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CLIENT ALERT

U.S. Access Board Advisory Committee's Recommendations for ADA-Accessible Medical Diagnostic Equipment: Implications for Health Care Providers

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For the past several years, the health care community has been not only at the center of vigorous policy debates about the method of health care delivery in this country, but also in the crosshairs of agencies charged with enforcement of the Americans with Disabilities Act ("ADA") and other disability laws. One such example is the U.S. Department of Justice's ("DOJ's") Barrier-Free Health Care Initiative, in which U.S. Attorneys' offices across the nation partner with the DOJ's Civil Rights Division to prosecute health care providers deemed to be noncompliant with the ADA and the Rehabilitation Act of 1973 ("Rehabilitation Act"). Hardly a month has gone by without the DOJ's announcement of a settlement or consent decree with one or more health care providers, often focused on the issue of communication with sight and hearing-impaired individuals through the use of appropriate auxiliary aids, among other issues.

At the same time, there has been significant regulatory activity associated with the ADA. In September 2010, the DOJ amended the ADA's regulations and issued updated standards for the accessible design of facilities, including health care facilities. The revised standards, which became effective on March 15, 2012, included many additional technical requirements for medical care facilities. A guidance document titled "Access to Medical Care For Individuals With Mobility Disabilities," which was jointly issued by the DOJ and the U.S. Department of Health and Human Services in July 2010, set forth general requirements for accessible examination rooms and medical equipment, such as examination tables and chairs, scales, and radiologic and mammography equipment. A significant portion of that guidance document was devoted to methods for safely transferring wheelchair users to and from examining tables and medical diagnostic equipment ("MDE"), using transfer boards and different types of lifts.

Now, the United States Access Board has published the report and recommendations of its Advisory Committee on standards for the design of MDE for adults with disabilities, following a Notice of Proposed Rulemaking and subsequent comment period on this subject in 2012, about which we previously reported. (See the Epstein Becker Green

Client Alert titled "PPACA Amends Rehabilitation Act to Mandate Standards for Medical Diagnostic Equipment to Accommodate Individuals with Disabilities.") The authority for this regulatory activity derives from Section 4203 of the Patient Protection and Affordable Care Act, which amended a section of the Rehabilitation Act to require the Access Board, in consultation with the Food and Drug Administration ("FDA"), to issue accessibility standards for MDE. To arrive at these recommendations, the Advisory Committee considered the interests of a variety of different stakeholders, including medical device manufacturers, health care providers, standards setting organizations, advocacy organizations for individuals with disabilities, and federal regulatory agencies.

The Committee structured its analysis and recommendations around different categories of MDE: (1) equipment used by patients in supine, prone, or side-lying positions (exam tables, imaging equipment designed for use with platform beds, reclining exam chairs); (2) equipment used by patients in a seated position (exam chairs, imaging equipment with seats, weight scales with seats); (3) imaging equipment and weight scales designed for wheelchair users; and (4) imaging equipment used by patients in standing positions. For each category, the Committee recommended technical criteria for many different features of the equipment, such as transfer surface (including height, size, and transfer sides), transfer supports, stirrups, head and back support, lift compatibility, and features affecting wheelchair users (such as the orientation, depth, width, knee and toe clearance, and surface slope required to provide effective wheelchair access to different pieces of equipment).

The DOJ's 2010 guidance document addressed general considerations relating to transfer of patients with disabilities to and from MDE but provided little technical information. The far more detailed Advisory Committee recommendations would require, among other things, that: (1) examination tables have an adjustable height range with a maximum height of 25 inches, and be capable of adjustment in small, virtually continuous increments; (2) stretchers and non-imaging equipment used by patients in supine, side-lying, or prone positions have a minimum transfer surface of 28 inches in width and 17 inches in depth; (3) imaging equipment for those in supine, side-lying, or prone positions have a minimum transfer surface of, optimally, 28 inches in both width and depth (although, where 28 inches minimum depth is technically infeasible, the depth may be no less than 21 inches), with the transfer surface located so that the length dimension is parallel to the scanning/imaging side of the table; and (4) examination chairs and other seated MDE have a minimum transfer surface of 21 inches in width.

