



# Access

New England

*A publication of the New England ADA & Accessible IT Center*

*A project of Adaptive Environments, Inc. [www.AdaptiveEnvironments.org](http://www.AdaptiveEnvironments.org)*

## This Issue Highlights

### Health Care and Medical Services

- Disabled Medical Students Entering Health Professions, Page 2
- Hospital Sued Over Patient Care, Page 6



## Contents

- 1 | Project Director's Report
- 4 | Frequently Asked Questions
- 5 | Great Web Sites
- 7 | News
- 10 | Updates
- 12 | Accessible ITems
- 13 | Publications
- 14 | Events and Announcements

### For more information

1 (800) 949-4232 voice/tty

[ADAinfo@NewEnglandADA.org](mailto:ADAinfo@NewEnglandADA.org)

[www.NewEnglandADA.org](http://www.NewEnglandADA.org)

## New England ADA & Accessible IT Center Staff

**Oce Harrison, Ed.D.**

Project Director

oharrison@AdaptiveEnvironments.org

**Kathy Gips**

Director of Training

kgips@AdaptiveEnvironments.org

**Rachel Tanenhaus**

ADA Information Specialist

rtanenhaus@AdaptiveEnvironments.org

**Andy Washburn**

ADA Information Specialist

awashburn@AdaptiveEnvironments.org

**Gabriela Bonome-Sims**

Director of Administration

gsims@AdaptiveEnvironments.org

**Mike DiLorenzo**

Information Technology Administrator

mdilorenzo@AdaptiveEnvironments.org

**Nahlia Smith**

Project Assistant

nsmith@AdaptiveEnvironments.org

**Ana Gomez-Moreno**

Coordinator of Design and Communications

agomez@AdaptiveEnvironments.org

**Valerie Fletcher**

Principal Investigator

vfletcher@AdaptiveEnvironments.org

**Lisa Spitz**

Designer

lspitz@AdaptiveEnvironments.org

[Access New England](#) is available in large print, Braille, audiocassette, computer disk, and e-mail upon request and online at: <http://www.NewEnglandADA.org>.

**Andy Washburn**, Editor

## Access New England is published by the New England ADA & Accessible IT Center

The center is one of ten Regional Disability and Business Technical Assistance Centers funded by the National Institute on Disability and Rehabilitation Research (NIDRR) to provide information, materials and technical assistance to individuals and entities that are covered by the Americans with Disabilities Act (ADA). However, please be aware that NIDRR is not responsible for enforcement of the ADA. The information, materials and/or technical assistance are intended solely as informational guidance and are neither a determination of your legal responsibilities under the Act, nor binding on any agency with enforcement responsibility under the ADA.

## Regional Advisory Board

The Regional Advisory Board meets twice a year. The members' input and commitment greatly assists the New England ADA & Accessible IT Center in its mission.

### Connecticut

**John Ficarro**, Ph.D., Connecticut Tech Act Project

**Michael Kurs**, Pullman & Comley, LLC

**Suzanne Liquerman**, Connecticut Department of Administrative Services

**Candace Low**, ADA Coalition of Connecticut

### Maine

**Kathy Powers**, Maine Consumer Information and Technology Training Exchange

**Steve Tremblay**, Alpha One

### Massachusetts

**Richard Arcangeli**, Massachusetts Rehabilitation Commission

**Myra Berloff**, Massachusetts Office on Disability

**Chuck Hitchcock**, CAST

**William Kelley**, Massachusetts DMR Regional Assistive Technology Center

**Kerim M. Munir**, M.D., D.Sc., Children's Hospital

**Kathy Petkauskus**, Resource Partnership

**Cathy Taylor**, Cape Organization for Rights of the Disabled (CORD)

### New Hampshire

**Carol Nadeau**, New Hampshire Governor's Commission on Disability

**Therese Willkomm**, Ph.D., ATECH Services

### Rhode Island

**Bob Cooper**, Rhode Island Governor's Commission on Disabilities

### Vermont

**James P. Dorsey**, Vermont Department of Employment and Training

**Deborah Lisi-Baker**, Vermont Center for Independent Living

**David Sagi**, Vermont Division of Vocational Rehabilitation

# Access to Health Care and Medical Services



Oce Harrison, Project Director

“The possibilities still await our participation.”

For people with disabilities, facility and service barriers still remain; indeed, many health care facilities and programs are inaccessible despite the requirements of the ADA. The consequences of access inequities are reduced quality of health care for people with disabilities.

This issue of Access New England highlights stories about fighting the traditional fight for access to health care services for people with disabilities as well as pioneering approaches. Beginning with Hospital Sued Over Patient Care, patients allege that their civil rights were violated and their health and safety jeopardized when they were denied vital equipment and services (page 6). Our Connecticut affiliate, the ADA Coalition of Connecticut (ADACC) shares work they are doing to increase access to mammography

for women with disabilities (page 9). Similarly, our Massachusetts affiliate, the Massachusetts Office on Disability (MOD) will be assessing each mammography facility in the state for accessibility, and providing technical assistance on removing barriers to access (page 8).

A more futuristic way to make change is revealed in the article Disabled Medical Students Entering Health Professions where faculty in health sciences describe a noticeable increase of students with disabilities who are applying for and being admitted to medical, dental, and nursing programs... The possibilities still await our participation.

