Screening for All

Implementation Plan

Making preventive health screenings accessible for everyone

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MCD Global Health

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Screening for All: Implementation Plan

About This Plan

This is a flexible plan to help your practice better serve patients with disabilities. Work is broken down into phases, with specific steps you can take to train staff, update systems, and create a welcoming environment for all patients.

We have incorporated elements from well-tested models of how organizations can make lasting change. The four phases map onto the first four of the six implementation stages described by Fixsen et al. (2005): exploration and adoption, program installation, initial implementation with real patients, and full operation (the remaining two stages, innovation and sustainability, are folded into Phase 4 of this plan). Phase 1 draws on Kotter's 8-Step Process for Leading Change, which stresses building urgency, forming a guiding team, and communicating the vision before changing daily work (1995). Phase 2 is about building the operational infrastructure for accessibility: analyzing current operations and making a path to improve them. Phases 3 and 4 follow a pilot-and-adjust approach based on the Model for Improvement (Langley et al., 2009): start small, learn from what happens, and expand what works.

Who should use this plan: Primary care practices, community health centers (including federally qualified health centers, or FQHCs), screening facilities such as imaging centers or endoscopy centers, and health systems of all sizes.

How this plan defines disability: In this plan, disability includes people with mobility, sensory (hearing or vision), intellectual and developmental, cognitive, mental health, and chronic health conditions, whether a disability is visible or not. Under the ADA, a person has a disability if a physical or mental impairment substantially limits one or more major life activities.

Why focus on preventive screenings?

More than 1 in 4 U.S. adults (28.7%) reported a functional disability in 2022. The patients in your practice are unlikely to be an exception to that statistic, whether your records reflect it or not. And people with disabilities are not screened at the same rate as everyone else. Adults with disabilities are less likely to be up to date on breast and cervical cancer screening than adults without disabilities. Among women 50 to 74, 71% of those with a disability had a mammogram in the past two years, compared with 79% of those without (Centers for Disease Control and Prevention, 2022). Screening for All's Data Summary: Health and Screening Disparities for People with Disabilities compiles the available national data on all 29 preventive screenings graded "A" or "B" by the USPSTF, disaggregated by disability type where it exists, and documents how thin that evidence base still is.

These national figures come from CDC's Disability and Health Data System (DHDS), which draws on the Behavioral Risk Factor Surveillance System. DHDS reports the same mammogram and colorectal cancer screening indicators by disability status for individual states, so you can replace the national number above with your own state's: see the DHDS Prevention and Screenings data guide for more information.

A missed mammogram can become a late-stage diagnosis. And for people with disabilities, that later diagnosis compounds care that is already difficult to coordinate: more specialists, more appointments, more transportation, and more accommodations to arrange, at exactly the point when they have the least capacity to manage any of it.

A screening visit is the last link in a chain that starts at the scheduling call and runs through transportation, the front door, check-in, the equipment, the imaging center you refer to, and the follow-up. This is why it is so important to record disability status and access needs in electronic health records (EHRs). Without collecting data on disability status and access needs, both the screening gap and the barriers causing it are invisible. And when care is inaccessible, the need for care does not disappear. It resurfaces later when it is more complex to treat.

Screening for All's focus is to get more disabled patients screened for breast cancer, cervical cancer, colorectal cancer, and osteoporosis, and we have included additional guidance on best practices for carrying out questionnaire-based screenings.

But this work is not possible without establishing a foundation and a commitment to accessibility throughout your practice. Several organizations have produced substantial evidence-based guidance on how to do this, working together with both people with lived experience and healthcare administrators to do so. Where that work exists, we will point you to it.

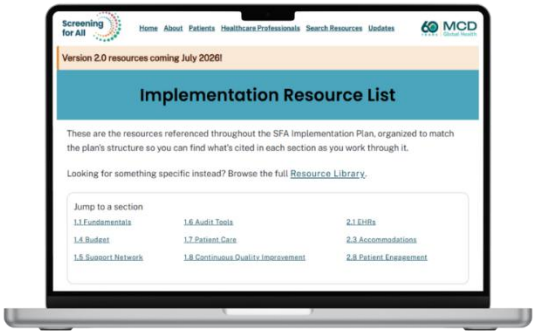
Here are some of the foundational resources this plan builds from:

- **The Agency for Healthcare Research and Quality (AHRQ)** provides both evidence and quality-improvement infrastructure: Healthcare Delivery of Clinical Preventive Services for People with Disabilities documents the near-total absence of disability-specific evidence on screening barriers and facilitators.
- **The Disability Equity Collaborative (DEC)**'s Accessible Healthcare for People with Disabilities: An Implementation Guide for Healthcare Organizations covers the institutional machinery, including program structure, documenting disability status in your EHR, effective-communication policy, staff training, and supplies templates you can adapt rather than build.
- **The Center to Advance Consumer Partnership (CACP)**'s Practice Library covers best practices for partnering with people with lived experience. It features practical models that show you how to structure the relationship, seat people where decisions actually get made, and report back on what you heard.
- **The Institute for Healthcare Improvement (IHI)'s** Model for Improvement, adapted from Langley, covers the improvement method itself, including how to set an aim, choose measures that will tell you whether a change worked, and run Plan-Do-Study-Act

cycles small enough to learn from quickly. It supplies worksheets and worked examples.

How to use this plan

Use this plan together with our Implementation Resource List (mcd.org/sfa-irl).



It is a curated list of tools, trainings, and templates from various organizations that support the work each section asks you to do.

Not all sections of this plan have corresponding resources, but those that do open with a line highlighted yellow that says “Resources” and lists the section of the Implementation Resource List where those resources can be found, with a direct link to that section. For example,

> **Resources: 1.1 Fundamentals**

Additional resources can be found on the Screening for All Resource Library.

> For the consolidated list of federal requirements with citations, see DEC’s Appendix 0.3: Federal Requirements for Providing Accessible Care (PDF), current as of April 2026.

Think of this plan as a blueprint rather than a rigid checklist. You do not need to use every single resource or complete every activity listed, although we do suggest that you complete the activities in the suggested order. Do what makes sense for your practice size, patient

population, and current capabilities. A small family practice will have different needs than a large health system.

Adjust the timeline to fit your needs. The months shown are a guide to the order and rough pacing of the work, not fixed calendar deadlines. Fixsen and colleagues found that fully installing an evidence-based program in a new community often takes two to four years (Fixsen et al., 2005), and AHRQ's review of its own primary care transformation work concluded that building a practice's capacity to improve takes years rather than months (Meyers et al., 2024).

Move at the pace your resources allow. A small practice might spend longer in Phase 1, while a larger system with a quality improvement team may move faster. What matters is reaching the milestones in order, at a pace you and your team agree would work for your organization.

People with disabilities are the key stakeholders in these efforts. Make a commitment to include them as partners in your planning, decision-making, and evaluation. You can satisfy every technical requirement in this plan and still get it wrong. Accessibility failures are rarely visible from inside the organization that creates them. The people who run into those failures are the only reliable source of information about them.

Bringing patients with disabilities into your planning is not a courtesy or a compliance gesture. It is how you find the problems your own walk-through will miss, and how you avoid spending a limited budget on the wrong fix. Hearing patients' perspectives directly can also move and motivate staff in a way training modules alone do not.

People with lived experience may be willing to volunteer, but you should prioritize paying them, or building toward a way to pay them, for their time (see Paying patient advisors and community experts in Section 1.5, Form Partnerships).

Find out who in your organization owns each change and bring them in early. You may not control every system this plan touches. Accessible

equipment, EHR configuration, and building changes often belong to different decision-makers. Bringing these stakeholders together, as well as acknowledging their efforts and experience, is key to ensuring inclusion efforts succeed.

Connect with local disability organizations and other practices working on similar efforts (see Appendix 1: Resources and Support for directories you can use to locate organizations near you). Local disability organizations can help you engage patients with disabilities, troubleshoot challenges, and celebrate successes. Meeting regularly with other healthcare professionals who are working on accessibility initiatives, or who have already implemented changes in their practice, builds in accountability, allows you to learn best practices from the field, and helps you save time by avoiding common pitfalls.

Review the Screening for All resources. We have created resources covering five types of preventive screenings: breast cancer, cervical cancer, osteoporosis, colorectal cancer, and questionnaires. Primary care providers and their office staff should review all of the resources. Healthcare providers who specialize in only some of these screenings, such as OB/GYNs or radiology technicians, may choose to focus mostly on the resources relating to screenings they themselves either provide or refer out to.

Understanding barriers and accommodations for disabled people in accessing these screenings is a crucial foundation for establishing effective referral partnerships with accessible screening facilities (covered in more detail in Section 2.8, Establish Referral Partnerships).

Example Timeline

Phase	Duration	Focus	Key Outcomes
1. **Foundation**	Months 1-12	Getting ready for change	Staff trained, leader chosen, systems updated
2. Assess and Build	Months 8-16	Develop new processes	Clear procedures for accommodations
3. Implementation	Months 12-20	Implement and test	Improved patient experiences
4. Monitoring	Months 18-24+	Monitor progress	Sustained improvements

Note: Phases overlap intentionally. You do not need to finish one phase before starting the next.

Phase 1: Getting Ready for Change

The first phase is about preparing yourself and your practice for change. You will:

- Familiarize yourself with basic topics in disability-informed care until you are ready to present the case for change to leadership and staff.
- Set up the foundation for continuous quality improvement.
- Begin to establish partnerships with disability advocacy organizations in your area.
- Create a budget and present the case to leadership and staff.

By the end of this phase, your practice's staff will have received training to gain confidence and skill in caring for patients with disabilities.

Key terms

Ableism refers to the policies, procedures, and everyday advantages that favor non-disabled people over people with disabilities.

Disability-informed care describes the goal of Phase 1: building foundational knowledge about disability, accessibility, and ableism into how your practice works every day. It is a continuous process of learning and humility for which there is no finish line.

There are multiple schools of thought on how to describe this type of care. Some frameworks use disability-competent care, including a national consensus framework of disability competencies for healthcare education developed by Susan Havercamp and colleagues at The Ohio State University Nisonger Center (Havercamp et al., 2021). This is a useful reference for the baseline skills a care team needs.

However, others prefer the concept of humility rather than competency. The objection to competency is that it implies an endpoint. Humility has no endpoint. It asks clinicians to keep examining their own assumptions, to notice and correct the imbalance of power between clinician and patient, and to work alongside disability communities as partners rather than on their behalf (Tervalon & Murray-Garcia, 1998).

Access needs vs. accommodations. An access need is what a patient requires to receive care. An accommodation is the specific change your practice makes to meet it. When we are describing the patient, we say access needs, because that phrasing treats access as information you collect and plan around rather than a favor granted on request. When we are describing what your practice provides, what the law requires, or what a field in your EHR is called, we say accommodations, because that is the word you will find in federal regulation and in your own policies.

1.1 Prepare Yourself

> **Resources: 1.1 Fundamentals**

Before you can lead change at your practice, you will need to understand the basics of disability-informed care to build a compelling case for why this work matters.

Complete the activities in 1.1 Fundamentals of the Implementation Resource List. These include resources such as videos, eLearning materials, and PDFs on disability awareness, inclusive communication, and universal design.

Having strong foundational knowledge will help you more effectively advocate for change.

1.2 Gain Leadership Commitment

Practice leaders and health system administrators need to understand why this work is important, understand how much time and expense it requires, and be willing to support it fully. They must regard accessible healthcare and health literacy as core values of the organization, and prove that commitment by building in sufficient time, and clear goals and accountability structures for the work to be done. A practice where one enthusiastic person is quietly absorbing the accessibility work has not yet gained leadership commitment, however supportive leadership sounds.

> DEC's Appendix 0.10: Leadership Support: Key Individuals maps out which executives and department heads usually hold the levers on work like this.

Key discussion points

Detail your practice's full legal responsibilities at the federal, state, and local level. ADA compliance is just one part of your legal requirements. At the federal level, Section 504 of the Rehabilitation

Act, and Section 1557 of the Affordable Care Act also apply, as well as state and local regulations.

Show where your facility may be out of compliance, and show the consequences if these issues are not addressed.

Share how failing to provide access carries real legal and compliance risk. Patients can file complaints with the HHS Office for Civil Rights or the Department of Justice at no cost, and enforcement is active.

In December 2025, a Seattle clinic failed on multiple occasions to provide an interpreter for a patient who was deaf and blind. They agreed to pay $25,000 to that patient and set aside $350,000 for others after repeatedly failing to provide interpreters. In addition to these payments, they were required to overhaul their systems to ensure full compliance with the ADA (*U.S. Attorney's Office and Polyclinic Resolve Allegations It Violated the Americans with Disabilities Act*, 2025).

Longer appointments are not automatically lost revenue under current CMS time-based coding, eligible practices can claim the IRS Disabled Access Credit, and some state Medicaid quality programs will pay for exactly this kind of upgrade (see Section 1.4, Create the Budget for Phase Two). Then ask your quality lead which measures your leadership is already judged on, and which of those move with access. Screening completion rates, patient experience scores, and no-show rates are the likeliest candidates, and they may already be sitting in a contract or a dashboard someone reports on every month.

More than 1 in 4 U.S. adults has a disability (Centers for Disease Control and Prevention, 2025), and that disability may or may not be visible. Chronic pain, long COVID, epilepsy, hearing loss, low vision, traumatic brain injury, mental health conditions, learning and intellectual disabilities, autism, and chronic illnesses like lupus, multiple sclerosis, and Crohn's disease are all disabling, but none of them are reliably visible across a waiting room. This is why you should build access into your standard process rather than waiting to spot who needs it: you will not spot them. And when disabled patients get better

care, they are more likely to return to your practice and recommend you to others.

CDC's Disability Impacts All of Us Infographic shows the prevalence of disability in the U.S. You could use it when pitching these changes to others.

Bring the disparity numbers, not just the legal requirements. Leadership will want to know the size of the problem before they fund a fix. Screening for All's Data Summary: Health and Screening Disparities for People with Disabilities has the figures broken out by disability type, so you can name what is happening to your own patient population rather than speaking generally.

Talk about the curb-cut effect. Accessibility features implemented for people with disabilities end up being beneficial for people who are not disabled, as well (Blackwell, 2017). This makes the environment more usable and friendly for everyone. There is potential for patient satisfaction scores to improve when practices become more accessible, which can affect quality incentives and reputation.

- Height-adjustable exam tables help older patients, pregnant patients, people recovering from surgery, and anyone having a bad pain day — not only wheelchair users.
- Longer appointment slots help patients with low health literacy, patients working through an interpreter in any language, and anxious patients.
- Plain-language and large-print materials help older patients, patients reading in a second language, and anyone who arrived without their glasses.
- Written visit summaries help family caregivers, patients who were too anxious to absorb what was said, and anyone managing several conditions at once.
- Clear signage and wayfinding helps first-time visitors, patients with dementia, and anyone navigating an unfamiliar building.

- Captions on patient videos help people watching in a noisy waiting room and people who take in written text more easily than speech.
- Asking every patient what they need at scheduling can bring to light barriers that may be affecting non-disabled patients' access to screening as well.
- In addition, accessibility initiatives can create opportunities for practices to authentically market their commitment to compassionate, inclusive care. Communicating these efforts can help reassure patients with disabilities and strengthen trust in the practice.

