

**NEW YORK LAWYERS FOR THE PUBLIC INTEREST
COMMENTS ON U.S. DEPARTMENT OF JUSTICE (DOJ)
NOTICE OF PROPOSED RULEMAKING, TITLES II AND III OF THE
AMERICANS WITH DISABILITIES ACT (ADA)
TITLE II, 28 CFR PART 35
[CRT DOCKET NO. 105; AG ORDER NO. 2967-2008]
RIN 1190-AA46
AND
TITLE III, 28 CFR PART 36
[CRT DOCKET NO. 106; AG ORDER NO. 2968-2008]
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Introduction

New York Lawyers for the Public Interest is a not-for-profit law office that provides services to New York City residents under the Protection and Advocacy for Persons with Developmental Disabilities (PADD), Protection and Advocacy for Individual Rights (PAIR), and Protection and Advocacy for Individuals with Mental Illness (PAIMI) programs. We are pleased to have the opportunity to provide comments regarding the June 17, 2008 Notice of Proposed Rulemaking which proposes to revise the implementing regulations of Title II and III of the Americans with Disabilities Act (ADA).

General Comments

We applaud many of the changes proposed in these regulations and specifically support the Department's proposals: to adopt the new 2004 ADAAG; to strengthen hotel reservation and assembly area ticketing provisions; to recognize psychiatric service animals; to require additional companion seating in theaters and stadiums; and to strengthen provisions for effective communication for people with hearing, visual, and speech disabilities. We would like to note, however, that although the adoption of the ADAAG into regulations is a positive step, we also urge the DOJ to revisit the treatment of subway accessibility for New York City. Today, there is no principled reason to continue the exceptional treatment of New York City subways, and the definition of "key stations," especially in light of the scant progress towards opening up the city's subways to people with disabilities since the passage of the ADA.

There are also many negative proposed changes that would significantly reduce the rights of people with disabilities to accessible facilities. We would like to register our opposition to the DOJ's proposals: to significantly weaken the readily achievable barrier removal requirement for public accommodations; to significantly reduce elements required to be accessible in state and local government facilities; to exempt all existing facilities from the new recreation and playground rules; and to restrict what species can be covered by the definition of a "service animal."

We would like to state our support for and urge the adoption of the comments contained in the letter submitted by Kenneth Shiotani on behalf of the National Disability Rights Network (NDRN) on August 15, 2008. The changes they propose will greatly enhance our work on behalf of people with disabilities living in New York City. We would also like to comment specifically on the proposed changes regarding medical care facilities, including hospital room dispersion, medical equipment and furniture, and covered entrances at medical care facilities.

Hospital Room Dispersion

With respect to the request for public comment by the DOJ regarding section 36.406(g) regarding a dispersion requirement for accessible sleeping rooms, we believe it would be a mistake to omit a dispersion requirement for each hospital unit in the federal regulations. Without guidance, hospitals are likely to do what is easiest, and that will lead to facilities that have no accessible patient rooms in some treatment areas, and a concentration of rooms in others. Since patients with disabilities must be housed in treatment areas related to their medical condition (e.g. cardiac care, obstetrics, respiratory care, psychiatry), they require accessible rooms in these areas and on floors where their providers work and specialized equipment is placed. The accepted standard of care would not be met if they were to be housed on a floor or wing of a facility that does not provide the specialty care they require solely because an accessible patient room is not available on the appropriate floor or within the appropriate area. Furthermore, aggregating accessible rooms in one or a few locations perpetuates segregation of people with disabilities and disregards the aging population's growing need for accessibility features. Therefore, we recommend that the regulations specify that the 10% of rooms that are mandated to be accessible must be dispersed proportionally throughout each specialty unit.

The industry commenters who cited "fluctuation in the population and other demographic and medical funding trends" as reasons to avoid regulations requiring dispersal were wrong for three reasons.

First, hospitals are accustomed to compliance with vigorous state and federal mandates to ensure quality of medical care, regardless of their size. They exist in one of the most heavily regulated industries, with guidance and regulations from a myriad of sources, such as the Emergency Medical Treatment and Active Labor Act (EMTALA), community service requirements, uncompensated care pool requirements, Limited English Proficiency requirements, fraud and abuse regulations, medical records

regulations, pharmaceutical price regulation, organ transplant regulation, certificate of need processes, hospital rate-setting, hospital accreditation and licensure, and state accreditation and licensure, Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) safety standards, and others. An accessible room dispersal requirement would not be onerous in this context.

Second, trends in utilization in hospital care are observable and thus predictable. For example, in New York State, the Berger Commission recently undertook a study of hospital utilization and trends.¹ It found that between 1994 and 2004, about ten percent of hospitals closed, hospital beds shrank about ten percent, and daily census rates went down about twenty percent.² From this information, statewide plans were formulated to change the size of hospitals. This data was gleaned from information already maintained by the hospitals and Department of Health.

