more down the line.

When construction is 90% complete, the architect, building inspector, and access specialist complete a thorough walkthrough of the building together, inspecting every modification for compliance. The access specialist notices the wrong doorknobs have been installed in two suites. The project manager corrects the mistake.

When construction is complete and the building is ready to reopen, the access specialist again conducts the same detailed inspection, finding all 127 previously non-compliant elements addressed.



Appendix 6.10

Physical Structures New Construction Guidance

New Construction

It is significantly easier to achieve an “accessible” facility when you are building a new facility or a new suite build-out in a leased facility (commonly referred to as “tenant improvements”). Almost universally, state and local building codes include federal Americans with Disabilities Act (ADA) Standards. Thus, new construction projects (for the most part) will be designed and built to have accessible parking lots, accessible entry doors, accessible toilet rooms, and accessible exam and treatment rooms.

Because accessibility standards are built into building codes, most questions of access come down to two issues:

1. **Construction quality assurance**
2. **Specific needs that exceed code minimums**

Success requires a deliberate process in which facilities are planned, constructed, and ultimately assessed by access specialists to confirm that the finished product indeed meets the accessibility standards as intended.

Example Project

In 2025, a healthcare organization constructs a new three-story medical office building. They intend to house the following services in this building:

- Urgent Care Clinic
- Outpatient Radiology
- Laboratory Services
- Pediatrics
- Adult Medicine
- Cardiac Care
- Dermatology
- Outpatient Surgery

During the design phase, the architect meets with leadership from each group to understand their needs. The architect recognizes that the outpatient radiology and surgery offices often see patients with accessibility needs that exceed building code minimums. The architect designs the radiology and surgery floors accordingly.

During the permitting phase, several accessibility issues are identified as non-compliant. After the architect makes the appropriate corrections in the building plan, construction is approved and the permit is issued.

During the construction phase, the architect and building inspectors are both responsible for periodically “walking” the project to confirm that the construction indeed matches the paper version of the permitted building.

- This phase requires excellent attention to detail on the part of the architect and inspectors. It’s during this time that external pressures, such as a scheduled grand opening, may result in overlooking “minor” issues that may result in

unequal access for your patients with disabilities, patient safety issues, legal challenges, and more.

Once the project is complete, an access consultant is hired to conduct a thorough evaluation of the facility for compliance with ADA Standards.



Appendix 6.11

Physical Structures Barriers and Strategies

Chapter 6: Accessible Physical Structures and Features

Below is a list of barriers that may be encountered when designing, constructing, and modifying facilities that are physically accessible to people with disabilities. 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](#)⁷ for descriptions of each strategy.

Category of Barrier	Barriers to Accessible Physical Structures and Features	Possible Implementation Strategies
Leadership, staff, and provider attitudes	Not seen as priority Not viewed as required Not viewed as valuable Not viewed as necessary	- Identify and prepare champions who can emphasize the necessity of accessible spaces with their colleagues - Provide ongoing consultation and check-ins via Disability Coordinator, legal team, or other(s) - Educate/train on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. Where possible, use voices of the patient to talk about their experience. - 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. - Collect data on health and healthcare outcomes and patient experience - Kudos to high performing staff/clinicians/sites
Staff and provider knowledge and comfort	Lack of knowledge about disability competency/barriers faced in healthcare	- Identify and prepare champions - Provide ongoing consultation and check-ins - Provide training on use of accessibility features/navigating accessible routes - Educate staff on legal requirements, implications for patient satisfaction, patient and workforce safety, etc. Where possible, use voices of the patient to talk about their experience.
	Lack of awareness that patients need accessible spaces to access care	
	Lack of knowledge/training on how to use/assist patients with accessibility features	
Workflow and logistics	Resistance to operational disruptions/lost revenue	- Designate a formal implementation team - Develop policies/standards/contingency plans for maintaining clinical operations - Workflow mapping - Promote adaptability - Provide ongoing consultation and check-ins - Establish centralized technical assistance - Provide training - Promote network weaving by strengthening relationships and collaboration within and outside of the organization, departments, or units

Chapter 6: Accessible Physical Structures and Features

	Limited time, budget, and resources available	• Conduct needs assessment • Reexamine the implementation plan • Workflow mapping • Identify and prepare champions • Promote adaptability • Provide ongoing consultation and check-ins • Establish centralized technical assistance • Reallocate resources or advocate to reallocate resources with leadership • Access new funding (e.g., identify internal and external grant opportunities for capital projects) • Use data to document need via patient experience surveys and EHR data (see Chapter 2: Documenting Disability Status and Accommodation Needs)⁷ • Relay clinical data to responsible individuals/roles/leadership
Patient-level challenges	Construction would interrupt accessible routes	• Workflow mapping • Promote adaptability • Provide staff and providers with tools (scripts, cheat sheets, quick guides) • Patient-facing educational materials • Prepare patients/consumers to be active participants • Obtain and use patients/consumers and family feedback



Appendix 6.12

*Physical
Structures
Monitoring
Progress and
Adaptations*

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 implementation/leadership team members proactively removed organizational barriers (such as attitudes and culture) to planning or initiating structural accessibility projects?

- ☐ Not started
- ☐ Just beginning
- ☐ Actively addressing
- ☐ Completed

WHAT stage is the organization at in the process of conducting an accessibility survey?

- ☐ Not started
- ☐ Just beginning
- ☐ Actively addressing
- ☐ Completed

WHAT stage is the organization at in hiring/contracting all professionals needed for construction or installation?

