Published in final edited form as:

JAMA Intern Med. 2015 February ; 175(2): 157–158. doi:10.1001/jamainternmed.2014.6740.

Ensuring Access to Health Care for Patients With Disabilities

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Patients with disabilities face barriers when they attempt to access health care.¹ These barriers include physical barriers to entering health care establishments, lack of accessible equipment, lack of a safe method for transferring the patient to an examination table, and the lack of policies that facilitate access.² The barriers persist despite 2 federal laws (the Americans With Disabilities Act [ADA] of 1990 and Section 504 of the Rehabilitation Act of 1973) that explicitly state that health care settings must be accessible to patients with disabilities.

Many patients with disabilities receive their health care through government programs, such as Medicare and Medicaid. How is it that the federal government does not adequately enforce the federal laws to protect patients with disabilities? The answer is related to both the scope of the ADA and the complexity of health care delivery in the United States. The Department of Justice is charged with enforcement of the ADA for public entities (under Title II) and public accommodations (under Title III). State and local governments fall under Title II, and physicians' offices and hospitals generally fall under Title III, along with restaurants, retail establishments, and hotels. The sheer number of entities that fall under Title III is a challenge. Moreover, the Department of Justice is separate from the Center for Medicare and Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which both have important responsibilities for health care delivery and access to health care for patients with disabilities.

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Conflict of Interest Disclosures: Dr Lagu has received consulting fees from the Institute for Healthcare Improvement, under contract to CMS, for her work on a project to help health systems achieve disability competence. No other disclosures are reported.

Role of the Funder/Sponsor: The funding source had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: Ms Griffin reports that this work contains her personal views and not those of the Disability Law Center.

This separation of health care delivery, accreditation, and enforcement has many consequences. The CMS and other government agencies generally follow the law when establishing contracts with government agencies and health care organizations and include a requirement for access for patients with disabilities in all contracts. There is, however, no easy mechanism to ensure that access has, in fact, been provided. Instead, responsibility gets passed from one entity to another: States pass the responsibility on to health plans and hospitals, who then pass it on to physicians and other health care professionals, who are less likely to invest substantial resources to address the problem.³ This “pass the buck” approach has led to complacency about ensuring that strategies are in place to care for patients with disabilities. The health care system is often unprepared to meet their needs.^{1,4}

To enforce the ADA and the Rehabilitation Act, the Department of Justice has focused on case-by-case litigation. This approach is problematic. Lawsuits are slow, regardless of whether they are brought against institutions, medical groups, or individual physicians. Moreover, patients may hesitate to bring complaints or lawsuits against physicians with whom they have longstanding personal relationships.³ Patients with disabilities often need ongoing care and may be concerned about retaliation. Individual lawsuits are also burdensome to the legal system, resented by physicians, and an ineffective way to catalyze system-wide changes. Although hundreds of disability access cases related to the ADA have been brought against physicians, hospitals, and health plans, their overall impact is unclear.⁵

Better access to care for patients with disabilities should be addressed through strategies whose scope extends beyond better access for individual patients. Four approaches should be considered.

Financial Penalties for Noncompliance

Most contracts between government agencies and health care organizations include clauses that mandate access for patients with disabilities, but actually providing access is not a prerequisite to payment. Improved oversight of current and future contracts and contractual language that links payments to compliance are likely to lead to substantial responses from clinicians and hospitals and improved access for patients. One potential barrier, however, is the difficulty of assessing compliance. An existing program could be used as a model to improve compliance: In 2010, CMS launched the Center for Program Integrity, which coordinates fraud prevention in the Medicare and Medicaid programs.⁶ Using data from a variety of other CMS antifraud initiatives, the program screens and subsequently monitors health care organizations and professionals, and suppliers to Medicare, Medicaid, and the Children’s Health Insurance program. Fraud terminates participation in all 3 programs. In addition, the Center for Program Integrity can stop payments to those who are under investigation for fraud. By adapting a similar model for disability access, CMS could use a combination of patient complaints and other detection methods to identify physicians, hospitals, and suppliers denying access to patients with disabilities and to stop payments as necessary.