Another progressive approach is educating health care professionals into thinking that it “could be me trying to get up onto that table,” and that it is more cost efficient in the long run to purchase equipment that is universally designed. A useful document published by the Center for Universal Design, Removing Barriers to Health Care: A Guide for Health Professionals, provides recommendations for universal design features in both the environment and equipment, such as weight tables and mammography machines ([www.fpg.unc.edu/~NCODH/RBar/](http://www.fpg.unc.edu/~NCODH/RBar/)).

I would be remiss if I did not mention a much larger problem — inadequate health insurance coverage and lack of health insurance for people with disabilities. A new national survey finds that many non-elderly adults (ages 18-64) with disabilities face difficulties paying for needed health

care; nearly half (46%) report that they go without equipment and other items due to costs; more than a third postpone care because of cost (37%); skip doses or split medication costs (36%); and spend less on basics such as food, heat, and other services in order to pay for health care (36%). These and other findings are published in a Kaiser Family Foundation Report, Understanding the Health Care Needs and Experiences of People with Disabilities: Findings from a 2003 Survey, available on-line at ([www.kff.org/medicare/121203package.cfm](http://www.kff.org/medicare/121203package.cfm).)

What are the consequences for being uninsured and disabled? The uninsured are sicker and poorer. It is no surprise that people with disabilities without health insurance face some of the greatest challenges. In a December 1993 study by the Kaiser Family Foundation, people with disabilities who don't have health insurance delay care, cannot afford medication, go without needed equipment, and cannot pay hospital and dental bills. An analysis of the Medical Expenditure Panel Survey (MEP, 2003) finds that of 15.5 million non-elderly adults (ages 18-64) with disabilities, 2.3 million were uninsured.

If we can't afford to get in the health care door, or if we get in the door but can't access needed equipment and services, then universal access to health care for all and access to universal health care for all should be our next mantra.

# Disabled Medical Students Entering Health Professions

“Over the past several decades, the doors have opened for kids with disabilities to go to school, get diplomas and graduate, so we’ve seen huge increases in the numbers of disabled students in undergrad.”

As a fourth-year medical student, Jeffrey Lawler listens — really listens — as patients run through their lists of physical complaints. When he touches a scar or feels for bumps, lumps or growths, he directs all of his focus into his hands, moving his fingertips slowly over skin, tissue and bone, occasionally pressing and prodding gently. A talking blood pressure cuff recites readings in an automated voice, and a nurse or fellow medical student lets Mr. Lawler know that a patient’s temperature is hovering around 100. He cannot read the numbers on a thermometer, blood pressure monitor or his pager.

His eyesight began failing 20 years ago, as a result of the disease retinitis pigmentosa. By 1993, Mr. Lawler, now 43, was legally blind. Still, he took the medical college application test with the help of a reader and a scribe and was accepted to Western University Medical School in Pomona, CA. He will graduate in June near the top of his class and hopes to practice physical medicine and rehabilitation.

In the past, students with physical disabilities were rarely accepted to medical school, and they rarely completed it. Now, Mr. Lawler joins a growing number of students with disabilities who are thriving in medical school. Though no statistics document how many of these students are attending medical school or how many disabled doctors are practicing, experts note that laws like the ADA allowed disabled students access to every level of education and helped propel the current increase in medical students.

“Over the past several decades, the doors have opened for kids with disabilities to go to school, get diplomas and graduate, so we’ve seen huge increases in the numbers of disabled students in undergrad,” said Martha Smith, project coordinator of the Center on Self-Determination of Oregon Health & Science University. A survey of the American Council on Education notes that the number of full-time freshmen with disabilities has increased to 11 percent from 7 percent from 1988 to 1999.

Ms. Smith and colleagues at the Center on Self-Determination have trained faculty and staff members at about 25 medical schools in the last three years, focusing on ways to accommodate the students without sacrificing medical standards and patient safety.

Brenda Premo, director of the Center for Disability Issues and the Health Professions at Western University, said: “When I first came here, the idea of a deaf or blind person being in medical school was so foreign that no one knew what I was talking about. Now I’m getting several calls a month from students with disabilities saying they want to go into health professions and many who want to become doctors.”

Dr. Lisa I. Iezzoni says times have changed from the early 80’s when she attended Harvard Medical School. In her book, *When Walking Fails: Mobility Problems of Adults with Chronic Conditions*, she writes of her battle with multiple sclerosis, which was diagnosed just as she began medical school. After graduating in 1984, Dr. Iezzoni, now a professor of medicine at Harvard, decided against practicing and chose research, partly because of an internship adviser who suggested that he could “pass a hat around to the chiefs of medicine at the various Harvard hospitals to see what they would donate toward a salary for my internship.”

“A top leader at a Harvard teaching hospital also told me that there were too many doctors in the country right now for us to worry about training a handicapped doctor,” said Dr. Iezzoni, 49, who uses a motorized scooter. “I do regret not becoming a physician, but at some point I realized that I would be fighting all the way, at the same time I was fighting my body.”

Despite increased acceptance of people with disabilities and changes in laws, attitudes may still be hard to sway, particularly in medicine.

“Doctors are the least comfortable and often the least knowledgeable about disability issues,” said Dr. Julie Madorsky, 58, who practiced from 1969 to 1995. She had childhood polio and was the prototype for the character Dr. Kerry Weaver, the attending physician who walks with the aid of a crutch on the television series “E.R.” Dr. Madorsky said: “There’s a concept that it’s ‘them’ and ‘us.’ The idea that someone can enter medicine with a physical disability is counter intuitive. It goes against the notion that doctors are healthy and perfect and able-bodied and patients are not.”