Demographic information about populations served by hospitals is widely available, and hospitals are aware of it. In New York, for example, the Berger Commission examined U.S. Census and other regulatory data and found that:

- The overall population of NYS is expected to be stable for the foreseeable future.
- The population is aging, but the impact of this will be gradual.
- Disability rates among older adults are slowly declining, but this positive trend is complicated by changes in morbidity and a growth in the numbers of minority elders and women living alone.³

Hospitals can – and do – plan effectively for shifts in usage. They plan their facilities to meet their patient and fiscal needs already; therefore, a requirement that accessible rooms be disbursed in a planned way would not be burdensome.

Third, medical funding trends are relatively foreseeable, and hospital construction does not ebb and flow as easily as free market construction. If the commenters’ concern was that a hospital might need to quickly close certain specialty units and therefore might incur unfair expenses in the meantime by dispersing accessible rooms in each special unit, this concern also lacks weight. Hospitals are constrained by state and local rules from suddenly shutting down or shifting uses of hospital wards. For instance, in New York, the Certificate of Need (CON) process governs the establishment and construction of health care facilities, and CON applications to the state are required for all health care facilities that propose construction, acquisition of major medical equipment, changes in ownership and the addition and deletion of services.⁴ Thus, hospitals act deliberately and will have the time to decide which units are going to continue to exist and thus need to be made accessible. No hospital need be in the untenable position of having to disperse the 10% accessible rooms in a unit about to suddenly or unforeseeably close.

¹ http://www.nyhealthcarecommission.org/docs/cfch_future_trends_white_paper.pdf

² <http://www.nyhealthcarecommission.org/docs/statistical.pdf>

³ http://www.nyhealthcarecommission.org/docs/cfch_future_trends_white_paper.pdf

⁴ New York State Public Health Law Article 28.

Therefore, for all the reasons described above, hospitals can fairly be expected to comply with non-segregation mandates in the form of dispersal requirements for accessible rooms.

Not only is the potential difficulty for hospitals overstated by the commenters, but the importance of a non-segregation mandate is downplayed. Significantly, in passing the ADA, Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U.S.C. § 12101(a)(2), (5). The Olmstead decision further clarified that unjustified isolation is a form of disability discrimination. The Court explained:

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Cf. *Allen v. Wright*, 468 U.S. 737, 755 (1984) (“There can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action.”); *Los Angeles Dept. of Water and Power v. Manhart*, 435 U.S. 702, 707, n.13 (1978) (“ ‘In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.’ ” (quoting *Sprogis v. United Air Lines, Inc.*, 444 F.2d 1194, 1198 (CA7 1971))). Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. See Brief for American Psychiatric Association et al. as *Amici Curiae* 20—22.

Olmstead, 119 S.Ct. 2176, 2179. Similarly, in the hospital context, the history of racial segregation in hospitals has taught us that segregation not only harms by stereotyping and stigmatizing, it also harms by creating environments for lesser standards of care.⁵ Therefore, the importance of prohibiting segregation suggests that the DOJ should require dispersal of the accessible rooms in each unit of a hospital.

Medical Equipment and Furniture

We would like to register our strong opposition to the Department’s decision not to add specific regulatory guidance or clarify requirements for accessible equipment and furniture in the federal regulations. In particular, we are deeply concerned that the failure

⁵ Health Care Divided: Race and Healing a Nation, David Barton Smith.

to list explicit examples of accessible medical equipment will exacerbate the unequal access to medical care for persons with disabilities that is prevalent today. We strongly recommend that medical care facilities be provided with more concrete guidance to determine their legal obligation to provide equipment that assists or accommodates persons with disabilities.

As identified in the NPRM, there is a lack of clarity with regard to the obligation of covered entities to acquire and use accessible equipment in their facilities. Although users of many types of public accommodation may be negatively impacted by this ambiguity, lack of guidance in health care settings can mean the difference between life and death for a person with a disability. Depositories, change machines, fuel dispensers, and ATMs have already been identified as equipment worthy of mention in the federal regulations; it is difficult to imagine a more critical setting than medical care facilities in which to provide similarly explicit guidance concerning accessible equipment.