Share stories from real health systems that have already implemented accessibility changes. Examples include:

- **UCHealth (Colorado)** trained its central scheduling team to ask every new patient two short questions about disability and access needs, across 53 primary care clinics. Before the change, fewer than 1 in 10 patients had this information recorded. Afterward, just over half did — 9.5% to 53.5% — and clinics could prepare accommodations before the visit instead of scrambling during it (Morris et al., 2021).
- **Michigan Medicine** added a "Disability and Accommodations" tab to its EHR. Patients list their access needs once through the patient portal, and every care team member sees the same information at every visit (Halkides et al., 2022).
- In **Montana**, mammography centers that received accessibility assessments and simple action plans improved over several years: by the final review, every center had at least one machine that lowered for patients who stay seated during screening (Traci et al., 2020).
- Through the Provider Accessibility Initiative, a partnership between Centene health plans and the National Council on Independent Living, over 500 provider sites received accessibility

reviews from local Centers for Independent Living, and $2.9 million in grants helped 298 providers in 16 states remove barriers (National Council on Independent Living, n.d.).

- **Northwell Health (New York)** redesigned its mammography experience after a wheelchair user was turned away from a screening appointment. Technologists are now trained to call in a second staff member for atypical positioning instead of turning patients away, an intake question asks about access needs before the visit, and the greeter now sits rather than stands, so they are at eye level with patients who use wheelchairs (American College of Radiology, 2021).

1.3 Choose Your Accessibility Lead and Assemble Your Advisory Council

Federal rules require organizations with 15 or more employees to designate a Section 504 and Section 1557 coordinator (45 C.F.R. §§ 84.7, 92.7). A separate rule requires public entities (state, county, and city health systems) with 50 or more employees to designate an ADA coordinator (28 C.F.R. § 35.107). If your organization employs either, they might be a good candidate to lead these efforts. Private practices fall under ADA Title III, which carries no equivalent requirement, but naming someone anyway is good practice.

If it is not clear who should take on this role, you must identify who can. This person should be a supervisor, office manager, or someone who has time to work with different departments. They do not need to be a disability expert, but they should be interested and invested in this role, organized, willing to learn, and have enough authority to make decisions, including the authority to approve and arrange accommodations. This person will lead meetings, track progress, and make sure everyone knows their responsibilities.

Build in accountability from the start. Agree on who the Accessibility Lead reports to, how often they share progress (for example, a standing

item at monthly leadership meetings), and which outcomes they own. Without a clear reporting line, the role can drift into a side task and lose momentum.

Give them dedicated time each week to focus on this work. Trying to fit it in around other duties is a recipe for failure. How much time depends on your size: DEC recommends at least one employee with dedicated time to oversee accessibility, with larger organizations needing more. Accessibility work should be treated like any other scheduled duty: blocked on the calendar, covered in staffing plans, and reported on monthly.

Responsibilities of the Accessibility Lead

- Complete online trainings from 1.1 Fundamentals to learn about disability-informed care.
- Determine and assign appropriate trainings (see Section 1.7, Ensure Everyone Gets Trained on the Basics) for staff members and ensure that training is completed.
- Coordinate with different departments (front desk, staff, billing).
- Create a budget for implementing accessibility changes.
- Track your practice's progress and report to leadership.
- Be the point person who maintains partnerships with local disability organizations, ensures they are involved in decision-making processes, and seeks their guidance when needed.
- Troubleshoot issues as they come up.

> DEC's **Appendix 1.10: Example Disability Coordinator Job Description** is a ready-made posting you can pull duties and required experience from, rather than drafting the role from a blank page.

Who else should be at the table?

From your team

Accessibility touches almost every part of your organization, so involve every department that interacts with patients or the systems behind their care. The right mix depends on your size:

- **Small independent practice:** the office manager, front desk staff, clinical staff (medical assistants, nurses, providers), and whoever handles billing.
- **Mid-size or multi-site group:** all of the above, plus scheduling or call center staff, your IT or EHR analyst, facilities or building maintenance, HR or whoever runs staff training, and your compliance officer.
- **Hospital or health system:** all of the above, plus the departments that already touch access: patient experience, your ADA or Section 504 coordinator, interpreter services, compliance, and health equity.

Set these arrangements up for sustainability. Write the accessibility role into a job description rather than leaving it as a favor, and note who covers it during a vacancy. Section 4.2, Plan for Sustainability picks this up in detail.

Invite staff with disabilities. These team members understand both the patient and healthcare provider experience, and will have rich insights into what solutions will work best.

> DEC's **Appendix 1.8: Accessibility Program Organizational Structure** runs through several ways practices have positioned this work — which department owns it, and who answers to whom — if you are still deciding where your team should sit.

From your partnerships

Build in a place for patients with disabilities now, not later. Your advisory council should include staff members (clinical and

administrative), community members with disabilities, and community partners. The council could take whatever form works best for your practice. Some examples:

- A disability-focused Patient and Family Advisory Council,
- 2-3 patient advisors added to a committee you already run, or
- A standing quarterly meeting with your local Center for Independent Living.

What matters is that the people who run into the barriers are in the room while decisions are still open, rather than consulted once they are made. Plan to pay these advisors: see Paying patient advisors and community experts in Section 1.5, Form Partnerships.

What your advisory council should do:

- Review your accessibility priorities while the budget can still change, rather than after it is set.
- Look at what your facility audit shows and help prioritize which barriers to address first.
- Review the accommodation requests that came in and what happened to each one, including the ones that fell through.
- Judge whether the practice is ready to move from one phase to the next (see Section 1.8, Establish the Foundation for Continuous Quality Improvement).

Your accessibility lead should prepare the agenda, and at the following meeting, report back on what changed since the previous meeting. Reporting back is important: participants will lose motivation if they do not feel their efforts are resulting in change.

1.4 Create the Budget for Phase Two

> **Resources: 1.4 Budget**

You will want to **ensure your plan is practical, is responsive to the real needs of your patients, and takes advantage of tax incentives and grants**. Some accommodations require equipment purchases or longer appointment times, but many require staff to do things differently. Determine which investments would be feasible to start with for the first year and which could be considered for the next year. You might choose to begin investing in equipment improvements now or wait until awareness and buy-in is better established before investing (see Section 2.7, Select and Purchase Accessible Equipment).

Start by building a comprehensive list of the accommodations you are legally required to provide. At this stage you are deciding how much you can spend, not what you will spend it on. You will not know exactly which barriers exist in your practice until you complete your facility and policy audit (see Section 2.2, Audit Your Facility). Budget for the obligations below, and leave room to price the specifics once the audit tells you what they are.

Check legal requirements at the federal level (The Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act), as well as state and local levels.

To find out which rules apply to you:

- Confirm your ADA title. Privately owned practices fall under Title III, and practices operated by a state, county, or city fall under Title II.
- Check whether you receive federal financial assistance. Medicare and Medicaid reimbursement counts, and receiving it triggers Section 504 and Section 1557 as well.
- Locate your regional ADA National Network center, or call 1-800-949-4232.

- Ask your state human rights or civil rights agency what it adds beyond the ADA.
- Contact your local building department for the code edition your jurisdiction has adopted. Where a state or local requirement provides more access than the ADA Standards, follow the one that provides more access (U.S. Access Board, n.d.). A local occupancy permit or a passed building inspection does not establish ADA compliance.

Once you have your list of legal requirements, your next step is to budget for staff training. At bare minimum, this may be a cost in paid staff hours since credible curricula are available at no charge.

However, this training is not about compliance or checking a box; it is about staff changing their attitudes and behaviors when working with people with disabilities. If you notice that free trainings are not resulting in improved patient experiences, consider investing in live training.

Budget considerations that are legally required

Everything in this first list is an obligation rather than a choice. If your practice cannot fund it, you are out of compliance, so treat these as fixed line items and build the rest of the budget around them.

- **Interpreter services.** Required under the ADA's effective-communication rules and Section 1557, and they cannot be billed to the patient (28 C.F.R. § 36.301(c)). Budget for them as a fixed cost, not a discretionary one.
- **Equipment,** like accessible exam tables, Hoyer lifts, and communication devices. Where equipment is what stands between a patient and the screening, providing it is part of providing equal access.
- **Barrier removal** is required wherever it is “readily achievable” — that is, able to be carried out without much difficulty or expense

(28 C.F.R. § 36.304). “Readily achievable” is a moving standard, not a permanent exemption: what was not achievable in a lean year may be achievable in a better one.

- **Digital accessibility.** If your practice receives federal financial assistance from HHS — Medicare and Medicaid reimbursement counts — your website, patient portal, and mobile apps will have to meet WCAG 2.1 Level A and Level AA (45 C.F.R. § 84.84). The deadlines are staged by size: practices with fifteen or more employees must comply from May 11, 2027, and practices with fewer than fifteen from May 10, 2028. Budget for it now rather than in the compliance year, because remediating an existing site takes time as well as money, and because every patient-facing PDF you publish between now and then is either accessible on the way out or work you will redo. The rule allows an exception where compliance would fundamentally alter your program or impose undue financial and administrative burdens, but that is a demonstration you have to be able to make, not an assumption. Sections 1.8 and 2.8 cover what this means for feedback channels and patient materials specifically.

Budget considerations that are not legally required, but make the required ones work

Nothing in this second list is required on its own. Each one is what keeps the required items from failing in practice.

- Staff training (both initial and ongoing). This is what ensures the accommodations above are used correctly.
- Allotting longer appointment times for certain patients.
    - **Note:** Longer appointments are not automatically lost revenue. Under current CMS rules the level of an office visit may be selected using the practitioner's total time on the date of the encounter, including counseling, care coordination, and documentation, so a visit that would

otherwise be coded at a lower level may qualify for a higher one when the practitioner genuinely spends the additional time (Centers for Medicare & Medicaid Services, 2026). Two limits matter:

  - Only the practitioner's own time counts toward that total; time spent by clinical staff does not.
  - Accommodations themselves are not reimbursable. Medicare has no benefit category for sign language interpreters, and the ADA bars passing that cost to the patient, which is what the tax incentives above are there to offset. Ask your billing lead what your current documentation captures.

- Process improvement costs, such as staff time, consultation fees, and technology updates.

Where to look for funding

The following incentives can help offset the cost of equipment and environmental changes:

- **Take advantage of available tax incentives.** Eligible small practices may claim the **IRS Disabled Access Credit** (Form 8826), which covers 50% of eligible access expenditures between $250 and $10,250 (up to a $5,000 credit). Eligible expenditures include interpreters, equipment, and barrier removal.
- Architectural Barrier Removal Tax Deduction (a second tax break for construction costs). Any business can also deduct up to $15,000 per year for removing physical barriers, like steps, narrow doors, or inaccessible restrooms, under Section 190 of the tax code. The credit and the deduction can be used in the same year; ask your accountant which expenses fit each one.
- **Some Medicaid managed-care plans fund accessibility improvements directly.** Through the Provider Accessibility

Initiative, a partnership between Centene and the National Council on Independent Living (NCIL), the Barrier Removal Fund offers participating providers a free on-site accessibility review conducted by a local Center for Independent Living, plus grant funding to remove priority access barriers. Availability depends on your state and the health plans your patients use, so ask the managed care organizations you work with whether a barrier-removal or accessibility-review program is available in your area.

- **HRSA funding (for health centers).** Section 330 grant funds can cover equipment and minor renovations within your approved scope, and HRSA periodically offers one-time capital funding. Watch the Bureau of Primary Health Care funding page. The nonprofit Community Health Center Capital Fund offers loans designed for smaller health centers.
- **Medicaid managed care quality programs.** Some state Medicaid programs and their plans offer quality incentive or value-based payments that can support accessibility upgrades, training, and longer visits. Ask each plan's provider-relations team what is available in your state.
- **USDA Rural Development (rural communities).** The Community Facilities Direct Loan & Grant Program helps nonprofit clinics, hospital districts, and local governments in towns of 20,000 or fewer build and improve medical facilities, including equipment. Applications are accepted year-round.
- **Foundation and community grants.** The Christopher & Dana Reeve Foundation Quality of Life grants have funded accessibility projects by nonprofits and community hospitals (check the site for current cycles), and your state Developmental Disabilities Council may offer small grants for healthcare access projects.
- **Hospital community benefit dollars.** Nonprofit hospitals must invest in community health to keep their tax-exempt status. If

accessible preventive care shows up in your local hospital's community health needs assessment, propose a partnership.

1.5 Form Partnerships and Create an Advisory Council

> **Resources: 1.5 Support Network**

Disability advocacy organizations are irreplaceable partners in this work: they bring lived experience and practical accessibility insight that no checklist can replace.

> June Isaacson Kailes's Effectively Including People with Disabilities in Policy and Advisory Groups (PDF) is a practical guide to making this work: how to recruit, how to run the meeting, and the habits that turn a token seat into a working one.

Centers for Independent Living (CILs)

One of the most important community partners should be your local **Center for Independent Living, or CIL.** CILs are community-based organizations run by and for people with disabilities. Services vary by location, but, generally, CILs provide independent living skills training, advocacy, peer support, and transition services for people with disabilities. They specialize in connecting people with disabilities to resources, so they may be able to assist patients who need assistance with transportation, access to affordable or accessible housing, or social connections. **Representatives from your local CIL should be included in your planning committee.**

How CILs can support your efforts

CILs vary widely in size, capacity and services offered. Treat the list below as the starting point for a conversation to find out more about how your local CIL might be able to contribute. CILs may be able to:

- **Review documents** for plain language, respectful terminology, and usability. For digital accessibility conformance and formal document remediation, go to your Regional ADA Center or a qualified vendor.
- **Give a presentation on CIL services and referrals.** This could cover what the center does, who to refer, and how to ask patients about accommodations.
- **Provide disability etiquette and communication training for staff.** Plan on two to three hours. Schedule it annually and again at new-hire orientation.
- **Do an advisory walk-through of your facility.** A CIL walk-through produces a prioritized list of barriers, but keep in mind that this is not a compliance determination (see Section 2.2, Audit Your Facility). Each center may use its own checklist built on the ADA Standards, so ask which one your CIL works from.
- Identify candidates to serve as representatives on your advisory council.
- **Help you locate accessible equipment** through referrals and in partnership with your State Assistive Technology Act Program.
- **Support you in developing a system for providing referrals to accessible screening facilities.** Many CILs do not yet maintain a list of facilities with accessible screening equipment, and some keep lists only for places they have walked through themselves. You could plan to build this list together if it does not already exist (see Section 2.8, Establish Referral Partnerships).

CILs are not legal counsel and do not enforce the ADA. Rights enforcement and legal advocacy sit with your state's Protection and Advocacy organization, which you can find through the National Disability Rights Network member agency directory. They are not certified ADA inspectors; for a formal compliance opinion, use your Regional ADA Center, a qualified access consultant, or an architect.

And they do not supply qualified medical interpreters. That obligation is your practice's. A CIL may be able to share vendor lists, and a few larger centers run their own interpreting service as a separate, fee-based offering.

Ask about cost in your first conversation, but do not assume there will be one. For many CILs, sitting on community coalitions and councils is already part of their core outreach work and carries no fee. Most centers fund partnership work by writing grants and subcontracting rather than by billing the practices they work with. Some (more often, larger centers) operate on a fee-for-service basis. The only way to know is to ask.