The Committee also made detailed recommendations about the size, shape, and positioning of transfer supports and gripping surfaces for different types of equipment; about alternate methods to support the legs of patients who use stirrups; about the use of armrests for seated equipment; and about the use of specific types of lifts for compatibility with particular MDE, such as CT machines.

Imaging equipment—and, in particular, mammography equipment—presents unique challenges in the treatment of individuals with disabilities. The FDA regulates the majority of diagnostic imaging equipment as Class II medical devices and requires

clearance from the agency prior to the marketing or sale of MDE. Each piece of MDE covered by the accessibility standards is comprised of a complicated system of interacting components, permanently mounted in fixed installations. Specially designed spaces that perform essential functions may interfere with transfer or other access to the equipment by individuals with disabilities.

For instance, mammography equipment requires a very large base to provide structural support and seismic stability. The size of the base obstructs the floor space around the machine and creates obstacles to wheelchair proximity. Representatives of MDE manufacturers on the Committee thus proposed a design configuration that would cause minimal obstruction to the floor space and allow wheelchair footrests to ride over it.

The Advisory Committee acknowledged that "with some important exceptions, current equipment designs rarely accommodate fully persons with disabilities," and that improving accessibility will require new equipment design and engineering. The Committee urged MDE designers and manufacturers to be "forward thinking, perhaps pushing aside historical design techniques" to devise new methods for accommodating patients with disabilities. In light of these considerations, as well as the enormous capital investment for such equipment, the Committee recommended what it termed "imaging system accessibility configurations" to render existing MDE more accessible. These include making architectural changes to sites where equipment is installed, such as raising the room floor or embedding parts of the equipment in the floor; installing ramps or scissor-lifts next to equipment, to raise wheelchair users closer to transfer surfaces; and using ceiling-mounted lifts if there is not sufficient space to accommodate a portable lift.

The rulemaking authority for this report applies only to adults with disabilities and excludes pediatric MDE, despite the growing number of children with disabilities. Further, during the course of its deliberations, the Committee determined that it lacked the time and data needed to establish technical standards for MDE for severely obese patients, and therefore it did not make technical recommendations related to this population. Many Committee members expressed concern about the need for such criteria and endorsed the urgency of addressing this topic.

These Advisory Committee recommendations have not yet been adopted by the Access Board and do not have the force of law. However, given the ADA's mandate to accommodate disabled individuals to the maximum extent possible, as well as the long-term implications of investing in accessible MDE, it is never too soon to begin planning how to meet these new technical standards.

Health care providers, suppliers, and manufacturers also should keep in mind that advocacy groups for the disabled are already pursuing litigation with claims about the accessibility of MDE. Given such litigation and the Advisory Committee's recommendations, providers, suppliers, and manufacturers should begin to address the issue of accessible MDE in their particular settings and circumstances. This is a process that will be ongoing for a significant period of time.

Actions for Health Care Providers to Consider

- Conduct an audit of all currently used MDE to determine whether the MDE already complies with the technical standards recommended by the Advisory Committee.

- Evaluate whether there are any steps that can be taken at this time to bring MDE accessibility in line with the Advisory Committee's recommendations, including the use of ceiling-mounted or other lifts and the modification of equipment. Consult with MDE suppliers and manufacturers as part of this assessment.

- Consider making accessibility a factor in the purchase process for new MDE. Providers that are planning purchases of MDE should work with suppliers and manufacturers to make the MDE selected as accessible as possible to patients with disabilities, consistent with the Advisory Committee's recommendations.

- Create a long-term plan for converting facilities to full accessibility for disabled patients, consistent with technical needs and cost considerations.

- Monitor developments and participate in future rulemaking as to potential standards for pediatric MDE and MDE for severely obese patients.

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This Client Alert was authored by **Frank C. Morris, Jr.,** and **Andrea R. Calem**. *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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