Medical facilities consistently fail to make available accessible equipment, resulting in the delivery of incomplete or inferior health care services to persons with disabilities. Lawsuits and court actions have revealed the lack of basic accessible medical equipment in health care settings.⁶ The absence of accessible examination tables and weight scales are commonplace. In a national survey of people with disabilities or activity limitations, 69% of wheelchair users reported that they had difficulty using exam tables, 60% had difficulty being weighed due to inaccessible scales, 45% had difficulty using x-ray equipment (such as mammography equipment), and 43% had difficulty using medical chairs.⁷ Dental care settings also routinely fail to provide accessible dental chairs and x-ray machines for persons with disabilities. The result of these failures to acquire and utilize accessible equipment can range from unnecessary pain to misdiagnosis to the development of life-threatening conditions that may have been prevented had they been detected earlier.⁸

As a Protection and Advocacy agency charged with protecting the rights of persons with disabilities, we have received complaints from individuals with disabilities who are negatively impacted by the lack of accessible medical equipment in medical care facilities. For example, individuals with mobility impairments from New York City have reported that they do not obtain gynecological exams due to the inaccessibility of examination tables and the embarrassment, difficulty, and danger of transferring from a wheelchair to the table. We have also heard from individuals with disabilities who are

⁶ *Metzler et al. v. Kaiser Foundation Health Plan, Inc. et al.* See also, U. S. Department of Justice, *Enforcing the ADA: A Status Report from the Department of Justice*, Washington, D. C., Apr-Jun 2002; *Settlement agreement between the United States of America and Georgetown University*, full settlement available at: <http://www.ada.gov/gtownhos.htm#anchor262953>.

⁷ Kailes, J.I., 5 “G’s” Getting Access to Health Care for People with Physical Disabilities, 2008 Version 1, Published and distributed by Center for Disability Issues and the Health Professions, Western University of Health Sciences, 309 E. Second Street, Pomona, CA 91766-1854, Phone: (909) 469-5380, TTY: (909) 469-5520, Fax: (909) 469-5407, Email: ahcs@westernu.edu, www.CDIHP.org, available at: <http://www.cdihp.org/Five%20Gs%20apr21.pdf>.

⁸ See, e.g., <http://www.cdihp.org/briefs/brief1-exam-tables.html>.

not weighed because the weight scales are inaccessible. Individuals have also complained about the lack of accessible dental chairs.

In New York in 2001, a group of people with developmental disabilities who use wheelchairs sued Staten Island University Hospital (SIUH) in New York City for failing to provide accessible medical equipment and other violations of the ADA. Among other things, plaintiffs specifically alleged in their complaint that SIUH discriminated against them by failing to provide accessible gynecological exam equipment in SIUH clinics and by failing to provide reasonable accommodations to people with disabilities. In 2003, a Consent Decree was signed by the hospital promising do the following:

- SIUH shall purchase accessible Ob/Gyn examination tables that raise and lower, allowing patients to transfer to tables without assistance.
- SIUH shall properly transfer OB/Gyn patients to treatment and examination tables.
- SIUH shall purchase a sufficient number of accessible tables and other appropriate accessible equipment to serve people with disabilities in the Ob/Gyn clinic within two (2) months of the effective date of this consent decree.
- SIUH shall provide headrests for dental patients in wheelchairs when practicable and requested by the patient as a reasonable accommodation and not medically contraindicated.
- Requests for reasonable accommodations, such as requests for headrests, shall be evaluated on an individual basis and shall not be rejected based on blanket policies of the dental clinic staff.
- SIUH shall establish a protocol for ensuring appropriate prior communication with OMRDD or voluntary agency staff concerning preparation of patients for dental and Ob/Gyn exams, and ensuring that information concerning the needs of patients be shared.

Without litigation, these patients would still lack accessible equipment. Had SIUH officials had more guidance from the federal regulations regarding lifts, tables, transfers, and headrests – very basic equipment – perhaps litigation could have been avoided, and voluntary compliance would have improved the situation at the hospital sooner than 2003.

According to the NRPM, some businesses expressed concern that they lack control of the design or manufacturing of accessible equipment, however, in this context there are a range of accessible products and equipment available on the market.⁹ Increased demand for products will only lower the cost. Moreover, as made clear by existing regulatory guidance, a public accommodation shall not discriminate against individuals with disabilities directly or through contractual, licensing or other arrangements by denying an individual the opportunity to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of a place of public accommodation. A lack of direct control over the production of equipment does

⁹ *Id.*

not justify or excuse a failure to provide accessible services and goods to the public. Covered entities are required to make purchases and secure services keeping in mind their legal obligations to ensure equal access.

The Department indicates that it intends to conduct an economic impact analysis of regulations governing specific types of free-standing equipment, presumably out of concern for the financial impact new regulatory language will have on businesses. We submit that this concern is unwarranted given the balancing test built into the existing federal regulations; covered entities need not purchase or acquire equipment if it would result in a fundamental alteration of services or an undue burden. Adding a section similar to 36.303(f) would suffice to exclude the purchase or acquisition of equipment that would result in an undue burden, thereby providing the flexibility that small businesses may need to gradually acquire accessible medical equipment.