Establishing a work plan with your local CIL: Example Timeline

If your practice is ready to engage a CIL, the following process can help you initiate and structure the partnership:

1. **Inquiry (Weeks 0–2):** Email your local CIL with your goals, sites, timeline, and budget window, and request a brief scoping call.
2. **Scoping call (Weeks 2-4):** Align on priorities — training, an accessibility walk-through, or council participation — and confirm decision-makers and points of contact.
3. **Memorandum of understanding (MOU) or scope of work (Weeks 3–6):** Define deliverables, schedule, staff roles, and any costs (or the pro bono scope if the work is grant-supported). Many CILs have templates.
4. **Baseline assessment (Month 1-3):** Conduct an advisory walk-through using a tool such as OHCUP or an ADA checklist, and interview front-desk and clinical staff to produce a prioritized action list (no-cost, low-cost, and capital items).
5. **Action plan and training (In the first year):** Deliver disability etiquette and communication training, finalize accommodation procedures, and align on equipment purchases using the U.S. Access Board's Medical Diagnostic Equipment (MDE) standards.

6. **Quarterly reviews (ongoing):** Invite a CIL representative to join an advisory council meeting once per quarter to monitor progress, troubleshoot, and recognize successes (a stipend is recommended).

Some Medicaid managed-care plans also fund CIL-led accessibility reviews and barrier removal directly; see Section 1.4, Create the Budget for Phase Two.

How to reach out to your local CIL

- Email a single point of contact. Include your goals, your timeline, the sites involved, the scope you have in mind (training, walk-through, council participation), and your budget, or a request for a quote.
- Describe what you need at the program or process level.
- Ask what access needs CIL staff and peer advisors have for visiting your site.
- Offer stipends for patient advisors and community subject matter experts. This applies to the people a CIL connects you with, not to the CIL itself, which is acting as the liaison.
- Expect a memorandum of understanding or statement of work that spells out deliverables, schedule, and fees if there are any.

Questions to have answered by the end of that first conversation

- What, if anything, carries a cost?
- Which of the five core services does this center currently have the staff to deliver?
- What languages does the center work in, and what cultural and linguistic competencies does it bring?
- Will the center co-facilitate an advisory council and help recruit stipended advisors?

- Will the center co-author a practical accessibility action plan with you? Who does what, by when?

Services various disability advocacy organizations offer

CILs are just one type of disability advocacy organization you might reach out to for support. However, for any tasks out of scope for your local CIL, the table below details additional organizations who might be able to support your efforts and provide guidance.

What you need	Who to call first	Why
Disability etiquette training, inclusive communication, local resource navigation	Your local CIL	Trains staff, connects patients to community supports, and can join your accessibility council as capacity allows.
Formal ADA technical assistance on the built environment and communication	Your Regional ADA Center (ADA National Network)	Free and authoritative. Not legal counsel and not an enforcement body.
Rights enforcement and legal advocacy	Your state's Protection and Advocacy (P&A) organization	Investigates rights violations, provides legal advocacy, and reviews policies for rights implications. They can answer legal advocacy and rights questions.

What you need	Who to call first	Why
Accessible equipment discovery, demonstrations, and short-term loans	Your State Assistive Technology Act Program	Vendor-neutral device trials and training. They can arrange device demonstrations and short-term equipment loans and give vendor-neutral advice on accessible equipment. These programs are federally funded, and their information and assistance services are free.
Purchasing specifications for exam tables and scales, and compliance timelines	U.S. Access Board MDE standards and the 2024 HHS rule	Sets the specifications to buy against and the 2026 milestones for covered entities (see 2.7).
Interpreter contracting and policy	Your practice's accessibility leader, using ADA and Section 1557 guidance	The obligation to furnish qualified interpreters is the practice's. A CIL can share vendor lists (see Section 2.4, Develop Accommodation Procedures).
Tax credits and deductions that offset access costs	Your finance staff or accountant	IRS Disabled Access Credit (Form 8826) and the ADA barrier-removal deduction (see Section 1.4, Create the Budget for Phase Two).

What you need	Who to call first	Why
Systems advocacy, capacity building, and small grants for disability access projects	Your state's Council on Developmental Disabilities	Funds and supports projects that expand community access for people with developmental disabilities. They may offer small grants for healthcare access projects. Councils also convene people with developmental disabilities and family members who can advise your efforts.

Paying patient advisors and community experts

> For detailed guidance on compensation for people with lived experience, see the Center to Advance Consumer Partnership's guidance on supporting participation.

This plan asks you to bring patients with disabilities onto your advisory council and your facility walk-throughs. Paying them for that time is what separates a real advisory relationship from an extractive one. It is also a practical question of who ends up in the room: when participation is unpaid, an advisory council narrows to the people who can afford to volunteer, and that is rarely the same group facing the barriers you are trying to fix.

- **Cover costs up front instead of reimbursing later.** Asking someone to pay for a ride or a day of childcare and then wait weeks to be paid back screens out the people whose input you most need.
- **Ask how each person wants to be paid rather than assuming.** Extra income can affect eligibility for public benefits. Do not try to guess those to whom this applies; raise it openly with everyone and offer choices. Splitting a payment into smaller amounts over

time, gift cards, covering a specific bill or a training registration, or buying a needed item can all work where a single check would cause problems. Pointing people toward benefits counseling and ABLE accounts is worth doing.

- **Put your policy in writing.** Name which activities are paid, at what rate, how someone submits for payment, what paperwork you need, which payment methods you offer, how long each step takes, and who to ask when something goes wrong. Improvising this in the moment is what erodes trust.
- **If you cannot pay everyone, be honest and choose a defensible subset.** Paid leadership roles within a larger volunteer council, or paid roles on specific projects, work better than a vague promise to everyone. Writing advisor roles and rates into grant budgets from the start is the durable fix.
- **Budget participation costs separately from payment for time.** Transportation, parking, childcare, internet or a device for remote meetings, and food at in-person meetings are the cost of making participation possible. They are not compensation for someone's expertise.
- **Make the meeting itself accessible by default.** Provide captioning, interpreters, and materials in accessible formats as standard practice rather than waiting for someone to ask. Consider meeting somewhere other than the clinic, too: a community location is often easier to reach, and for people whose experience of healthcare settings has been poor, it is an easier room to walk into.

> For help setting a rate, the National Health Council publishes a **fair market value calculator** built specifically for patient engagement, along with template agreements for working with patients.

Consider training and hiring disabled community health workers

Community health workers (CHWs) are trusted community members trained to provide health education, outreach, and one-on-one navigation. The Community Preventive Services Task Force recommends engaging CHWs to increase breast, cervical, and colorectal cancer screening.

The natural extension for this plan is to **recruit, train, and pay people with disabilities to fill these roles**. Peer providers with lived experience are already a fast-growing part of the workforce supporting people with disabilities (Administration for Community Living, n.d.), and shared experience builds a kind of trust that no script can.

Success stories

- **Peer navigators with physical disabilities (Chicago).** The Our Peers — Empowerment and Navigational Support (OP-ENS) program trained and paid people with physical disabilities to work as peer health navigators for Medicaid beneficiaries with physical disabilities. Over roughly a year, each navigator helped peers name their healthcare priorities, work through barriers one at a time, and build self-advocacy skills. The program was co-designed with the disability community and tested in randomized trials; navigators' own experience of the healthcare system was central to building rapport and to surfacing barriers, including disability discrimination, that would otherwise have gone unaddressed (Magasi, Papadimitriou, et al., 2019).
- **Screening events designed by and for the disability community (Chicago).** The same partnership built ScreenABLE, which turned community-identified barriers into community-based screening programs, including the ScreenABLE Saturday wellness fair described in Section 2.8, Patient Engagement Strategies (Magasi, Reis, et al., 2019). Peer health workers are natural planners, greeters, and navigators for an event like this.

- **Peer-taught screening education for women with intellectual disabilities (North Carolina).** The Women Be Healthy classroom curriculum walks through what happens during breast and cervical screening, step by step, alongside self-advocacy and anxiety-management skills. In a randomized trial, women who completed it knew significantly more about screening than women who had not (Swaine et al., 2014). It is a ready-made curriculum for a trained peer educator to deliver.

No published evaluation has yet combined community health worker screening programs and peer navigators with disabilities inside a single primary care practice. If you try it, set a baseline, measure it through your continuous quality improvement process, and share what you learn.

Join a working group

It is crucial to meet regularly with other healthcare professionals who are also working to improve accessibility. Sharing experiences and lessons learned, as well as staying on top of the latest developments in accessible healthcare, helps sustain momentum and accountability.

> DEC hosts three workgroups and provides learning opportunities on this topic. Visit their **Workgroups page** to learn more.
>
> 2axend, a Deaf-owned accessibility consulting firm, hosts healthcare roundtable discussions for organizations working to make accessibility standard practice rather than an exception. **Visit 2axend's website** to learn more.

You should also consider creating your own workgroup together with other local practices and health systems who are engaged in accessibility improvements. Imagine: your efforts could lead to higher screening uptake not just in your own practice or health system, but region-wide.

1.6 Present an Urgent Case for Change to Staff

> **Resources: 1.6 Audit Tools**

The next step is to share information with staff to **help them understand why a change is necessary**. Some team members may feel nervous, overwhelmed, or skeptical about changing established routines. Address these concerns directly by focusing on the law, patient care, and practical benefits. Even the best plans fail if staff members are not ready to change how they work.

Change stalls when staff believe things are basically fine. Make the cost of the status quo concrete. Kotter also warns about the opposite failure: if urgency is delivered with alarm, this can cause defensiveness instead of creating momentum. To avoid this, pair the problem with a first step small enough that people can picture themselves taking it (Kotter, 1995).

It might help you design your first presentation to gauge staff's current attitudes and biases around disability in a non-judgmental way. Depending on your organization's size, this might look like having a discussion at a staff meeting, sending out a survey, or asking staff to take the Disability Implicit Association Test (IAT), a test measuring unconscious disability bias. *To find the test, click "I wish to proceed," at the bottom of the page, then "Disability IAT."*

Your presentation should cover

- Data on disparities in healthcare access for patients with disabilities, and how accessibility efforts can reduce these.
- Legal requirements and potential risks of noncompliance.
- How accessibility improvements benefit all patients, not only those with disabilities.
- Practical examples of simple accommodations that make visits easier.

- Your practice's commitment to providing excellent care for everyone.

> You can use Screening for All's Data Summary: Health and Screening Disparities for People with Disabilities for more data broken out by disability type.

Tips for presenting to staff

- Use patient stories to make the need real and personal. You could use or adapt patient stories from academic articles or social media (see examples below).
- Acknowledge that some changes may feel challenging at first.
- Emphasize that most accommodations are simple and low cost.
- Explain that training and support will be provided.
- Be clear that this is a practice priority, not optional.

Published patient stories you can share

- **Four Women Tell Their Stories**, from Centers for Disease Control and Prevention, Right to Know campaign. Four women with disabilities who survived breast cancer describe their mammography experiences. Audio with transcripts; US federal work, free to reprint.
- **Navigating Health Care with a Disability: Our Stories**, from Centers for Medicare & Medicaid Services (2019). Three-minute video of disabled people describing good and bad healthcare experiences.
- **How to Speak Up for Your Health: Role Models Share Their Stories**, from the University of Arizona Sonoran Center for Excellence in Disabilities. Short videos from four self-advocates.
- **Breast Health Experiences in Women with Cerebral Palsy** by Ehrlich-Jones et al. (2021), Women's Health Reports. Open access

under CC-BY 4.0, so quotes may be reprinted on a slide with citation.

- **Healthcare Stories: Denise Sherer Jacobson** from the Disability Rights Education and Defense Fund (DREDF). Short video segments.
- **Wheelchair Barbie Goes to the Gynecologist**, a recorded lecture by Cody Unser, MPH (University of Utah OB/GYN Grand Rounds). A patient advocate's talk on the pelvic-exam and reproductive-health experience for women with mobility disabilities, paired with points for clinicians.
- **Wheelchair Barbie Gets a Mammogram**, a personal Substack essay by Cody Unser, MPH. A patient advocate's first-person account of getting a mammogram as a wheelchair user.

1.7 Ensure Everyone Gets Trained on the Basics

> **Resources: 1.1 Fundamentals, 1.7 Patient Care**

Your practice should make a commitment to ensure that every employee will be given the opportunity, and the paid time, to get proper training in disability-informed care.

All staff need to understand disability etiquette and effective communication. We have included training materials on these topics in section 1.1, Fundamentals of the Screening for All Implementation Resource List. Additionally, you may choose to hire a trainer who specializes in disability awareness.

Schedule training during paid time and require everyone to attend. This shows your commitment to the work. Make training recurring, not one-time: build in refreshers at least yearly, and include training for every new hire during orientation.

Training in these interpersonal skills is as important as having the right equipment. You can have perfect accessibility features but still provide

poor care if staff do not know how to communicate respectfully with patients with disabilities.

Nurses, medical assistants, and community health workers have a special role in facilitating screening. These are the professionals who, in many practices, explain what a mammogram will feel like, why a stool test matters, and follow up when a result comes back. The Community Preventive Services Task Force's review of interventions engaging community health workers to increase breast cancer screening found a substantial effect: screening rates increased by a median of 12.7 percentage points (The Community Preventive Service Task Force (CPSTF), 2019).

Topics to cover in staff trainings

Legal requirements, including

- ADA requirements,
- State and local regulations (your Regional ADA Center can tell you what your state adds),
- Section 504 of the Rehabilitation Act and
- Section 1557 of the Affordable Care Act, if applicable.

Legal requirements for effective communication, including who provides a qualified interpreter, who pays, when video remote interpreting is and is not adequate, and what CART is.

- What to do when an arranged accommodation fails on the day: an interpreter no-show, a dropped VRI connection, a lift out of service. Tell the patient what happened and what you are doing about it, call your backup vendor before you touch the schedule, and ask the patient what would work right now. Do not reschedule as your first move, do not ask a family member or child to interpret, and do not charge the patient for the fix. Log what failed and route it to whoever owns your accessibility program so the pattern gets fixed, not just the visit.

- The U.S. Department of Health and Human Services (HHS) publishes a sample nondiscrimination policy and a sample notice of availability of language assistance services and auxiliary aids that your practice can adapt, plus translations of that notice in dozens of languages. Under 45 C.F.R. § 92.11, the notice must also be provided in alternate formats for patients who need auxiliary aids to communicate effectively.
    - HHS Sample Document as a PDF
    - HHS Sample Document as a DOCX

> See DEC's **Appendix 4.9: Deafness and Sign Language Guidance**, which you can hand to staff as-is.

Trauma-informed care. Some patients arrive carrying experiences, including violence, past medical harm, being held down or overridden, that make an ordinary exam feel unsafe. This is not a side issue for a screening program. The screenings in this plan involve undressing, positioning, and being touched or examined internally, so they are exactly the encounters where an unaddressed history turns into a cancelled appointment.

Ground your training in SAMHSA's six principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. Then make each one concrete for the screenings you offer (Substance Abuse and Mental Health Services Administration, 2023). Staff should be able to:

- Say what they are going to do before they do it, and wait for a yes. This is a standing expectation for every patient, not an accommodation someone has to request.
- Explain why a screening or a sensitive question is being asked, and what happens to the answer. A question that arrives with no explanation can do lasting harm. A patient may keep circling back to it for days afterward.