- ☐ Not started
- ☐ Just beginning
- ☐ Actively addressing
- ☐ Completed

WHAT stage is the organization or each clinic/unit/department on the project timeline(s)?

- ☐ Not started
- ☐ Just beginning
- ☐ Actively addressing
- ☐ Completed

WHAT stage is the organization in complying with federal or state accessibility standards? If multiple locations, what stage is each clinic at?

- ☐ 0%
- ☐ Up to 25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-99%
- ☐ Full requirements met

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 6.13

Physical Structures Training Resources

While building new or modifying existing physical structures are critical components of facilitating an equally accessible space, environmental modifications alone are not enough to ensure patients actually receive equal access to their care. Staff must be trained on what features, layouts, and/or structures were intentionally created to support accessibility and how to maintain those features over time.

Educational Resources

Below are some sample resources and trainings to educate staff on the Americans with Disabilities Act (ADA) Standards for Accessible Design and physical accessibility generally.

- U.S. Access Board: [ADA Accessibility Standards](#)[↗]
- U.S. Access Board: [Guide to the ADA Accessibility Standards \(with animations\)](#)[↗]
- U.S. Access Board: [Webinars and Training](#)[↗]
- ADA National Network: [Self-Guided Trainings](#)[↗]
- U.S. Centers for Medicare and Medicaid Services: [Modernizing Health Care to Improve Physical Accessibility; A Primary for Providers](#)[↗]

Training Development Guidance

Below are a few considerations when developing your organization's internal training policies and/or materials.

- Avoid an overly legalistic approach unless it is a group that will respond to this (legal, compliance, patient safety, etc.). Instead, link accessibility to positive patient outcomes and improved patient experience.
- All staff members can play a role in maintaining an accessible environment. Provide training tailored to how each role can participate in maintaining the accessibility of their space(s). See the "Role-specific" section of the Training Table below.
- Periodically review patient complaints, safety incidences, and stories to inform training development. These accounts reveal barriers specific to your organization. Provide a follow-up training when a patient complaint or incident indicates staff was unprepared.
 - For example, consider hosting a panel of persons from a local disability group who can speak to their experiences in your organization's spaces. Accessibility is often better understood when staff hear a patient's personal experience.

- Utilize pictures and diagrams whenever possible.
 - For example, take a photo of an exam room when it's arranged for accessibility elements like approach, turning space, and clearances in mind. Post the photo in a visible location, such as the back of the exam room door, so that any staff who rearrange furniture (between patients, to clean, etc.) can refer to the photo to maintain the accessibility of the space.
- Create “tip sheets” for staff with guidance that can be accessed and understood in real time. For physical structures and features, this may include:
 - *Disability Discrimination*: An overview of responsibilities to ensure patients can access care areas and places of public accommodation.
 - *Maintaining Accessible Inpatient & Outpatient Spaces*: Describe workflow and information about accessibility features and navigating accessible routes, including those temporarily created during construction.
 - *Installation Instructions*: Models that show proper reach ranges and installation instructions for features installed by facilities staff. This may include diagrams with instructions on items that are especially complicated.
- Facilitate opportunities for staff to meet and share solutions across departments.
 - In a large health system, this could look like an annual meeting where the ADA Coordinators (one from each facility) meet with Operations Managers to present on physical access issues relevant to both groups.
 - In a smaller entity, this could involve more roles. Sharing the time is valuable and gives more context to accessibility information through discussion and questions.

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 trainings include role-specific responsibilities (e.g., who identifies a patient's need, who requests room access, etc.) to ensure each staff member clearly understands their role in maintaining accessible physical structures and features.

Who	What	When	How
Leadership	Disability competency: creating an affirming environment; language to use with people with disabilities	- Annually - Ad hoc as issues arise	Didactic
	Accessibility overview: examples of accessibility features, layouts, designs, etc.; who benefits from accessible spaces; why accessible spaces are important for patient care		
	Laws/regulations and standards related to accessible physical structures and features		
Implementation team	Disability competency: creating an affirming environment; language to use with people with disabilities	- Annually - Every two years - Every 6 months - Ad hoc as issues arise	- Didactic (could be in-person or online) - Laminated guides
	Laws/regulations related to accessible physical structures and features		
	Existing barrier removal plans, deferred maintenance lists, complaints, grievances, patient experience survey results, model departments/units/clinics, etc. (if applicable)		
	Accessible physical structures and features: what makes a space "accessible"; what's available, how to use accessibility features		
Clinician and staff	Disability competency: creating an affirming environment, language to use when speaking with people with disabilities, including how to ask the patient about how they would like to be transferred and moved	- Orientation - Annually - Every two years - Every 6 months - Ad hoc as issues arise	- Didactic (could be in-person or online) - EHR tools (e.g., best practice advisories) - Laminated guides
	High-level overview of accessible physical spaces and features laws and regulations, including how/if they apply to staff and what patients are covered		
	Availability of accessibility features		
	Policies related to maintenance/replacement of accessibility features, including signs that structures/features may be nearing the end of its useful life or when a repair is needed		
Role-specific	Facilities and Maintenance Staff: measurements, maintenance, signage, hardware, restrooms, clearances	- Orientation - Annually - Every two years - Every 6 months - Ad hoc as issues arise	- Didactic (could be in-person or online) - Laminated guides
	Environmental Services: keeping accessible routes clear, floor transitions, maintaining room set-up		
	Front Desk and Administrative Staff: maintaining an accessible check-in area, effective communication, seating		
	Compliance, Risk & Safety Coordinators/Officers: disability access complaints, maintenance issues that are safety risks		
	Clinical Managers: exam room layouts, accessible patient flow, room turnover procedures		