Seventeen years have passed since the federal regulations were first proposed, providing ample time for the Department of Justice to have assessed the financial impact of particular free-standing equipment on businesses. By explicitly listing high priority equipment commonly used in health care settings, covered entities will have more incentive to budget for and acquire this necessary equipment. The Department must not wait for the industry to interpret its obligations – it must provide clear regulatory guidance in this important area.

We recommend that the Department list, at a minimum, the following pieces of high-priority medical equipment in the federal regulations: accessible examination tables, accessible weight scales, accessible x-ray equipment (including mammogram machines), accessible medical chairs (including dental chairs). We also encourage the Department to list other pieces of equipment, though the aforementioned equipment is most critical to ensuring comprehensive and equal medical treatment for persons with disabilities.

An exemplary list is a method the Department already uses to provide guidance to industry. We recommend that the Department adopt the structure that it uses in the “Auxiliary aids and services” section of the Title III regulations (Part 36.303). In this section the federal regulations provide a clear list of supports and services that are necessary to ensure that individuals with communication differences as a result of their disability are able to communicate with a public accommodation. Although the list is not exhaustive, it is illustrative of the range of efforts that need to be made in order to ensure that no individual with a disability is excluded, denied services or treated differently than other individuals. Individuals with disabilities in health care settings similarly deserve such explicit protections and health care providers should be provided with such regulatory guidance.

We strongly urge the Department to adopt the following language in ADA regulation for Title II [see brackets] and Title III:

Sec. --- Accessible Medical Equipment.

(a) General. A public accommodation [public or government-funded entity] shall take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of accessible medical equipment and treatment, unless the public accommodation can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden, i.e., significant difficulty or expense.

(b) Examples. The term "accessible medical equipment and treatment" includes --

(1) Examination tables with accessible features (i.e. height adjustable, with a minimum height of 15" from the floor, extra-wide top and higher weight capacities, adjustable hand rails, and adjustable foot/leg supports), weight scales with accessible features that allow people using wheelchairs to be weighed, diagnostic and imaging equipment (including mammogram machines) with accessible features, medical chairs (including dental chairs) with accessible features such as height adjustment allowing transfers, and lifts and other equipment that allow people using wheelchairs to transfer to tables themselves or with assistance from staff;

(2) Acquisition or modification of equipment or devices and implementation of necessary policies;

(3) Provision of appropriate training for staff; and

(4) Other similar actions, such as provision of headrests or pillows.

(c) Equal treatment. A public accommodation [public or government-funded entity] shall furnish accessible medical equipment where necessary to ensure full and equal medical care for individuals with disabilities.

(d) Alternatives. If provision of a particular piece of accessible medical equipment by a public accommodation [public or government-funded entity] would result in a fundamental alteration in the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or in an undue burden, i.e., significant difficulty or expense, the public accommodation [public or government-funded entity] shall provide an alternative accommodation, if one exists, that would not result in an alteration or such burden but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the goods, services, facilities, privileges, advantages, or accommodations offered by the public accommodation [public or government-funded entity].

We also propose that the Department add the following section regarding floor space in the context of medical equipment:

Sec. -- Clear Floor Space. Medical Equipment. Exam tables, scales, and diagnostic and imaging equipment shall have a clear floor space

complying with 305 positioned for transfer or for use by an individual seated in a wheelchair. Clear floor or ground spaces required at diagnostic and imaging equipment shall be permitted to overlap.

Advisory for 1004.1 One clear ground or floor space is permitted to be shared between two pieces of medical equipment. The position of the clear floor space may vary greatly depending on the use of the equipment. For example, to provide access to a bone density scanner that operates with the patient in a supine position, clear floor space next to the table would be appropriate to allow for transfer. Clear floor space for a mammography machine, designed for use by an individual seated in a wheelchair, however, will most likely be centered on the scanning mechanisms.

Medical Care Facilities – Covered Entrances

We would like to register our opposition to the Department's decision not to reinstate the 1991 Standards' requirement of a canopy or roof overhang at passenger loading zones at medical care and long-term care facilities. The Department has provided no support for eliminating the existing requirement, and there is no reason to think that persons with disabilities are no longer in need of protection from inclement weather when using passenger loading zones at medical care facilities. Persons with mobility impairments may require assistance and generally require additional time to enter and exit vehicles, making them vulnerable to harsh weather for longer periods of time.

Conclusion

New York Lawyers for the Public Interest appreciates the opportunity to comment on the Notice of Proposed Rulemaking and looks forward to continuing our work on behalf of the individuals served by our agency.

Sincerely,

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