- Agree on a stop signal before the exam begins, and honor it. Offer low-effort ways to respond mid-procedure. This could look like a short menu like stop, back off, more time, or water. Open-ended questions are nearly impossible to answer when someone is overwhelmed.
- Ask who the patient wants in the room, and offer time alone. Do not assume the person who came with them should stay.
- Let a patient decline, defer, or skip part of a questionnaire without making them justify it, and offer to finish it later.
- Repair when something goes wrong. Name it, stop, and ask what would help, rather than pressing on and hoping it passes.

Shared decision-making. Screenings should be a decision the patient makes with the clinician, not an order they receive. Medicare makes this explicit for one of them: before a patient's first low-dose CT scan for lung cancer, there must be a documented counseling and shared decision-making visit that includes the use of one or more decision aids (Centers for Medicare & Medicaid Services, 2022). For patients with disabilities, shared decision-making tends to fail in a few predictable ways. Staff should know how to:

- Presume the patient can decide, and speak to the patient. Assume capacity to consent unless established otherwise, recognize that capacity can change, and address the patient directly rather than the person who came with them (American College of Obstetricians and Gynecologists, 2025).
- Give the patient what they need to weigh the choice: what the preparation involves, how long it takes, what it will feel like, what happens if a result is abnormal, and what it may cost, including whether accommodations cost anything. Missing detail (not disagreement) is the most common reason a patient cannot decide.

- Treat format as part of the decision. A decision aid the patient cannot read, hear, or process is not a decision aid. Keep plain-language and alternate-format versions, and use teach-back to confirm the patient understood the options, not just the instructions.
- Allow the decision to happen after the visit. Not everyone can weigh options while also managing a conversation, a room, and a clock. Offer a follow-up call or email so the patient can think it through and come back with questions.
- Know what guardianship does and does not change. Where someone else holds legal decision-making authority, the patient still participates in the conversation and their preferences still shape the plan. Supported decision-making arrangements are increasingly common and are not the same as guardianship.
- Document a decline as a decision. A patient who weighed the options and said no is a different situation from a patient who was never really offered the screening. Only the second is a gap your practice should be closing.
- Your practice's specific policies and procedures, including how staff with disabilities request work accommodations.
- Disability etiquette, cultural humility, unconscious bias, microaggressions, and diagnostic overshadowing. Screening for All's Summary of Adjustments and Adaptations, Instruction, sets out these training needs as barrier-and-adaptation pairs, with separate guidance for intellectual and developmental, mobility, and sensory disabilities. It also covers ground this section does not: symptom assessment for patients who may not report changes, keeping current on screening guidelines, bias against using interpreters, and the assumption that disabled patients are not sexually active.

Role-specific training needs

- **Front desk:** How to ask about accommodations when scheduling, making forms available in different formats.
- Medical assistants, nurses, and clinical support staff (MA, RN, LVN, CNA) as well as community health workers (CHWs) or peer providers: How to walk patients through the screening process, describing the preparation, positioning, length of time, what sensations to expect, and what will happen afterward. How to help patients determine what accommodations they need and organize questions to ask their primary care provider. How to use teach-back to confirm the patient understood, and who to escalate to when an accessibility support must be arranged.
- **Clinicians:** Disability-informed patient care, respectful communication during exams, and modified screening approaches for people with disabilities.

How you will know the training worked

Together with your advisory council, decide on the behavioral changes that you would like to see in clinicians and staff and how they can be measured. Staff can take trainings and you can use completion percentage as a metric, but that is superficial information. A true measure of success would be reflected in, for example, patient satisfaction scores, or a higher uptake in screenings among patients with disabilities.

You need a baseline. You can establish this through data, if you have it, as well as through pre- and post-assessments to evaluate learning. Most trainings in our Resource Library that carry continuing education credit should assess understanding before they issue a certificate. For trainings without CE credit, you could establish your own questions.

1.8 Establish the Foundation for Continuous Quality Improvement

Resources: 1.8 Continuous Quality Improvement

Consider potential metrics

A few key metrics you could discuss tracking include:

- Screening completion rates for patients with and without disabilities.
- Patient satisfaction scores, feedback, and complaints: Issue regular surveys about their experience and document any unmet needs.
- Staff feedback: Assess workflow effectiveness, confidence levels, and training needs on an ongoing basis.
- Number and types of accommodations provided.
- Share of accommodation requests fulfilled and the reasons when one falls through.
- Staff training completion: the percentage of staff, including new hires, who have finished disability awareness training this year.
- Facility audit progress: barriers found, barriers fixed, and the date of your most recent audit.
- Time required to provide different accommodations.
- Quality-of-care measures: for example, the percentage of patients with disabilities who are up to date on each recommended screening, compared with patients without disabilities.
- Loop closure: whether you reported back to your advisory council and your patients what changed because of the feedback they gave you, and how long that took.

> The Center for the Advancement of Consumer Partnership's Understanding the Impact and Outcomes of Engaging People with Lived Experience offers questions to consider and metrics you can track, including qualitative measures of success defined by the people who gave you the feedback.

Making the case internally

At some point you will need to explain to whoever controls the budget why this work should continue. Here are some metrics you could use:

- No-show rate among patients with a documented disability, compared with your overall no-show rate. A patient who could not get onto the table, or who was never told whether the building was accessible, often does not come back. This is the closest thing on these lists to a revenue measure.
- Accommodation fulfillment rate. An accommodation that falls through usually becomes a rescheduled or abandoned visit, which is a slot you did not fill.

Combine those with the cost offsets described in Section 1.4, Create the Budget for Phase Two: longer appointments are not automatically lost revenue under current CMS time-based coding, eligible practices can claim the IRS Disabled Access Credit, and some state Medicaid quality programs will pay for exactly this kind of upgrade.

Improvement cycles

This plan asks you to change how your practice works, and no plan survives first contact with a real schedule. So rather than designing a perfect process and launching it, change one thing at a time, in small tests, and keep what works. This approach is also known as the Model for Improvement, or Plan-Do-Study-Act, and applying it to each phase will strengthen your work.

A cycle is a small, fast trial of one change.

- You **plan**: name the one thing you will try, who will try it, for how long, and what you will write down.
- You **do** it, often with one staff member and a handful of patients, sometimes for a single day.
- You **study** what happened, comparing it against what you expected before you started.
- Then you **act**: keep the change, adjust it, or drop it, and start the next cycle.

The three questions that frame this cycle (Langley et al., 2009) are:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

The Agency for Healthcare Research and Quality writes that a cycle should cover a single step rather than a whole new process, should "be as brief as possible for you to gain knowledge that it is working or not (some can be as short as 1 hour)," and "will likely involve only a portion of the practice (maybe 1 or 2 doctors)" (Plan-Do-Study-Act Worksheet, Directions, and Examples, 2024). That means: instead of planning a three-month rollout before you can complete an initial cycle, ask what you could do by next Friday.

Building accessibility into your practice is not a one-time project; it requires **ongoing attention and refinement**. If your organization has a diversity, equity, or community health office, partner with them. Establish regular review processes that help track progress, identify problems early, and celebrate successes with your team.

Here are some recommendations for how to break this work down into actionable steps:

1. **Schedule monthly staff meetings** specifically focused on accessibility topics. In these meetings you might consider:

- Coming with one change you tried, what you expected, what actually occurred, and what you propose to do next.
- Reviewing any accommodation requests from the past month, discuss what worked well and what did not, and brainstorm solutions to new challenges.

You can tie monthly meetings to disability awareness observances so the education has a built-in calendar:

- **February:** Low Vision Awareness Month
- **March:** Developmental Disabilities Awareness Month and Brain Injury Awareness Month
- **April:** Autism Acceptance Month and National Deaf History Month
- **May:** Mental Health Awareness Month and National Speech-Language-Hearing Month
- **June**: Alzheimer's and Brain Awareness Month
- **July 26**: the anniversary of the Americans with Disabilities Act
- **September**: International Week of Deaf People during the last full week
- **October**: National Disability Employment Awareness Month, Blind Equality Achievement Month with White Cane Awareness Day on October 15, and Down Syndrome Awareness Month
- **November:** National Family Caregivers Month
- **December 3:** the International Day of Persons with Disabilities

2. **Every three months, conduct a more comprehensive quarterly assessment** of your progress, and include your advisory council. Is the practice actually becoming more accessible?

   It is important to invite representatives **from local disability organizations to these meetings**, to provide feedback on your

efforts and suggest improvements. Their perspectives can help you see barriers that you have become accustomed to and identify new opportunities for partnership.

You should bring your scored monitoring rubric, your accommodation documentation rate, your accommodation provision rate, and anything patients have told you since last quarter. And you should leave this meeting with a short list of what worked and what did not, one priority for the coming quarter, and a report back to anyone whose feedback shaped it.

> DEC's **Appendix 1.9: Accessibility Program Monitoring Progress and Adaptations** gives you a template for tracking your progress.

3. **Close the loop on what you hear.** Asking for feedback creates an obligation for you to report back on it. When a patient advisor or community partner raises something, tell them what happened to it: what you changed, what you have planned, and what you decided not to act on and why. People can accept a "no" that comes with a reason, but silence makes it seem like the input never mattered.

   Make sure the feedback channel itself is accessible. If your only route is an online form a screen reader cannot navigate, you are systematically excluding the patients you most need to hear from. Label every field, make every control operable by keyboard, avoid CAPTCHA or pair it with an alternative that works in a different sensory mode, write in plain language, and offer large print and other formats on request. Offer more than one channel, for example, paper, phone, online, in person, and assisted response. Follow up by mail or phone with anyone who does not respond online. Practices that receive federal financial assistance from HHS must bring their web content and mobile apps to WCAG 2.1 Level A and Level AA (45 C.F.R. § 84.84).

4. **Use more than one method to gather that feedback.** AHRQ's Get Patient Feedback (Tool 17) sets out several ideas a small practice can coordinate without a budget.

5. **Keep a simple running record: feedback received, what was decided, and when you reported back.** A shared spreadsheet is enough. Credit the people whose input drove a change when you share results internally and with patients.

> The Center to Advance Consumer Partnership's guidance on establishing feedback loops that support action covers this in more detail and includes a sample tracker.

Larger organizations might consider a disability-centered Patient and Family Advisory Council, or PFAC (Agency for Healthcare Research, n.d.). This is a standing body where patients and family members sit down with staff on a regular schedule and work through policy and program questions together. The Institute for Patient- and Family-Centered Care (IPFCC) suggests 12 to 18 patient and family members as a manageable size, with no more than three or four permanent staff seats and recommends meeting monthly (Institute for Patient- and Family-Centered Care, 2022).

Budget for the costs of transportation, parking, and childcare for participants. Otherwise, the people you most need may not be able to attend.

A different kind of readiness check: let the people you serve decide

Most plans check whether staff finished training. However, whether your practice is ready to move forward is better judged by the people you serve, not by staff self-report.

We recommend working together with your advisory council to draft a short set of questions that you can ask patients regularly about their experiences. This will help you document changes and gauge organizational readiness.

Keep in mind that collecting this feedback is not the difficult part. Acting on it is. A PCORI-funded randomized trial tried something like this: a patient-reported quality measure developed with people with

disabilities, with results mailed back to primary care practices. Neither the mailed report nor a companion advocate-led approach improved patients' experiences of care. Practices largely did not engage with what the reports said, and doctors often declined to meet the disability advocates who brought them (Iezzoni et al., 2018).

If you do this part right, your accessibility lead will close the loop and tell your advisory council what changed because of what they said.

What Success Looks Like After Phase 1

Here are some example SMART goals to work toward. Your advisory council can adjust any aspect of these to fit your organization's needs and goals. Just make sure you document your starting number before you begin. Without a baseline you cannot show change.

1. By month one, an accountability structure is established.
2. By month two, an accessibility lead is named in writing, with the role written into their job description and protected time on their calendar.
3. By month four, you have met at least twice with your local Center for Independent Living or another disability organization, and they have agreed to a specific next step.
4. By month nine, every scheduler and front-desk staff member can state the access-needs question from memory, checked at a staff meeting.
5. By month ten, a named budget line for accessibility exists for the coming year, approved by whoever signs off on the budget.
6. By month twelve, at least 90% of patient-facing staff have completed disability-informed care training, and a repeat of your baseline confidence survey shows improvement against the Month 1 result.

Remember, these are a few examples, but you should write your own SMART goals together with your advisory council.

Potential Challenges and Solutions in Phase 1

- **Staff resistance:** Some staff may feel overwhelmed or skeptical. Address concerns directly and emphasize that most accommodations are simple and help all patients.
- **Staff burnout:** Accessibility work tends to land on the same one or two people until it stops happening. Keep the recurring commitment short, rotate specific tasks across the team, and give the accessibility lead protected time rather than one more unpaid duty.
- **Competing priorities:** Accessibility can slip when a new initiative arrives. Attach your accessibility measures to a report leadership already reviews, and roll out one change at a time instead of several at once.
- **Budget concerns:** Start with changes that require staff time rather than capital, like training and communication improvements. Build the case for equipment purchases over time.

Phase 2: Assess and Build

Now that the foundation is set, you will **develop specific procedures for different types of accommodations**. This phase overlaps with Phase 1 because you can start working on procedures while staff training is still happening. The goal is to create clear, step-by-step processes that any staff member can follow.

2.1 Map Out Your Current Screening Referral Processes to Understand Gaps

> **Resources: 2.1 EHRs**

First, **record the current state of what happens in your practice today when patients need to be referred for a screening.** Document the interplay between the experiences of the patient and the office(s).

Start with the patient's path through a visit as the backbone of your map. At each stop on the patient's path, write down:

- what the patient encounters, and
- what clinical staff actually do.

Look at how patients currently move through your practice from scheduling to checkout. **Document each step and identify where barriers might exist** for patients with different disabilities. For example, are forms only available in one format? Do you have stairs or steps in your building? Are appointment slots too brief for patients who need extra time?

Then, identify which accommodations your practice currently provides, where they are available, and how they are tracked.

> DEC's Appendix 0.7: Accessibility Screening Tool Template is a ready-made version of this map. It walks the visit in order, from booking through follow-up, and asks the same three things at every stop: can you offer it, do you have a process for offering it, and does your staff know how. Your staff fill it in rather than your patients, and there is a spreadsheet version if you would rather work in Excel.
>
> DEC's Appendix 0.6: Project Planning shows you how to draw one — what the shapes mean, and how to build the diagram step by step.

You can use DEC's screening tool, or your own version of it in the form of a table, a simple diagram, or a marked-up floor plan of the patient's path with the barriers marked on it.

Two additional considerations to add to your screening process map:

1. What happens on the day of the appointment when an arranged accommodation fails? Record whether anyone currently owns that.
2. How do a patient's documented accommodations travel with a referral? (Section 2.8, Establish Referral Partnerships covers this in more detail, as well.)

Right now you are not recording what a policy says should happen. You are recording what actually happens in practice. The gap between the policy and actual practice is usually where the barrier lives.

2.2 Audit Your Facility

> **Resources: 1.6 Audit Tools**

Once staff understand the importance of accessibility, conduct a comprehensive audit of the physical space. This systematic evaluation helps identify specific barriers that patients with disabilities encounter in your practice.