ADA Compliance as a Focus of Accreditation

Health care organizations are motivated to comply with the requirements of accreditation organizations, such as the JCAHO and state health departments. Participation in Medicare, Medicaid, and other government health programs requires accreditation. Some might argue that the current JCAHO accreditation standards are adequate because they include broader language that is applicable to patients with disabilities, such as “the hospital plans the patient’s care.”⁷ Hospital care, however, is complex; the lack of standards relating to the specific needs of patients with disabilities has meant, in practice, that their access to care is frequently overlooked. The importance of specific standards is illustrated by the evolution of the JCAHO’s stance on smoking on hospital property. The general standard, “The hospital plans activities to minimize the risks in the environment of care,”⁷ may have implied that a smoke-free environment was desirable. Yet it took a far more specific standard, introduced in 1992, “The hospital prohibits smoking except in specific circumstances,” to markedly increase the percentage of hospitals that prohibit smoking on their property, from 3% in 1992 to 45% in 2008.⁸

Solving the Problem of Inaccessible Medical Equipment

Inaccessible medical equipment is a major problem for patients whose mobility is impaired.¹ Despite a 2014 federal report that recommended new standards for accessible medical equipment, the onus remains with physicians, hospitals, and health care organizations to purchase accessible equipment.^{2,9} It is clear that many do not.¹ To facilitate such purchases, the federal regulations that outlaw the sale of unsafe child safety seats for use in automobiles could be used as model. If the federal government were to ban the manufacture and sale of medical equipment that was inaccessible to people with disabilities, such equipment would, over time, no longer be used.

Holding Government Health Care Agencies Accountable for System-Wide Failures

In some situations, the failure to provide access to medical care for an entire group of patients suggests that a public entity may be operating in a segregated and discriminatory way. For example, if most Medicaid patients with disabilities in a state are unable to access primary or specialty care, the failure might be considered “systemic.” The ADA states that contracting or licensing does not absolve entities of their obligations under the law, suggesting that legal remedies against the federal government or states could be pursued under Title II of the act.

Conclusions

Financial penalties for noncompliance, ADA compliance as a focus of accreditation for hospitals and health care organization, solving the problem of inaccessible medical equipment, and holding government health care agencies accountable for system-wide failures are all approaches that could improve access to health care for patients with disabilities. Of course, these approaches could have unintended consequences, for example,

if they led to an increase in the number of physicians who would not care for Medicare or Medicaid patients. Nonetheless, case-by-case litigation on behalf of individual patients has not been an effective approach to the broader problem of access to care for all patients with disabilities. The time is ripe for novel strategies.

Acknowledgments

Funding/Support: Dr Lagu is supported by the National Heart, Lung, and Blood Institute of the National Institutes of Health under award No. K01HL114745.

References

1. Lagu T, Hannon NS, Rothberg MB, et al. Access to subspecialty care for patients with mobility impairment: a survey. *Ann Intern Med*. 2013; 158(6):441–446.10.7326/0003-4819-158-6-201303190-00003 [PubMed: 23552258]
2. Lagu T, Iezzoni LI, Lindenauer PK. The axes of access: improving care for patients with disabilities. *N Engl J Med*. 2014; 370(19):1847–1851.10.1056/NEJMs1315940 [PubMed: 24806165]
3. The Current State of Health Care for People with Disabilities. Washington, DC: National Council on Disability; 2009. <http://www.ncd.gov/publications/2009/Sept302009#Americans%20with%20Disabilities>. Accessed May 5, 2014
4. Mudrick NR, Breslin ML, Liang M, Yee S. Physical accessibility in primary health care settings: results from California on-site reviews. *Disabil Health J*. 2012; 5(3):159–167.10.1016/j.dhjo.2012.02.002 [PubMed: 22726856]
5. US Department of Justice. Enforcing the ADA: status reports from the Department of Justice, Washington, DC, April 1994–June 2011. <http://www.usdoj.gov/crt/ada/statrpt.htm>. Accessed November 5, 2014
6. CMS 2013 National Training Program: Module 10 Medicare and Medicaid Fraud Prevention. Baltimore, MD: Centers for Medicare & Medicaid Services; 2013. <http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-Fraud-and-Abuse-Prevention-Workbook.pdf>. Accessed September 16, 2014
7. Joint Commission Resources. 2014 Hospital Requirements. Joint Commission; Oakbrook Terrace, IL: 2014. <http://www.jointcommission.org>. Accessed November 5, 2014
8. Williams SC, Hafner JM, Morton DJ, et al. The adoption of smoke-free hospital campuses in the United States. *Tob Control*. 2009; 18(6):451–458.10.1136/tc.2009.030494 [PubMed: 19700437]
9. United States Access Board. Advancing Equal Access to Diagnostic Services: Recommendations on Standards for the Design of Medical Diagnostic Equipment for Adults with Disabilities. 2013. <http://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking/advisory-committee-final-report>. Accessed January 29, 2014