Some people in the field worry that the physically disabled cannot fulfill the clinical requirements of medical school and that they need special treatment to graduate. There is no national criterion for technical standards for admission and graduation, and each of the nation’s 126 medical schools is responsible for creating and publishing its own graduation requirements. Advocates for disabled students argue that some medical school standards that create hurdles for the disabled are outmoded.

“Too many schools are using the standard that a doctor has to see perfectly, walk perfectly and hear perfectly, but if they really followed that standard, no one would graduate,” said Ms. Premo. “I support dropping students who don’t achieve and I don’t believe in lowering standards,” she added, “but you have to allow for difference.”

The ADA may have had other influences as well. No studies have looked at malpractice and whether disabled doctors and medical students are at higher risk. But, according to the Physician Insurers

“There’s a concept that it’s ‘them’ and ‘us.’ The idea that someone can enter medicine with a physical disability is counterintuitive. It goes against the notion that doctors are healthy and perfect and able-bodied and patients are not.”

Association of America, a trade association of medical malpractice insurance companies, there is no difference in underwriting medical liability policies for doctors who are disabled and those who are not.

“Our application and underwriting process is blind to disabilities,” said Frank O’Neil, a senior vice president at the ProAssurance Corporation, one of the nation’s largest medical liability insurance companies. “As long as a doctor is trained and able to perform the procedures for which they are applying for coverage — with or without an accommodation — we don’t care.”

Source: “Barriers Fall for Disabled Medical Students,” by Linda Villarosa, New York Times, November 25, 2003.

# ADA Q & A: Health Care Providers

## Covered Health Care Providers

### Q. Which health care providers are covered under the ADA?

A. Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health care providers covered by the Title III of the ADA. Title III applies to all private health care providers, regardless of size. It applies to providers of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA.

Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA.

Health care providers that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

## Effective Communication, Auxiliary Aids & Services

Health care providers must find appropriate ways to communicate effectively with persons who have disabilities affecting their ability to communicate. Various auxiliary aids and services such as interpreters, written notes, readers, large print or braille text can be used depending on the circumstance and the individual.

### Q. Why are auxiliary aids and services so important in the medical setting?

A. Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these aids and services, medical staff run the risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem, and prescribing inappropriate treatment. Similarly, patients may not understand medical instructions or warnings that may have a serious impact on their health.

## Policies and Procedures

Health care providers are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require providers to make changes that would fundamentally alter the nature of their service.

### Q. What kinds of modifications to policies or procedures might be required?

A. Modifying standard policies, practices or procedures can be an inexpensive but effective way to provide access to health care services. This may mean taking extra time to explain a procedure to a patient who is blind, providing assistance to help a patient with a mobility impairment through the cafeteria line, or arranging to meet a patient at an accessible entrance that is normally kept locked after hours.

### Q. Must hospitals allow service dogs in their buildings?

A. The ADA requires admission of service animals to hospitals and the offices of health care providers unless it would result in a fundamental alteration or jeopardize safe operation. The determination of a direct threat to health or safety must be based upon medical or other evidence not on stereotype or conjecture.

## Existing Facilities/Barrier Removal

### Q. When must private medical facilities eliminate architectural barriers that are structural in nature from existing facilities?

A. When the removal of those barriers is readily achievable, meaning easy to accomplish, without much difficulty or expense. Like undue burden, readily achievable is determined on a case by case basis in light of the resources available to an individual provider.

### Q. Must publicly funded health care providers meet special ADA requirements to make their existing buildings accessible?

A. Yes. Title II of the ADA requires public health care providers to make all of their health care programs and services available to people with disabilities. However, they may do so in a variety of ways. If portions of existing facilities are inaccessible, they can relocate programs or services to accessible facilities, remove architectural barriers that keep people with disabilities from using services,

# Building Your Rolodex

or find a different way to provide the services. The ADA also requires public providers to provide integrated access to their programs. They must make integrating people with disabilities into their regular programs a priority when choosing the best means to achieve program access.

For example, if a public hospital offers monthly child birth classes on an upper floor of an older building without an elevator, the hospital has a number of options in how it may make this program accessible. It could install an elevator, schedule the class in a ground floor classroom in the future, or relocate the class to a ground floor room, when individuals who use wheelchairs register for the class.

## Transportation

**Q. What does the ADA require regarding transportation services such as a hospital van used to pick up elderly patients from outlying areas?**

A. The ADA does not require a van to be retrofitted with a lift. However, the hospital must provide equivalent transportation services for people with disabilities who are unable to use the hospital's van. If a new van is purchased, and if it seats more than 16 people, it should be accessible to individuals with disabilities unless equivalent transportation services are provided.

Source: "ADA Q & A: Health Care Providers," by Deborah Leuchovius, PACER Center, [www.pacer.org/pride/health.htm](http://www.pacer.org/pride/health.htm).

## ExceptionalNurse.com

[www.exceptionalnurse.com/](http://www.exceptionalnurse.com/)

By sharing information and resources, ExceptionalNurse.com hopes to facilitate inclusion of students with disabilities in nursing education programs and foster resilience and continued practice for nurses who are, or become, disabled.