Work through your practice systematically, examining everything from parking and entrance accessibility to exam room layouts and emergency procedures. Pay attention to the patient's journey from arrival to departure. Can someone using a wheelchair navigate your hallways? Are your signs readable for patients who are blind or have low vision? Do you have adequate lighting and noise control? Document everything you find, both positive features and areas that need improvement.

Include signage and wayfinding. Check that signs are readable from a distance and in high contrast, that room numbers and directions do not rely on color alone, and that a patient with low vision can find the restroom, the lab, and the exit without having to ask someone.

Consider hiring an accessibility consultant or working with local disability organizations to conduct this audit. They can identify barriers you might overlook and provide specific recommendations for improvements. Many state ADA centers offer free consultations that can be invaluable during this process.

> The **ADA Checklist for Existing Facilities** covers the built environment in dimensional detail.

If you plan to hire an architect or access consultant, talk to your Regional ADA Center first for guidance on what to look for.

You do not need to build your own list. The ADA Checklist above covers the built environment in dimensional detail, including parking, entry, door width, reception height, waiting areas, exam rooms, restrooms, alarms, and egress.

Screening for All's Summary of Adjustments and Adaptations, Accessibility of the Built Environment and Screening Equipment covers additional considerations for primary care clinics and screening facilities.

For a facility offering mammograms, specifically, two questions are worth adding to any facility walk-through:

- Does the unit have a positioning chair with a braking device and adjustable arms kept ready for use? and
- Does the breast platform lower far enough to image a seated patient?

> For current room-level guidance on clearances, transfers, and positioning, including mammography, gynecological exams, and bone densitometry, see the Department of Justice's Access to Medical Care for Individuals with Mobility Disabilities. Note, however, that it is guidance; not a binding standard.

Confirm these requirements separately, because they carry deadlines:

- Accessible medical equipment: at least one height-adjustable examination table and one weight scale that meets the Standards for Accessible MDE. Practices receiving federal financial assistance were required to have these by July 8, 2026 under Section 504 (45 C.F.R. § 84.92(c)).
- Practices operated by a state, county, or city have until August 9, 2026 under ADA Title II (28 C.F.R. § 35.211(c)).

Audit your policies as well as your space

A walk-through will not surface a broken process. Separately from the physical audit, work through what actually happens when something fails: the VRI connection drops mid-visit, the interpreter does not arrive, the one accessible exam room is already occupied, the lift is out of service. For each, write down who decides what happens next, and whether that person has the authority to hold the room, extend the appointment, or call a different vendor rather than defaulting to rescheduling the patient.

2.3 Build Disability Data Into Your Electronic Health Record System

> **Resources: 2.1 EHRs**

In this step, you will establish a standardized system for documenting disability and access needs. Documenting these data enables healthcare teams to proactively provide appropriate accommodations, prevents patients from repeatedly explaining their needs at every visit, ensures legal compliance, and supports efforts to identify and address healthcare disparities affecting people with disabilities.

Consider the following questions as you evaluate the data that you currently gather:

- Do you currently ask patients about their disability status and/or accommodation needs?
- Do you have any data on the current status of preventive care or screenings for patients (with and without disabilities)?
- Do you have any data on patients with disabilities?

Then look at the workflows you already have for documenting disability status and access needs: who asks, at what point in the visit, where the answer is stored, and who can see it afterward.

Adding disability status and accommodation fields to your EHR may require coordination with your EHR vendor and/or your IT staff. **Disability status** is a federally standardized data element in USCDI v3, so most certified systems can carry it. However, a discrete **accommodation** field is not standardized and usually has to be built. How long this takes depends on whether you can build fields yourself or have to file a request with your vendor.

We recommend incorporating DEC's Patient-Centered Disability Questionnaire, since it was developed and tested in U.S. healthcare

settings specifically to identify access needs (Morris et al., 2017). Its questions include:

7. Are you deaf, or do you have serious difficulty hearing?
8. Are you blind, or do you have serious difficulty seeing, even when wearing glasses?
9. Do you have difficulty remembering or concentrating?
10. Do you have serious difficulty walking or climbing stairs?
11. Do you have difficulty dressing or bathing?
12. Using your usual language, do you have difficulty communicating (for example, understanding or being understood)?
13. Due to a disability, do you need any additional assistance or accommodations during your visit?

> These questions are reproduced from DEC's Appendix 2.7: Documentation Disability Questions, which shows the differences between these questions and two other sets of disability questions.

In addition to the disability questionnaire, have a place to record patient-specific triggers or actions to avoid, such as a patient who needs to be told before being touched, who cannot tolerate a particular position, or who needs the door left open. Make sure that flag is visible to every staff member who will be in the room rather than buried in a note.

The questionnaire has a standard code your EHR team can use to build it: LOINC panel 98067-2.

> DEC's Chapter 2, Step 4: Create Electronic Health Record Build walks through the build itself, including deciding which fields you need, then standing them up and testing them.
>
> DEC's Appendix 2.5: Documentation LOINC Codes gives your EHR team the standard code for each individual question, so the fields you build are readable outside your own system.

> DEC's Appendix 2.10: Documentation Who and When lays out your options for who on the team asks these questions and at which point in the visit, along with what each choice costs you.

Build the reporting path at the same time as the fields. A field that no one can report on will not tell you whether this plan worked. While your vendor or IT staff are in the system, confirm that disability status and access needs are reportable. You should be able to pull a list of patients with a documented disability and cross it against screening completion. Internally: agree on who runs that report and how often.

Worried this will slow scheduling down? One health system that added disability questions to its centralized scheduling calls found that if schedulers asked one disability question, it added a median of about 18 seconds per call. A fuller set of disability questions took about a minute (Morris et al., 2021).

2.4 Develop Accommodation Procedures

> **Resources: 2.3 Accommodations**

For each accommodation, work out who receives the request, who arranges it, how much notice is needed, who confirms it actually happened, and what the fallback is when it does not. Drawing this makes the handoffs visible and shows where handoffs may be failing.

> DEC's Appendix 0.9: Disability Accommodations Inventory Table is a grid built for exactly this. For every accommodation you record when the need surfaces, who sets it up, how much lead time it takes, who keeps the equipment working, and who has been trained to use it.

Common accommodations to plan for

Needs vary widely even within the same disability category, so treat these as starting points and ask each patient what works for them.

> Screening for All's My Health Care Accommodations Checklist is a patient-facing list of accommodations your patients can use to document their access needs.
>
> Screening for All's Summary of Adjustments and Adaptations catalogs these barriers and their matching adjustments across five domains, with separate breakouts for mobility, sensory, and intellectual and developmental disabilities.

> DEC's Appendix 0.8: Disability Accommodations Examples groups accommodations by the kind of barrier they remove.

Screening-specific accommodations

Screenings often require specific equipment and/or positioning that may present challenges for people with different disabilities. Accommodating these challenges requires specific attention to each step of the screening process. The resources we have created provide guidance for both patients and healthcare professionals to think through.

> Screening for All's Summary of Adjustments and Adaptations for Preventive Health Screenings for People with Disabilities provides a full list of barriers and matching adjustments, with breakouts for mobility, sensory, and intellectual and developmental disabilities.

Screening For All Patient Guides

These resources walk patients through each screening step by step and let them indicate access needs and preferences.

> Screening for Breast Cancer: A Guide for Patients (PDF)
> Screening for Cervical Cancer: A Guide for Patients (PDF)
> Screening for Colorectal Cancer: A Guide for Patients (PDF)
> Screening for Osteoporosis: A Guide for Patients (PDF)
> Questionnaire Screenings: A Guide for Patients

Screening For All Quick Reference Guides

Two-page summaries to use during a visit. They highlight the most critical accommodations and considerations for patients with sensory, mobility, and intellectual or developmental disabilities.

> Breast Cancer Screening Quick Reference Guide (PDF)
> Cervical Cancer Screening Quick Reference Guide (PDF)
> Osteoporosis Screening Quick Reference Guide (PDF)

Screening For All Practice Considerations

Detailed clinical guidance for planning. These cover patient assessment, disability-specific clinical considerations, and alternative screening options for each screening.

> Breast Cancer Screening Practice Considerations
> Cervical Cancer Screening Practice Considerations
> Osteoporosis Screening Practice Considerations
> Guidelines for Questionnaire Screenings

Meeting your effective communication obligations

Effective communication means making sure communication is clear and actionable for everyone, including neurodivergent patients, patients with cognitive or speech disabilities, patients with limited English proficiency, and patients under stress — not only patients who are Deaf or hard of hearing.

In a national survey of 526 physicians, more than 80% acknowledged that patients with significant hearing loss receive worse care, yet about half never used an in-person sign language interpreter and nearly two-thirds never used video remote interpreting (Iezzoni et al., 2023).

> DEC's Chapter 4: Effective Communication covers the legal baseline: who counts as a qualified interpreter, why family and friends cannot fill that role, what a compliant VRI setup requires, and the rule that the practice always pays.

> Appendix 4.9: Deafness and Sign Language Guidance (PDF) covers interpreters and VRI in detail.

Ground rules for interpreters

- **Use qualified interpreters.** A qualified interpreter is trained to interpret accurately, impartially, and with the medical vocabulary the visit requires. Being bilingual is not enough by itself (45 C.F.R. § 92.202; 28 C.F.R. § 35.160).
- **The practice pays, never the patient.** Interpreter services must be free to the patient, even when the interpreter costs more than the visit brings in. You cannot ask patients to bring their own interpreter (28 C.F.R. § 36.301(c)).
- **Family and friends are not interpreters.** Rely on an adult companion only in a true emergency, or when the patient specifically asks. Never use a minor child to interpret except in an emergency with no qualified interpreter available.
- **Contract with an interpreter vendor in advance** and build the request into scheduling. Booking the interpreter should happen immediately after booking the appointment.
- **The patient chooses the modality.** At scheduling, describe the procedure and ask the patient what modality they need, rather than defaulting to the same modality every time. The right choice depends on the length and complexity of the visit and how the person usually communicates, and the options go beyond in-person versus video. Record the answer with the patient's access needs and re-verify at every appointment.

> The National Deaf Center's guide to interpreting describes each type, including Certified Deaf Interpreters teamed with a hearing interpreter and tactile or Protactile interpreting for DeafBlind patients.

Screening-specific decisions regarding interpreters

Four points that bear repeating in the context of preventive screening access:

- **An in-person interpreter is the default; VRI is a last resort.** Reserve VRI for the narrow situations DEC describes: while waiting for an in-person interpreter to arrive, for a visit shorter than two hours, when you need to communicate outside the window an interpreter was scheduled for, or when the patient has expressed no preference and VRI meets the federal performance standards.
- **VRI does not work for most imaging.** It fails whenever the patient cannot see the screen — prone positioning for mammography, procedural drapes, and limited line of sight during a pelvic exam or colonoscopy prep discussion. Schedule an on-site interpreter for those encounters rather than discovering the problem in the room.
- **Written notes alone are never appropriate for a patient who uses sign language.** ASL is grammatically distinct from English, so notes do not provide equivalent access. This applies at check-in and scheduling, not only in the exam room. For a patient who is hard of hearing but does not use sign language, ask what they prefer. Written notes may be exactly right.
- **CART is live captioning typed by a trained captioner.** This might be the right aid for a patient who is hard of hearing but does not use sign language. Automatic captions on a video platform are not CART, and are not an acceptable substitute.

Resources for Communication Compliance Support

> Interpreter directories and certification registries, national interpreting standards, VRI guidance, and staff training on communicating with Deaf and hard of hearing patients are in the Screening for All Resource Library. You can find them by following this direct link for the filtered

view of the resource library for communication compliance support. Or use the following filters on the Resource Library:

Tag: Effective Communication
Disability type: Hearing

DEC's Appendix 4.4: Effective Communication Policy Planning Guidance provides a checklist and a template.

2.5 Adapt Standard Scripts and Forms

Resources: 2.1 EHRs

Develop practice-wide templates for the conversations that come up most, including phone scheduling, check-in, and the exam room itself.

Create flexible scripts for phone scheduling, in-person check in, and clinical interactions.

DEC's Appendix 2.11: Documentation Sample Script and Question Prompts gives you wording staff can say out loud, including an answer for the patient who asks why you want to know. Having the words ready keeps the conversation consistent and takes the pressure off whoever is doing the asking.

Ask everyone, not only the patients you expect will need something. In practice that means the access-needs question belongs in the standard scheduling script for every patient, not in a side workflow triggered by a diagnosis code or by how someone looks or sounds on the phone. Asking everyone also takes the burden of disclosing off the patient, and it avoids the guesswork that misses non-apparent disabilities entirely.

Make **intake forms** available in multiple formats (large print, simple language, electronic versions). Train staff on how to help patients complete forms, if needed, while respecting the patient's privacy. You

can use the Patient Intake Form Technical Guidelines to guide this process.

Make a simple accommodation question form. This could be a half-page form on paper, or in your patient portal using the seven questions in Section 2.3, Build Disability Data Into Your Electronic Health Record System.

Whether you record the answers in a paper chart or in the EHR, make sure they are visible to both office and clinical staff so that the patient does not have to ask again next time.

> For training slides, table tents, and clinic signage, see DEC's **Appendix 2.12: Documentation Training Materials**.

2.6 Update Your Computer Systems

> **Resources: 2.1 EHRs, 2.3 Accommodations**

Make sure disability and access information can be seen in your scheduling views and daily appointment reports, not only in the chart. Staff plan the day from those reports, and an accommodation that only becomes visible once the patient is roomed is too late to arrange.

Give the EHR work a realistic runway. In a large health system a build request can sit in a queue behind other priorities for considerably longer than this phase allows, depending on existing workflows and what leadership has already committed to.

Your electronic health record (EHR) needs to track what accommodations each patient needs. Work with your IT support to add fields for disability status and accommodation notes. Make sure this information appears prominently so staff see it when scheduling appointments and during visits. This process often takes longer than expected, so **start early and be patient with technical challenges.**

> DEC's **Appendix 2.4: Documentation Electronic Health Record (EHR) Features** lists the fields and flags to ask your vendor for, including

> disability status questions, accommodation flags, what worked and what did not at previous visits, and how the data was collected.

2.7 Select and Purchase Accessible Equipment

> **Resources:** 1.4 Budget, 2.3 Accommodations, 1.6 Audit Tools

Your facility audit in Section 2.2 and your policy review have now told you what is actually missing. Price those items against the total you set in Section 1.4, Create the Budget for Phase Two. You do not need to buy everything at once, but you should make prioritization decisions together with your advisory council.

Equipment to consider:

- Height-adjustable exam tables.
- Accessible weight scales.
- Communication devices.
- Wheelchair-accessible blood pressure cuffs.
- Adjustable lighting.
- Magnifying devices.
- Pocket talkers.

Environmental modifications:

- Clear pathways through your office.
- Accessible parking designation, including the access aisle and signage, which are often missing at existing locations.
- Improved lighting.
- Noise reduction in waiting areas.
- Private spaces for sensitive conversations.

When purchasing medical equipment, use the U.S. Access Board's Medical Diagnostic Equipment (MDE) standards as your specification guide. The Access Board does not enforce these standards itself, but two federal agencies have adopted them: in 2024, HHS adopted them for recipients of federal financial assistance under Section 504 of the Rehabilitation Act, and the Department of Justice adopted them for state and local government entities under the ADA Title II rule.

Both rules set the same first milestone: a practice that uses examination tables must have at least one that meets the MDE Standards, and a practice that uses weight scales must have at least one that meets the Standards. Equipment already in place counts if it meets the Standards. The deadlines for this are:

- July 8, 2026 for practices receiving federal financial assistance from HHS (45 C.F.R. § 84.92(c))
- August 9, 2026 for practices operated by a state, county, or city (28 C.F.R. § 35.211(c)).

Building these standards into your purchasing decisions now helps ensure new equipment meets accessibility requirements from the start.

2.8 Establish Referral Partnerships

> **Resource: Appendix 2: Screening Referral Site Accessibility Starter Questions**

Build relationships with the specialists who perform common screenings, as well as any other healthcare professionals in your area who are committed to accessibility.

When referring patients with disabilities, you want to know that they will receive the same quality care. **Create a list of accessible providers and facilities in your area.** Your practice's accessibility leader, or a medical assistant or community health worker might take charge of this.

1. Contact imaging centers in your area and identify which have accessible equipment and provide accommodations.
2. Develop the list and store it somewhere all staff can easily find it.
3. Review and update the list at least once a year.

Accessibility gaps often reappear once a patient leaves your practice, so treat the referral as part of the care you are responsible for.

> **Appendix 2: Screening Referral Site Accessibility Starter Questions**, gives you the questions to ask a site before you add it to your referral list.

Document for each referral partner:

- Contact information.
- Their accessibility features.
- Types of accommodations they provide.
- How to communicate patient needs when making referrals.
- Notes on their experience working with people with different disability types (mobility, intellectual and developmental, hearing, vision).

Send access needs with every referral. When you refer a patient for a screening, send their documented access needs to the imaging center or specialist along with the referral order, and tell the patient you have done so.

2.9 Patient Engagement Strategies

> **Resources: 2.9 Patient Engagement**

Develop a comprehensive patient engagement strategy focusing on promoting yearly check-ups and reaching patients with disabilities who avoid healthcare due to previous negative experiences. This outreach

work is crucial because many patients with disabilities have learned to expect barriers and may not know that your practice is working to become more accessible. Say plainly how the visit will work and what you can accommodate. Clear, transparent communication builds trust, and it matters most for patients who have had a bad experience in healthcare before.

If possible, start by using your EHR to identify patients with disabilities who are overdue for preventive screenings. Reach out to those patients either through outreach phone calls or text message campaigns. Social media campaigns and sharing print materials in office with patients could be a productive alternative if there are no EHR data available to identify patients with disabilities or who need preventive screenings.

Key outreach strategies

- Phone calls or text messages from trained staff who can discuss the specific accommodations you offer.
- Letters and emails in accessible formats explaining your new accessibility features.
- Partnerships with local disability organizations to reach new patients.
- Clear messaging about your commitment to accessibility in all patient communications.
- Website information about specific accommodations and how to request them.

When speaking with patients, be specific about the accommodations you can provide rather than making general statements about being 'welcoming.' Patients need concrete information about what has changed in your practice, and what supports are available.

Include information on your website about your office's accessibility features and how to request accommodations.

When creating new patient materials, ensure they are accessible and available in multiple formats. This includes large print letters, plain language versions, and digital formats that work with screen readers.

Check your written materials before assuming they work

You should be designing print, audiovisual, and social media content that is easy to understand and act on. You will not know if it works until you evaluate the materials you distribute using established assessment tools and consumer feedback, rather than assuming they land (Brach et al., 2012). AHRQ's Patient Education Materials Assessment Tool (PEMAT) can support this process (Shoemaker et al., 2014). It is a free scored checklist that rates a handout, a webpage, or a video on two things:

- **Understandability:** Is the purpose obvious, is it in everyday language, is it broken into short sections with informative headers, do the visuals help rather than decorate?
- **Actionability:** Does the resource name at least one thing the reader can actually do, and break that into explicit steps?

Separate versions cover printable and audiovisual material. Two staff members can score the same handout in about twenty minutes and compare where they disagreed, which is usually where the material is weakest.

PEMAT measures understandability and actionability. It does not measure whether the file itself can be operated by assistive technology: screen reader access, keyboard navigation, color contrast, text resizing, captions, and audio description. Those belong to a different standard. The Web Content Accessibility Guidelines (WCAG) 2.1, published by the World Wide Web Consortium, are the international standard for that side of accessibility.

WCAG sorts its requirements into three conformance levels — A, AA, and AAA — under four principles: content must be perceivable, operable, understandable, and robust. Level AA is the level U.S. law points to, and the level to aim for.

A handout or a video can score well on PEMAT and still be unusable by a portion of your patients if the PDF is not properly tagged for a screen reader, if the text is too small, or if there are images with no alternative text. A video might be completely inaccessible to some if it has no captions or audio description.

Use PEMAT to check whether the content lands, and check the file itself against WCAG 2.1 Level AA. Note that for practices receiving federal financial assistance from HHS, WCAG compliance is becoming a requirement rather than a recommendation, phased in from May 11, 2027 for practices with fifteen or more employees and May 10, 2028 for smaller ones (45 C.F.R. § 84.84).

Make sure to export the PDF properly. Use the program's own Save as PDF or Export with "Document structure tags for accessibility" turned on. “Printing to PDF” strips those tags and produces a file a screen reader cannot navigate, no matter how good the original was.

> Read **Create Accessible Documents** from the U.S. General Services Administration for step-by-step guides and short video walkthroughs for building accessible Word documents, exporting them as tagged PDFs, and testing the result.

After checking the resource’s accessibility, ask your patient advisors to read the resource. It is important to include a Blind or low vision screen reader user in this review group, as well. They will find things no automated check will catch.

Local disability organizations can help spread the word about your accessible services

These organizations may maintain lists of accessible healthcare providers and can refer patients who are looking for disability-informed care. Consider hosting health education events in partnership with these organizations or attending community events where you can meet potential patients.

Consider a community screening event, or make an existing one accessible

Many health systems and health centers already run community health fairs and screening days. If yours does, make it accessible. Partner with local disability organizations to plan the event and spread the word, and offer stipends to community advisors who help.

Programs that did this, like the ScreenABLE Saturday wellness fair, showed that screening events can be designed with and for the disability community (Magasi, Reis, et al., 2019).

These events are usually easier to fund than practices expect. Nonprofit hospitals can count them as community benefit on their IRS reporting, and they often fit needs already identified in the hospital's community health needs assessment (James, 2016). Health centers can run them under their HRSA-supported outreach and enabling services (Bureau of Primary Health Care, 2018). State breast and cervical cancer early detection programs, funded by CDC, may cover screenings for eligible patients, and health plans or equipment partners may co-sponsor events that improve screening rates (*About the National Breast and Cervical Cancer Early Detection Program*, 2026).

Use the GRAIDs framework to make the event accessible

Guidelines, Recommendations, Adaptations, Including Disability, or GRAIDs, is a free tool from NCHPAD for adapting any evidence-based health program so that people with disabilities can take part. NCHPAD's current materials on GRAIDs present these as five inclusion domains: built environment, service, instruction, equipment & technology, and policy. Walk your event through each one and design it together with people with disabilities and your local CIL from the start. In addition, you can contact NCHPAD for support in applying the GRAIDs domains for your specific event.

The GRAIDs domains and examples of what to check

- **Built Environment:** Accessible parking, entrances, routes, and restrooms at the venue or mobile unit.

- **Services:** transportation, on-site interpreters, and navigators who help people reach the event and follow up afterward.
- **Instruction:** staff trained in disability-competent care, plus plain-language, large-print, and Easy Read materials.
- **Equipment and Technology:** height-adjustable and seated-capable screening equipment, accessible exam tables, and accessible scales.
- **Policy:** longer appointment slots and accommodation-request steps booked and shared ahead of time.

Plan the diagnostic follow-up pathway

A share of participants will require diagnostic follow-up at a facility your program does not control, and if that facility cannot accommodate them, the event has generated a documented abnormal finding with no path to resolution.

In planning, identify the receiving facilities and confirm their capacity to provide the accommodations participants will need. Appendix 2: Screening Referral Site Accessibility Starter Questions gives you the questions to ask. Build accommodation questions into registration so you know what will be required before anyone arrives. At the event, record access needs in the referral order itself rather than in a note that will not travel with it. Afterward, assign ownership of follow-up completion and track it, since loss to follow-up concentrates in precisely the population the event is designed to reach.

Address barriers specific to each screening

Below are some considerations for screening-specific outreach events.

Breast cancer screening

Community screening often happens via a mobile mammography unit. Ask the vendor in writing whether the unit can image a seated patient and publish the answer in your outreach. Confirm whether a support person may stay in the room; they would need a lead apron and must stay out of the beam, and some vendors will not allow it at all.

Cervical cancer screening

Decide whether you are offering self-collection only or also clinician-collected exams (and if these are collected with a speculum or without). Detail the options in your event promotion. Self-collection is not automatically accessible: it still assumes a private space, undressing, positioning, and two hands. Plan for accommodations according to what types of tests you can offer.

Osteoporosis screening

Heel QUS or peripheral DXA devices need a bare foot, so train staff on how to help remove and replace shoes and ankle-foot orthoses (AFOs).

Colorectal cancer screening

A fecal immunochemical test, or **FIT**, needs only a small sample, but it has to be caught dry, before it reaches the water. This assumes the person can position a flush sheet in the bowl and reach behind themselves.

A **stool DNA kit** needs the entire stool, collected in a large container on a bracket sized for a standard toilet bowl.

Neither instruction set describes anyone using a commode chair, a bedpan, or a scheduled bowel routine.

Once you know which kit you are distributing, write an alternate-method sheet for that kit, and address it to whoever assists with bowel care (for example, a family member, a personal care attendant, or group home staff) as well as to the person themselves. Set a short return deadline and explain why (FIT loses sensitivity as samples sit in heat).

Front desk signage

You could place a sign at the clinic's front desk or inside examination rooms, such as Screening for All's **Ask About Accommodations Sign**, to help start the conversation about access needs with patients.

You are expected to provide the accommodations the law requires, and by asking this question, you may need to meet other access needs that you had not anticipated.

Before posting the sign in your office, ensure that staff are fully prepared to have productive and empathetic conversations about accommodations with patients. Posting the sign without adequate preparation may lead to unfulfilled expectations and potential risk to patient safety and trust. By posting the sign, your practice is making a public commitment to accessible, equitable care for all patients. Review your current practices and complete all necessary preparations before placing it in a visible location.

Ensure your team has successfully completed the following before printing and posting Screening for All's Ask About Accommodations sign:

- **Staff training:** All staff have completed trainings relevant to them from 1.1 Fundamentals and 1.7 Patient Care in the Implementation Resource List.
- **Policies and procedures:** You have developed and implemented clear policies and procedures for identifying, documenting, and fulfilling requests for accessibility and accommodations.
- **Resources and equipment:** Appropriate resources, auxiliary aids, and accessible medical equipment are available and functional.
- **Points of contact:** There are designated staff members responsible for supporting patients with disabilities and troubleshooting accessibility challenges.

What Success Looks Like After Phase 2

These are examples; adapt them or add others to fit the needs of your own practice.

- By month 8, you have produced a dated, costed equipment plan to cover at minimum one examination table and one weight scale that meet the Standards for Accessible MDE.

- By month 9, every patient-facing role can name who to contact and what the next step is (you can check this in a few minutes at a staff meeting).
- By month 10,
    - Written procedures exist for the five accommodations you are asked for most often, each short enough to follow on the day.
    - Your intake forms and top three patient handouts exist in large print and a screen-reader-accessible format, available on request within one business day.
    - At least three referral partners have answered your access questions, and their answers are recorded where schedulers can see them.

Potential Challenges and Solutions in Phase 2

- **EHR delays:** Technology changes take time. Start early and have backup plans for tracking accommodations manually, if needed.
- **Too many procedures:** Start with the accommodations you are legally required to provide, then add the ones your own patients request most often.
- **Skills fading over time:** Schedule annual refresher training and a short competency check, so disability-informed practice is maintained rather than assumed.
- **Staff confusion:** Practice procedures through role playing and provide quick reference guides.
- **Equipment costs:** Look for grants, phased purchasing plans, or partnerships with other practices.

Phase 3: Implementation & Testing

This phase is about implementing your new processes with real patients. During this phase, the goal is to deploy, consistently evaluate and refine your approach based on actual patient experiences.

3.1 Start with a Pilot Program

A pilot is one Plan-Do-Study-Act cycle, scaled to your practice. Decide in advance what you expect to happen and how you will know, so that when the pilot ends you are studying a result rather than recalling an impression.

If you want to monitor an uptake in preventive screenings for patients with disabilities, you can choose a specific group of patients or screening type to test the new processes. This might be existing patients with disabilities who are willing to provide feedback or focusing on one type of screening like mammograms or colonoscopies. This could also look like hosting a free and accessible screening event in your community (see Section 2.8, Patient Engagement Strategies).

This approach lets you work out any issues before expanding to all patients. Pay attention to staff and patient feedback so you can make immediate corrections. Document how you handle issues that arise, so the problem-solving approaches that work can be shared and processed together with the entire team.

3.2 Begin or Continue Patient Outreach and Engagement

Once you can identify with data which of your patients have a documented disability (ideally after finishing the documentation work in Section 2.3), you could use your EHR to identify patients with disabilities who are overdue for preventive screenings, and start inviting them to schedule an appointment to discuss further.

Outreach strategies:

- Phone calls from trained staff who can discuss accommodations.
- Letters in accessible formats explaining your new services.
- Partnerships with local disability organizations to spread the word.
- Peer outreach: If you have trained or hired peer health workers with disabilities, have them make these calls. Shared experience builds trust faster than a cold call from the front desk.
- Include information on your website about accessibility features.
- Use a short script so every caller covers the same ground: Why you are calling, that accommodations can be arranged, what to ask for, and who to contact with questions.
- Through text messaging and EHR patient-portal messages, share educational videos and articles about the importance of yearly check-ups and preventive screenings.
- Send a short patient satisfaction survey after visits and ask specifically whether the accommodations arranged actually worked.

3.3 Clinical Implementation

Start using your new procedures during actual patient visits. This includes modified screening approaches, accessible communication, and accommodation planning. Consistent practice will enable clinical staff to become more comfortable with new ways of doing things. Focus on:

- Using accommodation procedures consistently.
- Asking patients about their experiences and preferences.
- Documenting what works well for future visits.
- Adjusting your approaches based on patient feedback.

- Revisit quick-reference guides and resources on screening adaptations as needed.

Plan for the first weeks to be a bit uneven. This initial stage might be bumpy as the plan meets reality and staff are still learning, but do not give up here. You are stress-testing your system and this is the only way to identify opportunities for improvement.

Before the patient arrives

The work of this phase happens mostly before anyone walks in. Review tomorrow's schedule against your access-needs field and confirm that anything requiring lead time (i.e., an interpreter, a longer slot, a lift-equipped room, a ground-floor exam space) is already booked rather than merely noted. An accommodation that is recorded but not arranged reads to the patient exactly like one that was never requested.