## Massachusetts Office on Health and Disability

[www.state.ma.us/dph/fch/ohd/](http://www.state.ma.us/dph/fch/ohd/)

The mission of the Office on Health and Disability of the Massachusetts Department of Public Health is to promote the health and well being of people with disabilities and chronic conditions in Massachusetts.

## Promoting Awareness in Healthcare, Medical and Deaf (PAH, MD)

[www.studentorg.vcu.edu/amsa/pahmd.html](http://www.studentorg.vcu.edu/amsa/pahmd.html)

It is the aim of PAH, MD to: educate the medical community about the unique issues and responsibilities in providing effective health care to deaf and hard of hearing people, and to promote a basic understanding of Deaf culture, sign language, and hearing loss; engage medical students and healthcare providers in cooperative projects with members

of the local Deaf and hard of hearing communities to disseminate healthcare information and increase the awareness of d/hoh individuals' rights and responsibilities in healthcare settings; and encourage deaf and hard of hearing individuals to consider careers in medicine and other healthcare professions.

## National Women's Health Information Center

[www.4woman.gov/editor/aug99/aug99.htm](http://www.4woman.gov/editor/aug99/aug99.htm)

NWHIC is a free information and resource service on women's health issues for consumers, health care professionals, researchers, educators, and students. Link is to an article about "Fighting for Accessible Services to Beat Breast Cancer."

## Kaiser Family Foundation

[www.kff.org/medicare/121203package.cfm](http://www.kff.org/medicare/121203package.cfm)

Understanding the Health Care Needs and Experiences of People with Disabilities: Findings from a 2003 Survey. People with disabilities are at risk in the health-care system because of their wide-ranging health-care needs, their relatively heavy use of prescription drugs, health-care and support services, and typically low incomes. A new survey of people with permanent mental and/or physical disabilities explores their health-care experiences and challenges in accessing and paying for care.

# Hospital Sued Over Patient Care

“People who have unique needs because of their disability have a legal right to have providers respond to them uniquely.”

Four former patients, who have physical disabilities, have sued Washington Hospital Center alleging that their civil rights were violated and their health and safety compromised when they were denied access to vital equipment and services. Attorneys for the two men and two women said they intended to draw attention to the need for equipment, such as adjustable-height examination tables, as well as accessible nursing call buttons, restrooms and telephones.

“People with disabilities are not able to access routine medical care,” said Elaine Gardner of the Washington Lawyers’ Committee for Civil Rights and Urban Affairs. Most area hospitals, she said, have not gone beyond simple accommodations, such as wheelchair ramps, resulting in limited or inferior access to mammograms, physical exams and other services.

The Disability Rights Council of Greater Washington joined the four plaintiffs in suing the hospital. Marc Fiedler, a lawyer who chairs the council, said the group began planning the federal lawsuit last year after getting complaints about several hospitals. Patients are “made to suffer enormous hardship, humiliation and even the risk of unnecessary harm,” said Fiedler.

The suit, filed in US District Court in Washington, contends that the hospital violated the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973. It seeks unspecified damages and a court order directing that the hospital “bring its equipment, facilities, policies and practices” into compliance.

Chai Feldblum, a professor at Georgetown University Law Center, said the suit is “quite significant” because it marks the relatively new application of disability law to cases in which people are not denied care outright but instead are given inadequate care.

“People who have unique needs because of their disability have a legal right to have providers respond to them uniquely,” said Feldblum. She said disabled patients are denied access because of staff and funding shortages, not intentional discrimination.

D. Christopher Butler, an analyst at the Federal Communications Commission and a plaintiff, said at a news conference that his humiliating experience as a patient compelled him to take the city’s largest private hospital to court. Butler, 39, who has been paralyzed from the neck down for 18 years, spent 2 1/2 weeks at Washington Hospital Center in May 2002 after suffering a burn. Despite his impairment, he said, nurses did not help him eat or drink frequently enough and failed to turn him, resulting in inflammation of his left hip.

The most serious injuries, the suit says, occurred when staff failed to maintain a regimen of care that must be followed by people who have no control over their bowel muscles. As a result, Butler suffered dangerously high blood pressure and at one point had to lie in his feces for several hours. Butler said hospital staff members responded to his complaints “as if the services I had requested were extraordinary and required special care, when in reality these are things that are necessary.”

Source: “Disabled Sue Hospital Center,” by Sewell Chan, Washington Post, Page A08, November 26, 2003.

# News from the Center

## ADA Center To Exhibit At Upcoming Events

**ConstruCT 2004, March 30**  
Radisson Hotel, Cromwell, CT

## New England Building and Facilities Expo, April 7-8

Bayside Expo Center, Boston, MA  
(also presenting)

## CT Library Association, April 20-21

Mystic Marriott Hotel and Resort,  
Groton, CT

## Restoration & Renovation, April 22-24

Hynes Convention Center,  
Boston, MA (also presenting)

## MA Library Association, April 28-30

Sea Crest Resort, Falmouth, MA

## Access '04, June 18-19

UNH Whittemore Center, Durham, NH

## Invite an ADA Specialist for Lunch or Anytime!

ADA Specialist Andy Washburn will come to your office and you'll...