Make the information visible to whoever opens the chart. When Michigan Medicine added a dedicated disability and accommodations tab to its record system, patients entered their access needs once and every member of the care team saw the same information at every subsequent visit (Halkides et al., 2022). Whatever your system, the test is the same: can the person rooming the patient see what they need without asking the patient to explain it again?

During the visit

Speak to the patient, not to whoever came with them. Where a companion, aide, or interpreter is present, they are there to support the conversation, not to be the conversation.

- Say what you are going to do before you do it, and wait for agreement. This is the standing expectation for every patient, not a special step for disabled ones, and it puts two of SAMHSA’s trauma-informed principles into practice: trustworthiness and transparency, and empowerment, voice, and choice (Substance Abuse and Mental Health Services Administration, 2023).

- Check understanding rather than assuming it. Ask the patient to explain back, in their own words, what the screening involves and what happens next — the teach-back method set out in AHRQ's Health Literacy Universal Precautions Toolkit (Agency for Healthcare Research and Quality, 2024). Teach-back checks your explanation, not the patient's intelligence, and it is worth saying so out loud.
- Build in the time the visit actually needs. ACOG identifies inadequate appointment length as a barrier to care for patients with disabilities, and treats refusing to examine a patient because the exam will take longer as discrimination under the ADA (American College of Obstetricians and Gynecologists, 2025). Ask about needs ahead of the visit so the schedule reflects them.
- Use qualified interpreters, and match the modality to the patient. Auxiliary aids and services must be provided where needed for effective communication (28 C.F.R. § 36.303), and their cost cannot be passed to the patient as a surcharge (28 C.F.R. § 36.301(c)). Some visits call for a Certified Deaf Interpreter working alongside a hearing interpreter, and DeafBlind patients may need tactile interpreting (Registry of Interpreters for the Deaf, 2025).

When an accommodation fails mid-visit

Some will fail. The interpreter does not arrive, the video connection drops, the accessible room is occupied, the lift is out of service. Your staff already covered the protocol in training; Phase 3 is where it gets used. Tell the patient what happened and what you are doing about it, call your backup before you touch the schedule, and ask the patient what would work right now. Rescheduling is the last resort, not the first move. Then log it, so the pattern gets fixed rather than only the visit.

After the visit

Write down what actually worked, in the record rather than in someone’s memory. The point of documenting is that the second visit

starts where the first one finished, and that a patient who has already explained their access needs does not have to explain them again to the next person who opens the chart. Note the specifics: which transfer method, how much extra time was really needed, which position worked for the exam, what the patient asked you not to do.

Screening-specific adaptations

The clinical staff who carry out screenings will hit questions no general procedure answers: how to position a patient who cannot stand for a mammogram, how to adapt a pelvic exam for someone with spasticity, how to talk a patient with an intellectual disability through bowel preparation. Screening for All's Quick Reference Guides and Practice Considerations are written for exactly these moments and are short enough to consult between patients. Keep them somewhere clinical staff already work, so they are at hand in the moment rather than remembered later.

3.4 Monitor and Adjust in Real Time

Meet regularly with your team to discuss how things are going. What accommodations are patients requesting most? Which procedures are working smoothly? What is causing confusion or delays? Adjust quickly rather than waiting for formal review periods.

Track the measures you defined in Section 1.8, Establish the Foundation for Continuous Quality Improvement. At this stage you are watching them for early warning signs rather than for trends, so review them as they come in rather than waiting for a reporting cycle.

Keep a record of every accommodation request, and what happened. You cannot improve what you do not track. At minimum, keep a simple log (a spreadsheet works) with one row per request: the date, the patient or record ID, the accommodation requested, whether it was provided, what got in the way if it was not, and any follow-up needed. Review the log at your monthly accessibility meetings to spot patterns. For example, interpreter requests that keep falling through, or repeated requests for equipment you do not have yet. If you have an

EHR, build tracking into it instead: certified EHRs must now support standardized disability status fields, and systems like Epic offer flags and structured forms that surface a patient's access needs at scheduling and check-in (Halkides et al., 2022; Morris et al., 2021). Ask your EHR vendor what fields already exist before building anything custom.

3.5 Keep Building Community Partnerships

Your partnerships were built in Section 1.5, Form Partnerships, and this phase changes what you bring to them. Until now you have been asking disability organizations to react to plans. Now you have pilot data, an accommodation log, and patients who have been through the new process, so the conversation shifts from consultation to evidence. Take the results back to the partners who helped shape them, including what did not work, and let them tell you what to fix next.

What Success Looks Like After Phase 3

Here are some examples of potential goals:

- By month 14,
    - The no-show rate for patients with a documented disability is within five percentage points of your overall no-show rate.
    - A repeat confidence survey shows improvement against baseline, with no role scoring lower than it did in Month 1.
    - Fewer than 10% of logged accommodation requests record a failure or a workaround.
    - Your post-visit survey asks whether the accommodation worked, and at least 80% of respondents who requested one say it did.
    - Screening rates for patients with a documented disability have risen measurably against your Phase 1 baseline, and

the gap against patients without a documented disability has narrowed.

Potential Challenges and Solutions in Phase 3

- **Procedure failures:** Expect some accommodations not to work as planned. Document what happened and adjust your procedures.
- **Staff overwhelm:** Some staff may feel stressed about new responsibilities. Provide additional support and training when needed and allow time for rest and debriefing as a team on any complex issues that arise and lessons learned.
- **Patient hesitancy:** Some patients may be skeptical about accessibility claims. Be patient and demonstrate your commitment through consistent actions.

Phase 4: Monitoring and Improvement

The final phase focuses on **making your accessibility efforts permanent** and continuously improving based on data and feedback. This is where you establish long-term systems for maintaining and enhancing your work.

4.1 Consolidate Your Data and Look for Trends

Collect this data because it feeds the "study" step, not because it fills a report. If a measure never changes what you do next, stop collecting it.

Create systems to **track your progress** over time. These data help you understand what is working, identify areas for improvement, and demonstrate the impact of your efforts to leadership and potential funders.

Use the information and baseline metrics you gathered in Phases 1 and 2, such as your facility assessment and initial screening rates, as your baseline, so improvements can be clearly demonstrated.

Keep running the monthly and quarterly review cycle you set up in Section 1.8, Establish the Foundation for Continuous Quality Improvement. What changes in Phase 4 is what you bring to it: by now you have real data to review, not just process questions.

You can use DEC's monitoring worksheets to structure these reviews:

> DEC's **Appendix 1.9: Accessibility Program Monitoring Progress and Adaptations** for the program as a whole, and
>
> **Appendix 2.13**, **Appendix 3.6**, and **Appendix 4.13** are the matching worksheets for documentation, accommodations, and effective communication.

4.2 Plan for Sustainability

Develop long-term plans for maintaining your accessibility efforts. This includes ongoing funding, staff training, equipment maintenance, and leadership support. Consider how to maintain momentum when staff turnover or leadership changes.

Sustainability strategies

- **Watch for payer requirements.** Some Medicaid managed care plans have begun asking practices to document disability status and accommodations provided. Meeting these expectations early can strengthen the case for sustaining this work.
- **Name a specific person as owner** of each accessibility metric and process. Shared ownership tends to become no ownership.
- **Build accessibility into how you hire, onboard, and review.** Name it in job descriptions and performance reviews, cover it in new-employee orientation, and raise it during recruitment so candidates know it is part of the job.
- **Include someone with a disability in that orientation**, such as a patient advisor, a staff member who chooses to speak, or a

representative from a local Center for Independent Living talking about their own healthcare experiences. Pay them for their time.

- **Keep staff current** with best practices and new requirements.
- **Create annual budgets** for accessibility improvements.
- **Document your procedures** thoroughly so they survive staff changes.
- Build accessibility expectations into contracts with vendors and referral partners.

4.3 Expand Your Efforts

Once your core accessibility processes are working well, **consider expanding** into new areas. This might include additional screening types, outreach to new patient populations, or sharing your expertise with other practices.

Expansion opportunities include:

- Additional preventive screenings not covered in your initial plan.
- Mental health and behavioral health services.
- Specialty care coordination.
- Training and consultation for other healthcare professionals.
- Policy advocacy at local or state levels.

4.4 Measure Long-term Impact

Step back and evaluate the whole effort rather than the individual pieces. Use this to celebrate what moved, name what did not, and set the next year of work.

What Success Looks Like in Phase 4

- Your screening rates for patients with disabilities have improved measurably against the baseline you set in Phase 1.
- Patients with disabilities actively recommend your practice to others.
- Accessibility is part of how the practice runs day to day, and you keep improving it. You review your measures on a set schedule, act on what they show, and treat this as ongoing work rather than a finished project.
- Staff naturally consider access needs for all patients.
- You have strong partnerships with disability organizations.
- Other practices are asking you for advice on accessibility.

Potential Challenges and Solutions in Phase 4

- **Maintaining momentum:** Accessibility work can feel routine after initial enthusiasm fades. Regular celebration of successes and patient stories can help maintain motivation.
- **Staff turnover:** New employees need training in accessibility procedures. Make this part of standard orientation. Say in advance what happens when the training does not get done: who follows up, by when, and what the corrective step is. Self-paced eLearning is a practical way to keep this available to new staff without waiting for the next scheduled session.
- **Budget pressures:** Demonstrate the value of accessibility investments through data on patient satisfaction and screening rates.

Conclusion

Remember, you do not need to do everything at once. Small, consistent improvements can make a big difference for patients with disabilities. The most important thing is to start and keep moving forward.

Adapt the plan, including the goals, timeline, and specific activities, to align with your practice's resources and needs. We want to hear about what is working and what challenges you face as you work through it with your team. Please let us know how it works out (or does not work out) for your organization: send any comments or concerns to us at ScreeningForAll@mcd.org.

For ongoing support, consider attending conferences that relate to topics on disability in healthcare. Maintain relationships with disability advocacy organizations in your community. Join or build networks of healthcare professionals focused on accessibility.

Above all, keep engaging disabled patients to continuously monitor what is working and what is not. Conferences, professional networks, and academic literature will tell you what is possible, but only your disabled patients can tell you whether any of it is working at your practice. Prioritize their voices as you carry out this work.

References

About the National Breast and Cervical Cancer Early Detection Program. (2026, July 8). NBCCEDP; CDC. https://www.cdc.gov/breast-cervical-cancer-screening/about/index.html

Administration for Community Living. (n.d.). *Peer Providers – How Your Experience Makes You Right for the Job*. Retrieved July 29, 2026, from https://acl.gov/news-and-events/announcements/peer-providers-how-your-experience-makes-you-right-job

Agency for Healthcare Research. (n.d.). *Strategy 1: Working With Patient and Families as Advisors (Implementation Handbook)*.

Agency for Healthcare Research and Quality. (2024). *AHRQ Health Literacy Universal Precautions Toolkit*. https://www.ahrq.gov/health-literacy/improve/precautions/index.html

American College of Obstetricians and Gynecologists. (2025). *Access to Obstetric and Gynecologic Care for Patients With Disabilities | ACOG*. https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2025/04/access-to-obstetric-and-gynecologic-care-for-patients-with-disabilities

American College of Radiology. (2021, September 28). *Improving Care for Patients Living with Disabilities*. https://web.archive.org/web/20241208212914/https://www.acr.org/Practice-Management-Quality-Informatics/Imaging-3/Case-Studies/Quality-and-Safety/Improving-Care-for-Patients-Living-with-Disabilities

Blackwell, A. G. (2017). The Curb-Cut Effect. *Stanford Innovation Review*, *15*(1), 28–33. https://ssir.org/articles/entry/the_curb_cut_effect

Brach, C., Keller, D., Hernandez, L., Baur, C., Parker, R., Dreyer, B., Schyve, P., Lemerise, A. J., & Schillinger, D. (2012). Ten Attributes of Health Literate Health Care Organizations. *NAM Perspectives*, *02*(6). https://doi.org/10.31478/201206a

Bureau of Primary Health Care. (2018, August). *Health Center Program Compliance Manual*. https://bphc.hrsa.gov/compliance/compliance-manual

Centers for Disease Control and Prevention. (2025, April 14). *Disability Impacts All of Us Infographic*. https://www.cdc.gov/disability-and-health/articles-documents/disability-impacts-all-of-us-infographic.html

Centers for Medicare & Medicaid Services. (2022, February 10). *Lung Cancer Screening with Low Dose Computed Tomography (LDCT)*. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=364

Centers for Medicare & Medicaid Services. (2026). *MLN006764, Evaluation and Management Services*.

FDA. (2024, May 17). *FDA Roundup: May 17, 2024*. https://www.fda.gov/news-events/press-announcements/fda-roundup-may-17-2024

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. *University of South Florida, Louis de La Parte Florida Mental Health Institute, The National Implementation Research Network*, *231*. https://ctndisseminationlibrary.org/PDF/nirnmonograph.pdf

Halkides, H., James, T. G., McKee, M. M., Meade, M. A., Moran, C., & Park, S. (2022). Spotlighting Disability in a Major Electronic Health Record: Michigan Medicine's Disability and Accommodations Tab. *JMIR Formative Research*, *6*(12), e38003. https://doi.org/10.2196/38003

Havercamp, S. M., Barnhart, W. R., Robinson, A. C., & Whalen Smith, C. N. (2021). What should we teach about disability? National consensus on disability competencies for health care education. *Disability and Health Journal*, *14*(2), 100989. https://doi.org/10.1016/J.DHJO.2020.100989

Iezzoni, L. I., Chang, Y., Matulewicz, H., Heaphy, D., Warsett, K. S., & Donelan, K. (2018). Health plan enrollees with disability informing primary care practices and providers about their quality of care: A randomized trial. *Disability and Health Journal*, *11*(4), 537–544. https://doi.org/10.1016/J.DHJO.2018.05.006

Iezzoni, L. I., Rao, S. R., Ressalam, J., & Bolcic-Jankovic, D. (2023). Accommodating hearing loss in outpatient physician offices in the U.S. *Disability and Health Journal*, *16*(1), 101397. https://doi.org/10.1016/J.DHJO.2022.101397

Institute for Patient- and Family-Centered Care. (2022). *Creating Patient and Family Advisory Councils*. https://www.ipfcc.org/resources/Advisory_Councils.pdf

James, J. (2016). Nonprofit Hospitals' Community Benefit Requirements. *Health Affairs*. https://doi.org/10.1377/HPB20160225.954803

Kotter, J. P. (1995). *Leading Change: Why Transformation Efforts Fail Leaders who successfully transform businesses do eight things right (and they do them in the right order)*. https://fcm.ucsf.edu/sites/g/files/tkssra17611/files/Kotter_WhyTransformationEffortsFail.pdf

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd ed.). Jossey-Bass.