- Discuss & get answers to your ADA questions
- Learn how to use the ADA Accessibility Guidelines (ADAAG)
- Find out how the ADA relates to model building or local and state accessibility codes

You can reach him at:

The New England ADA & Accessible IT Center: 617-695-1225, ext.31  
awashburn@AdaptiveEnvironments.org

Note: Fee \$150 for 60-90 min.  
Only available to Greater Boston region

## Connecting the Commonwealth: Making IT in Massachusetts Accessible to All



Greg Pisocky from Adobe discusses how to make PDF files accessible.

On December 9, 2003 the New England ADA & Accessible IT Center, in conjunction with the Massachusetts Office on Disability and Northeastern University, co-sponsored a workshop about integrating accessibility into websites and other information technology (IT). The purpose of the workshop was to make state and municipal agencies, colleges, universities, public school districts, IT professionals and others aware of the need for web accessibility, and to assist them in making their web sites and other IT more accessible. Workshop presenters included Andrew Kirkpatrick from the National Center for Accessible Media (NCAM), Sarah Bourne from the Commonwealth of Massachusetts, Greg Pisocky from Adobe, Chuck Hitchcock from CAST, Joe Lazzaro from the Massachusetts Commission for the Blind, Barbara Lybarger from the Massachusetts Office on Disability, and Rachel Tanenhaus from the New England ADA & Accessible IT Center.

## Center Staff Attend IT Training



Janet Dermody from the Vermont Center for Independent Living and Kathy Gips, Rachel Tanenhaus, and Oce Harrison from the ADA Center enjoy a little California sunshine during a break at AccessIT's annual training.

New England ADA & Accessible IT Center staff and state affiliates from Vermont and Maine attended a training in Coronado, CA, January 11-13, sponsored by AccessIT. AccessIT, the National Center on Accessible Information Technology in Education, provides an annual training event for all ten ADA & Accessible IT Centers staff and affiliates across the country, focusing on technical assistance and policy issues in accessible IT in education.

## Tricky Question of the Month

Check out the Adaptive Environments website for our tricky question of the month!

[www.AdaptiveEnvironments.org/neada/tricky.php](http://www.AdaptiveEnvironments.org/neada/tricky.php)

## News From Around the Region

### Mammography Access Project

The Mammography Access Project, a program of the Massachusetts Department of Public Health's Office on Health and Disability, has been working to improve mammography screening rates for women with mobility disabilities. The project utilizes a number of strategies to achieve this goal including assessing each mammography facility in the state for accessibility, and providing the facility with technical assistance on removing barriers to access; disseminating information on the accessibility of facilities to consumers and providers; training radiologic technologists to work with women with mobility disabilities; and providing longer appointment slots for women with mobility disabilities.

There are currently one hundred and seventy six mammography screening facilities across the state. Since its inception in the spring of 2002, the project has provided basic technical assistance to facilities that have been surveyed and has conducted four trainings for radiologic technologists on working with women with mobility impairments. By the end of February 2004, each of these facilities will have been surveyed for access by the project. The information will be compiled and published in print and on the Department of Public Health's website.

For more information, contact Lisa Maisels at (617) 624-5960.

### Vermonters Speak out for New Approaches and Best Practices

Staff and peers from the Vermont Center for Independent Living (VCIL) braved some zero degree weather to bring their perspectives on disability and health into a taping studio at the UVM Medical School. VCIL and the Area Health Education Centers are partnering on a series of video clips of individuals with disabilities sharing their experiences and advice for health practitioners. Once the first of these video "shorts" are completed they will be used in a series of "grand rounds" educational sessions planned for Vermont hospital and allied health providers later this year. Future video projects include similar interviews on public access TV and use of these video clips on VCIL's website. The project is funded by Vermont's Disability and Health Promotion Project.

VCIL is also working with both peers and state agencies on improved funding and support for health and personal care services that support independence and work. Our peers and staff are speaking up about health benefits, home accessibility, adaptive equipment, personal care, and employment programs. Recently several peers shared their stories with members of the House Health and Welfare Committee. Their words convey how closely health, wellness, independence and work are linked in the lives of Vermonters with disabilities. As Scott Goyette, staff member at VCIL, said about

the Vermont's Participant Directed Attendant Care Program, "There are ways out there – living in a nursing home or assistance by family – that you can survive, but programs like this really allow you to live."

### Rhode Island Gains Publicity from Lane Case

The Rhode Island Governor's Commission on Disabilities has been working with the Providence Journal on a public awareness project about the Tennessee vs. Lane Supreme Court case. The Commission has been excited about the flurry of public interest surrounding this important case.

On January 14, 2004, the Providence Journal (ProJo) began a two-part series about the Lane Case. In the first installment, the ProJo investigated the background of the case, detailing the important case precedents and exploring the potential impact of the Lane decision. In the second installment, the ProJo interviewed Bob Cooper, the executive secretary of the Governor's Commission, for background information on accessibility in the state of Rhode Island. The Commission was happy to report that Rhode Island has nearly completed a multi-year, \$600K set of renovations to ensure ADA compliance in all courthouses in the state. The Commission is hopeful that the increased awareness about the importance of physical access in public buildings will result in improvements across the state.

## Changes to New Hampshire's Parking Law

As of January 1, 2004, changes to NH's parking law improved and enhanced the rights of persons with walking disability plates or placards.

### [The amendments to the parking law Chapter 265:](#)

1. Defines the "access aisle" as the crosshatched area adjacent to handicapped parking spaces required for individuals with a walking or mobility device to maneuver in and out of their vehicle;
2. Imposes fines for any vehicle parking in or overlapping into this space;
3. Increases the minimum fine for illegally parking in a place designated for a person with a walking disability; and
4. Permits persons with walking disabilities or their drivers to submit photographic evidence of a vehicle in violation of the designated space or access aisle along with a sworn statement so that a ticket can be issued by local enforcement.

The Governor's Commission on Disability and Central New England Chapter of the National Multiple Sclerosis Society were instrumental in the development and passage of this law and are now working with the Division of Motor Vehicles and the media to launch an awareness campaign to alert the public about the changes. Publicizing this widely will, hopefully, minimize confusion as well as facilitate each community's

implementation of these changes into their current parking enforcement system. People with walking disability plates or placards will be more aware of their rights and the general public will better understand the need for these new regulations.

## Connecticut Health Services for Women with Disabilities

During the 2003 Connecticut legislative session, the Women's Health Campaign, in collaboration with the Connecticut Women and Disability Network (CWDN), submitted Public Act No. 1152, An Act Concerning Gynecological Services for Women with Disabilities. This proposal was developed in response to concerns of women with disabilities, voiced at a CWDN meeting convened for the purpose of developing relevant legislation. The proposal also followed and built upon a 3-year effort, led by CWDN, to increase access to mammography for women with disabilities. The ADA Coalition contributed technical assistance and training during both of these initiatives.

The successful effort to pass the bill mobilized women's organizations to an unusual extent. The public hearing offered compelling personal testimony regarding disrespectful care, incomplete treatment and forced sedation. The final bill required that the Department of Public Health and the Office of Protection and Advocacy evaluate current conditions

affecting the gynecological health of women with disabilities and make recommendations pursuant to its findings.

The Coalition sat on the committee charged with developing these recommendations and participated in drafting the final report, which was completed and submitted for review to the Department of Public Health in December.

### [The report recommends:](#)

1. ADA compliance evaluation of selected private and public providers;
2. Creation of a Medical Advisory Committee that will develop, among other things, criteria for using sedation, best practices for treatment, and mammography quality standards;
3. Establishment of a Regulatory body charged with implementing the recommendations of the Advisory Committee; and
4. Public outreach and education conducted by those organizations, the ADA Coalition among them, that have shown both knowledge of and commitment to the issue of woefully inadequate healthcare for women with disabilities.

This initiative, carried out in partnership with the State Permanent Commission on the Status of Women, offers resilient testimony to the value of collaborations that reach beyond the disability community.

## Access Board Update

### Access Board Approves New Guidelines Under the ADA and ABA

At its January meeting, the Access Board unanimously approved new guidelines covering access to facilities covered by the Americans with Disabilities Act (ADA). The approved rule overhauls the existing ADA Accessibility Guidelines (ADAAG), which were first published in 1991. The rule also revises guidelines for federally funded facilities required to be accessible under the Architectural Barriers Act (ABA). Both the ADA guidelines and the ABA guidelines specify access in new construction and alterations and provide detailed provisions for various building elements, including ramps, elevators, restrooms, parking, and signage, among others.

The new guidelines are based on recommendations developed by an advisory committee the Board had chartered to review the existing ADAAG. The ADAAG Review Advisory Committee consisted of 22 members representing the design and construction industry, the building code community, state and local government entities, and people with disabilities. Based on this committee's report, the Board published in Fiscal Year 2000 a proposed set of guidelines that featured a host of updated provisions and clarifying revisions, as well as a new look and format. This proposal, which was made available for public comment

for six months, attracted over 2,500 comments. These comments provided considerable input on the substance of the guidelines. The Board made a variety of changes to the guidelines based on this feedback from the public.

The Board's recent action allows the finalized guidelines to move on to the Office of Management and Budget (OMB), which serves as a clearinghouse for Federal regulations. OMB has 90 days to complete its review. The Board will proceed to publish the new guidelines once approved by OMB.

The Board's guidelines, by themselves, are not enforceable or mandatory for entities covered by the ADA or ABA. Other agencies, such as the departments of Justice and Transportation under the ADA, and several others under the ABA, are authorized to set the design standards that must be met. Their standards are to be consistent with the Board's guidelines. These agencies will update their enforceable standards based on the Board's final guidelines. As part of this action, the agencies will specify when the updated standards take effect.

To receive updates by e-mail on the progress of this and other Board rulemakings, send an e-mail to [news@access-board.gov](mailto:news@access-board.gov) with "updates" in the subject field or visit the Board's website at [www.access-board.gov/news/updates.htm](http://www.access-board.gov/news/updates.htm).

## DOJ Update

### Effective Communication in Hospitals

People who are deaf or hard of hearing use a variety of ways to communicate. Some rely on sign language interpreters or assistive listening devices; some rely on written messages. The method of communication and the services or aids the hospital must provide vary depending upon the abilities of the person who is deaf or hard of hearing and on the complexity and nature of the communications. Effective communication is critical in health care settings where miscommunication may lead to misdiagnosis and improper or delayed medical treatment.

Under the ADA, hospitals must provide effective means of communication for patients, family members, and hospital visitors who are deaf or hard of hearing. The ADA applies to all hospital programs and services, such as emergency care, inpatient and outpatient services, surgery, clinics, educational classes, and cafeteria and gift shop services. Wherever patients, family members, companions, or members of the public are interacting with hospital staff, the hospital is obligated to provide effective communication.

Exchanging written notes or pointing to items for purchase will likely be effective communication for brief and relatively simple face-to-face conversations, such as a visitor's inquiry about a patient's room number or a purchase in the gift shop.

# Employment Update

Written forms or information sheets may be effective in situations where there is little interactive communication, such as providing billing and insurance information or filling out admission forms.

For more complicated and interactive communications, such as a patient's discussion of symptoms with medical personnel or a physician's presentation of diagnosis and treatment options to patients or family members, it may be necessary to provide a qualified sign language interpreter or other interpreter.

## Situations where an interpreter may be required:

- Discussing a patient's symptoms, medications, and medical history
- Explaining and describing medical conditions, treatment options, surgery and other procedures
- Providing a diagnosis, prognosis, and recommendation for treatment
- Obtaining informed consent
- Communicating with a patient during treatment, testing procedures, and physician's rounds
- Providing instructions for medications and post-treatment activities
- Providing mental health services or counseling for patients and family
- Discussing complex billing matters
- Making educational presentations, such as new parent classes or first aid training

Source: ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings, [www.usdoj.gov/crt/ada/hospcombr.htm](http://www.usdoj.gov/crt/ada/hospcombr.htm).

## Partial Victory in Supreme Court Decision

The US Supreme Court ruled 7-0 in the case of Hernandez v. Raytheon (No. 01-15512) that an employer's uniform and neutral policy barring the rehiring of a worker who was terminated for misconduct is a legitimate, nondiscriminatory reason to refuse to rehire a recovered drug addict who was fired for violating the company's policy on drug use. In 1991, Joel Hernandez, a missile plant worker, tested positive for cocaine and resigned in lieu of being terminated. More than two years later, he applied to be rehired. When Hernandez reapplied, he included documentation of his being in recovery. Raytheon refused to rehire him, citing its policy prohibiting the rehiring of employees that were fired or resigned because of work conduct violations.

The decision is a partial victory for people with disabilities because it left intact the ADA requirement that employers may not discriminate against applicants who have been rehabilitated and do not currently use drugs illegally. While the court ruled that Raytheon did not have to rehire workers who are dismissed for violating workplace conduct rules, it did not decide the broader question of the extent of protections afforded by the ADA to the more than five million workers with a history of substance abuse if they are disparately impacted by an employer's workplace policies.

While an individual currently engaged in the illegal use of drugs is not protected by the ADA, an individual who has recovered or is in recovery and no longer illegally using drugs is protected. Hernandez argued that his application was rejected because of his history of drug addiction, and that even if the person who reviewed his application was unaware of his prior drug addiction, the company's no-rehire policy violated the ADA because it had a "disparate impact" on recovering drug addicts. That is, Hernandez raised two claims – first, that Raytheon's rejection of his application amounted to "disparate treatment" (intentional discrimination), and second, that Raytheon's blanket policy of rejecting applicants formerly dismissed for workplace misconduct, had a "disparate impact" on recovering drug addicts.

As to Hernandez's claim that his application for employment was rejected because of his prior drug addiction, the Supreme Court found that the employer's policy of not rehiring previously dismissed employees would be a legitimate defense unless the plaintiff can show the policy was used as a pretext and that the employer based its decision on the applicant's disability. The Supreme Court's decision sends the case back to the Ninth Circuit Court of Appeals. A copy of the decision can be obtained at <http://supct.law.cornell.edu/supct/html/02-749.ZS.html>.

Source: "High Court Rules against Recovered Addict in ADA Case," HRnext.com, December 3, 2003.

## What is Video Relay Service and Video Remote Interpreting?

Video relay service (VRS) enables people who use sign language as their primary language and people who speak to communicate via videoconferencing. Imagine the deaf person, speaking person and sign language interpreter in three different locations. The deaf caller signs to the interpreter using a web camera. The interpreter relays that communication by voice over the phone — in real-time — to the hearing person. The hearing person speaks to the interpreter. The interpreter signs that communication to the deaf person. Video conveys all facial expressions and body language cues, to ensure nothing gets lost in the translation. VRS can occur over high-speed Internet connections using video conferencing software, such as Microsoft NetMeeting, or over special video-equipped phone terminals. For a list of Video Relay Service providers in the country go to [www.tdi-online.org/fs\\_videorelayservices.html](http://www.tdi-online.org/fs_videorelayservices.html).

Video Remote Interpreting (VRI) uses videoconferencing to provide sign language interpreting without an interpreter on site. VRI occurs with the interpreter located at his/her home or office, rather than traveling to the site to provide services. This saves on mileage, travel time, and minimum fees. Clients are often billed by the minute and pay only for the amount of time they work with the interpreter. VRI is used where a live interpreter

would usually be called in, for example, doctor visits, conferences, or trainings. Everything about the interpreting process remains the same, except the interpreter is working from a remote location. The interpreter can be arranged in advance and some companies provide on-demand services.

## Regional Advisory Board Meeting at CAST



Oce Harrison and Chuck Hitchcock listen intently during October's Advisory Board Meeting.

The New England ADA & Accessible IT Center's Regional Advisory Board met at CAST in Wakefield, MA on October 23, 2003. A presentation on universal design for learning software (K-12) was provided by Chuck Hitchcock. Chuck is CAST's Chief Education Technology Officer and Director of the National Center on Accessing the General Curriculum Project as well as a member of ADA Center's Regional Advisory Board.

## STEP508

### What Is STEP508?

STEP508, the Simple Tool for Error Prioritization for Section 508 compliance, is an electronic tool that:

- Prioritizes the repairs you should make to ensure that your Web site is compliant with the accessibility requirements of Section 508.
- Provides the metrics to report progress in improving the accessibility of your site.

### What is the role of STEP508 in the process of making Web sites accessible?

STEP508 assists Web developers in prioritizing the accessibility repairs that should be made to their Web sites.

STEP508 assists in the repair of Web sites with large numbers of pages (sites with legacy content, sites with many authors/owners who may not be familiar with accessibility issues.)

### Who developed STEP508?

STEP508 was developed through a collaboration of the US Department of Health and Human Services, the National Center for Accessible Media, and the Communication Technologies Branch of the National Cancer Institute, part of the National Institutes of Health.

### How do I get a free copy of the STEP508 software?

Download the STEP508 software at: [www.section508.gov/StepInstall0015.zip](http://www.section508.gov/StepInstall0015.zip).

## Medical and Health Care Related Publications

### [Communications Fact Sheet](#)

Discusses effective communication, examples of communication barriers and strategies for barrier removal. 4 pp.

### [Service Animals Q & A Sheet](#)

Explains the requirements regarding animals that provide services for people with disabilities. 3 pp.

### [Deaf & Hard of Hearing Q & A Brochure](#)

Auxiliary aids and services, duties of state and local governments, and public accommodations. 32 pp., \$1

### [EEOC Guidance on Pre-employment Disability-Related Inquiries and Medical Exams](#)

Q & A on what questions employers may ask applicants and when medical exams may be required. 26 pp.

### [EEOC Guidance on Disability-Related Inquiries and Medical Examinations of Employees](#)

Explains when it is permissible for employers to make disability-related inquiries or require medical examinations of employees. 26 pp.

### [EEOC Guidance on Worker's Compensation & ADA](#)

Question and answer format on occupational injuries, return to work, direct threat, medical exams and light duty. 25 pp.

### [EEOC: Obtaining and Using Employee Medical Information as Part of Emergency Evacuation Procedures](#)

Confidentiality issues, what can be asked, emergency procedures. 2 pp.

### [Title III Fact Sheet Series: Providing Effective Communication.](#) \$1

### [ADA Questions and Answers for Health Care Providers](#)

Covers sign language interpreters, TTYs, facility access, captioning. 25 pp., \$3

### [ADA Tech Sheets Series: Medical Care Facilities.](#) \$2

## New Publications Available from the ADA Center

### [EEOC: Q&A About Diabetes in the Workplace](#)

Addresses disclosure, medical documentation, reasonable accommodation and safety concerns. 9 pp., \$1

### [Accessibility of State and Local Government Websites to People with Disabilities](#)

DOJ provides guidance on making state and local government websites accessible. 5 pp.

### [Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings](#)

DOJ explains when ADA requires sign language interpreters, assistive listening devices, written messages and other means to ensure that communication is effective. 4 pp., \$.50

### [Access Board's Guides on Recreation Facilities](#)

Helpful diagrams, photographs and text clarify and expand on the US Access Board's Guidelines for Recreation Facilities:

- Amusement Rides. 15 pp., \$1
- Boating Facilities. 16 pp., \$1
- Fishing Piers and Platforms. 12 pp., \$1
- Golf Courses. 11 pp., \$1
- Miniature Golf Courses. 9 pp., \$1
- Sports Facilities. 14 pp., \$1
- Swimming Pools, Wading Pools, and Spas. 20 pp., \$1

All publications are available from our Center by calling (800) 949-4232 (voice/tty) or by ordering online using our shopping cart at [www.AdaptiveEnvironments.org/neada/adapublications.php](http://www.AdaptiveEnvironments.org/neada/adapublications.php). Many publications can be downloaded.

### [Design That Cares: Planning Health Facilities for Patients and Visitors, Second Edition](#) by Janet R. Carpman and Myron A. Grant.

This publication is available for review in the Adaptive Environments library or for purchase from Amazon.com.

Adaptive Environments  
374 Congress Street, Suite 301  
Boston, MA 02210

Non-Profit Org.  
U.S. Postage  
**PAID**  
Boston, MA  
Permit #52484

## EVENTS AND ANNOUNCEMENTS



Designing for the 21st  
Century III Conference

Adaptive Environment's third international conference on universal design, Designing for the 21st Century III, will be held in Rio de Janeiro on December 8-12, 2004. Plans call for over 800 attendees from around the world.

**Questions:**

Adaptive Environments  
374 Congress Street, Suite 301  
Boston, MA 02210 USA  
1 (617) 695-1225 voice/tty  
1 (617) 482-8099 fax  
info@AdaptiveEnvironments.org



...attend this event! Presenters are nationally recognized experts in their fields and include staff from the U.S. Department of Justice, U.S. Access Board and the Equal Employment Opportunity Commission. The Symposium is co-sponsored by the ten ADA & Accessible IT Centers.

Cost is \$295 per person prior to April 2nd, \$345 per person April 2 and on.

**For schedule and registration information:**

[www.adaproject.org/NationalADASymposium.html](http://www.adaproject.org/NationalADASymposium.html)

**Questions:**

Kathy Gips  
1 (800) 949-4232 voice/tty (in New England)  
kgips@AdaptiveEnvironments.org