Magasi, S., Papadimitriou, C., Panko Reis, J., The, K., Thomas, J., VanPuymbrouck, L., & Wilson, T. (2019). Our Peers — Empowerment and Navigational Support (OP-ENS): Development of a Peer Health Navigator Intervention to Support Medicaid Beneficiaries With Physical Disabilities. *Rehabilitation Process and Outcome*, *8*. https://doi.org/10.1177/1179572719844759

Magasi, S., Reis, J. P., Wilson, T., Rosen, A., Ferlin, A., & VanPuymbrouck, L. (2019). ScreenABLE: Breast Cancer Screening among Women with Disabilities from Community Identified Challenges to Community-Based Programs. *Progress in Community Health Partnerships: Research, Education, and Action*, *13*(5), 61–69. https://doi.org/10.1353/CPR.2019.0039

Meyers, D., Miller, T., De La Mare, J., Gerteis, J. S., Makulowich, G., Weber, G. H., Zhan, C., & Genevro, J. (2024). What AHRQ Learned While Working to Transform Primary Care. *The Annals of Family Medicine*, *22*(2), 161–166. https://doi.org/10.1370/AFM.3090

Morris, M. A., Hamer, M. K., Eberle, K., Jensen, K. M., & Wong, A. A. (2021). Implementation of Collection of Patients' Disability Status by Centralized Scheduling. *Joint Commission Journal on Quality and Patient Safety*, *47*(10), 627–636. https://doi.org/10.1016/j.jcjq.2021.05.007

Morris, M. A., Schliep, M., Liesinger, J., & Cameron, K. A. (2017). Collection of Patients' Disability Status by Healthcare Organizations: Patients' Perceptions and Attitudes. *Journal for Healthcare Quality*, *39*(4), 219–229. https://doi.org/10.1097/JHQ.0000000000000036

National Council on Independent Living. (n.d.). *Provider Accessibility Initiative: Barrier Removal Fund*. Retrieved July 29, 2026, from https://ncil.org/initiatives/provider-accessibility-initiative/

Plan-Do-Study-Act Worksheet, Directions, and Examples. (2024, March). Agency for Healthcare Research and Quality. https://www.ahrq.gov/health-literacy/improve/precautions/tool2b.html

Registry of Interpreters for the Deaf, Inc. (2025). *Professional Practice Paper: Deaf Interpreter*. https://rid.org/certification/available-certifications/

Rimmer, J. H., Vanderbom, K. A., Bandini, L. G., Drum, C. E., Luken, K., Suarez-Balcazar, Y., & Graham, I. D. (2014). GRAIDs: a framework for closing the gap in the availability of health promotion programs and interventions for people with disabilities. *Implementation Science 2014 9:1*, *9*(1), 100-. https://doi.org/10.1186/S13012-014-0100-5

Shoemaker, S. J., Wolf, M. S., & Brach, C. (2014). Development of the Patient Education Materials Assessment Tool (PEMAT): A new measure of understandability and actionability for print and audiovisual patient information. *Patient Education and Counseling*, *96*(3), 395–403. https://doi.org/10.1016/J.PEC.2014.05.027

Substance Abuse and Mental Health Services Administration, H. and H. S. D. (2023). Practical Guide for Implementing a Trauma-Informed Approach. *Govinfo.Gov*.https://www.govinfo.gov/app/details/GOVPUB-HE20_400-PURL-gpo222738

Swaine, J. G., Parish, S. L., Luken, K., Son, E., & Dickens, P. (2014). Test of an intervention to improve knowledge of women with intellectual

disabilities about cervical and breast cancer screening. *Journal of Intellectual Disability Research*, *58*(7), 651–663. https://doi.org/10.1111/JIR.12062;ISSUE:ISSUE:DOI

Tervalon, M., & Murray-Garcia, J. (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

The Community Preventive Service Task Force (CPSTF). (2019). *Cancer Screening: Interventions Engaging Community Health Workers — Breast Cancer*. https://doi.org/10.15620/CDC/164173

Traci, M. A., Horan, H., Russette, H., Goe, R., Ware, D., Powell, K., Hughes, R. B., & Hicks, E. (2020). Improving mammography access for women with disabilities: Outcomes of the CDC's right to know campaign. *Frontiers in Women's Health*, *5*(3), 10.15761/fwh.1000188. https://doi.org/10.15761/FWH.1000188

U.S. Access Board. (n.d.). *Chapter 1: Using the ADA Standards*. Retrieved July 29, 2026, from https://www.access-board.gov/ada/guides/chapter-1-using-the-ada-standards/

U.S. Attorney's Office and Polyclinic resolve allegations it violated the Americans with Disabilities Act. (2025, December 9). U.S. Attorney's Office, Western District of Washington. https://www.justice.gov/usao-wdwa/pr/us-attorneys-office-and-polyclinic-resolve-allegations-it-violated-americans

Appendix 1: Resources and Support

You do not have to navigate accessibility requirements alone. Various organizations offer support, guidance, and resources for ensuring your patient intake forms and services meet accessibility standards.

Free lookup tools to find your local organizations

- Independent Living Research Utilization (ILRU) CIL Directory: Find your nearest Center for Independent Living. Call them for disability etiquette training, an advisory walk-through of your building, peer navigators, and patient advisors.
- NDRN Member Agencies: Find your state's Protection & Advocacy agency. Call them for legal and rights questions, and when a patient believes their rights were violated. They are not a compliance consultant for your practice.
- State DD Councils (NACDD): Find your state's Council on Developmental Disabilities. Call them for systems-change partnerships, small grants for healthcare access projects, and advisors with developmental disabilities and their family members.
- UCEDD Directory (AUCD): Find your state's University Center for Excellence in Developmental Disabilities. Call them for clinical training, consultation, and help adapting materials for patients with intellectual and developmental disabilities.
- Eldercare Locator (or call 800-677-1116): Find your Area Agency on Aging. Call them for transportation to appointments and in-home support for older patients.
- 211: Dial 211, or search online, for local help connecting patients to food, housing, transportation, and healthcare services. Use it when the barrier to a screening is not clinical.

- AT3 Center State AT Program Directory: Find your state's Assistive Technology Act Program. Call them for equipment recommendations, device demonstrations, short-term equipment loans, and staff training on assistive technology. These programs are federally funded and their information and assistance services are free.

Remember, many of these organizations provide free or low-cost services and are committed to helping healthcare teams effectively serve all patients.

Centers for Independent Living (CILs)

- Contact your CIL directly through the ILRU CIL Directory, or reach your Statewide Independent Living Council if you would rather start at the state level.

ADA National Network

- Provides free information, technical assistance, training, and guidance on ADA compliance, including healthcare-specific resources.
- Regional ADA Centers can provide more localized guidance.
- **Website:** adata.org. To find your Regional ADA Center, visit adata.org/find-your-region.
- **Contact:** 1-800-949-4232 (toll-free) or complete their online form at adata.org/contact.

American Association of People with Disabilities (AAPD)

- Cross-disability rights organization advocating for full civil rights.
- **Website:** aapd.com
- **Services:** Policy advocacy, community building, and disability rights promotion.

International Association of Accessibility Professionals (IAAP)

- Professional association focused on accessibility skills and strategies
- **Services:** Training, certification, and professional development in accessibility

National Disability Rights Network (NDRN)

- Membership organization for federally mandated Protection and Advocacy Systems (P&As) and Client Assistance Programs (CAPs).
- Offers accessibility review of documents within five business days if you have followed accessibility guidelines: ndrn.org/accessibility-guidelines
- **Services:** Legal advocacy, rights protection, and technical assistance.

Protection and Advocacy (P&A) Agencies

- Every state has a federally mandated P&A agency that provides consultation, advocacy, and legal representation.
- **Services:** Individual advocacy, training, and systems change advocacy.
- **Examples:** Disability Rights California, Equip for Equality (Illinois), and Disability Rights Connecticut.
- **Contact:** Find your state's P&A agency through ndrn.org/about/ndrn-member-agencies.

U.S. Access Board

- **Contact:** Call 1-202-272-0080, extension 3, or email ta@access-board.gov

- **Services:** Accessibility standards development and technical assistance for built environment and digital accessibility.

Assistive Technology Act (AT Act) Programs (AT3 Center Network)

- Every state and territory has a federally funded Assistive Technology Act Program that offers device demonstrations, short-term device loans, and vendor-neutral guidance on accessible equipment and assistive technology.
- **Website:** Find your state's program through the AT3 Center at at3center.net/state-at-programs.
- **Services:** Equipment demonstrations and loans, device reutilization and exchange programs, financing options, and training on assistive technology.

U.S. Department of Justice (DOJ)

- ADA Information Line: 800-514-0301 (voice) or 1-833-610-1264 (text telephone (TTY)).
- Website: ada.gov
- Services: Official ADA guidance, complaint filing, and legal resources.

World Institute on Disability (WID)

- Creates innovative programs and provides technical assistance for accessibility.
- Website: wid.org
- Services: Research, training, advocacy campaigns, and technical assistance.

Appendix 2: Screening Referral Site Accessibility Starter Questions

Use this guide when calling imaging centers, endoscopy centers, and other screening facilities to find out whether they can meet the access needs of patients with disabilities before adding them to your referral list. It covers mammography, cervical cancer screening, bone density (DXA) referrals, and colorectal cancer screening.

Start with the **Call opener** and **Ask every site** sections, then use the screening-specific sections that apply. Record answers separately for each site, and review your referral list at least once a year.

Call opener

Hi, I am calling to ask a few questions about accommodations for patients with disabilities. I am [introduce self] and I'm trying to reach whoever knows the room setup or exam workflow for accessibility questions. Are you the best person to answer those, or is there someone else I should speak with?

1. Do you handle scheduling for this site, clinical questions, or both?
2. Are you the right person to answer questions about wheelchair access, transfers, exam positioning, or other accommodations?
3. If not, who would be the best person? I.e. Imaging lead / nurse / manager / technologist / other?
4. Would it be better to send these questions by email or speak with someone else?

Ask every site

Scheduling and coordination

5. Do you have a way of documenting patients' disability-related access needs before appointments?

6. Is there someone who can review accommodation requests and make sure they are set up before the visit?
7. Can you schedule extra time if a patient needs it for transfers, positioning, communication, rest breaks, or pain?
8. Can you schedule the patient at a quieter time of day or another low-volume time if needed?
9. If you cannot meet a patient's access needs, can you help identify another site or refer them elsewhere?
10. Who is the best person to speak with about access questions for this site? (Ask for their name and contact details.)

Communication access

Note to caller: The most important signals are whether the site proactively asks about communication needs at scheduling, and whether there is a clear, named process for arranging interpreter services. Sites that can answer both confidently have usually thought through communication access more broadly.

11. When scheduling an appointment, do you ask patients whether they will need any communication support? For example, an interpreter, large-print materials, or extra time to communicate?
12. If a patient identifies a communication need, is that recorded and acted on before the visit, not just noted on the day?
13. Do you have access to a qualified interpreter for patients who are Deaf or use American Sign Language? This can be in-person, video remote (VRI), or another format.
14. If yes: Is there a clear process for who arranges it and how far in advance it needs to be requested?
15. Do you also have access to a qualified oral interpreter or CART (real-time captioning) for patients who are hard of hearing but do not use ASL?

16. If a patient is Deaf or hard of hearing, does staff know not to assume they can lip-read, speak, or use written notes as a substitute for an interpreter?
17. Do you have assistive listening devices available for patients who are hard of hearing? For example, a hearing loop, personal amplifier, or similar device?
18. Do you have any low-tech communication supports on hand for patients who have difficulty speaking or understanding verbal instructions? For example, a communication board, picture board, or whiteboard?
19. Are patient instructions or consent forms available in large print or another accessible format on request? Is there a designated person responsible for providing them?
20. Can you schedule extra time for patients who need more time to communicate with the clinical team? For example, patients who use a speech device, need an interpreter present, or need more time to process instructions?

Mammography

21. Can the mammography machine be lowered to wheelchair level?
22. If not, do you use a dedicated mammography chair with locking wheels and back support?
23. If yes: Is there enough space next to the machine for a wheelchair or transfer? Is there knee/toe clearance under the breast platform so the wheelchair can pull close enough for positioning?
24. If needed, can staff help with positioning or use pillows/supports?
25. Who can I speak with for detailed positioning questions? For example, a mammography technologist, lead technologist, radiology nurse, or imaging manager?
26. If the standard exam cannot be done here, can you refer the patient to a site that can meet their access needs?

Cervical cancer screening

Note to caller: The Access Board's standards for accessible medical diagnostic equipment set the low transfer position at 17 inches from the floor, with a high position at 25 inches and at least four stops in between. A table that only reaches 19 inches is a common near miss. Those two inches decide whether a lateral transfer is possible for many wheelchair users.

27. Is there enough room for a patient using a wheelchair, walker, or other mobility device to get into the exam room and position next to the table?
28. Do you have a height-adjustable exam table?
29. If yes: What is the lowest height it reaches? (Even an approximate answer is helpful; i.e., about 17 inches, or knee height.)
30. Do you have transfer equipment, such as a slide board, gait belt, or mechanical lift?
31. Are staff trained and willing to use transfer equipment?
32. Do you have alternatives to standard foot stirrups, such as adjustable or padded leg supports or knee-crutch supports?
33. If you use stirrups, do you also have leg supports that hold and secure the legs?
34. Can clinicians use alternative positions when standard lithotomy is not possible? For example, side-lying, frog-leg, or a different table configuration? Has that been done here before?
35. Do you offer or coordinate HPV self-collection for eligible patients?
36. If yes: Is it available in clinic, through a home kit, or by referral?
37. (If questions were not answered) Who is the best person to speak with about positioning, transfer support, or HPV self-collection? (Write down their name and contact details.)

Osteoporosis screening / bone density referral

38. Which bone-density screening options are available at your site?
    a. Standard central DXA of the hip and spine
    b. Forearm DXA, including 33% radius / one-third radius
    c. Other peripheral DXA, such as heel or wrist
    d. Quantitative ultrasound/QUS on the heel
    e. Other:

    _____

39. If standard hip/spine DXA cannot be done or cannot be interpreted, which alternatives can your site perform or directly refer for?
    a. Forearm DXA, including 33% radius / one-third radius
    b. Other peripheral DXA, such as heel or wrist
    c. Quantitative ultrasound/QUS on the heel
    d. Other:

    _____

40. What is the weight limit for your DXA table?
41. Are staff trained and allowed to assist with transfers onto the DXA table?
42. What transfer supports are available? For example, slide board, gait belt, portable Hoyer/mechanical lift, or ceiling lift?
43. What positioning supports or modified workflow can your site provide for patients who have difficulty lying flat, staying still, or positioning their legs/hips? Examples: pillows, foam wedges, rolled towels, staff assistance, breaks between scans, extra appointment time.
44. Who is the best person to speak with about DXA setup or positioning questions? (Write down their name and contact details.)

Colorectal cancer screening

Note to caller: These questions apply to the procedure-based screenings: colonoscopy, sigmoidoscopy, and CT colonography. Stool-based tests and blood tests are usually arranged through the ordering office or a lab and do not need a site call.

45. Which colorectal screening procedures does your site perform: colonoscopy, sigmoidoscopy, or CT colonography?
46. What sedation options do you offer? For example, standard sedation, deeper anesthesia with an anesthesia provider, lighter sedation, or no sedation? Can the patient discuss sedation options with the care team before the day of the procedure?
47. If sedation at an outpatient center is not safe for a patient because of their disability, can the procedure be done in a hospital-based endoscopy suite, or can you refer them to one?
48. Are bowel prep instructions available in plain language with pictures, in large print, or in video format? Is there a nurse teaching call before the procedure, and can a caregiver or supporter join it?
49. Do you offer more than one bowel prep option? For example, pill-based or lower-volume preps for patients who cannot manage the standard liquid prep? Do staff tell patients about these options, or only if the patient asks?
50. If doing bowel prep at home is not safe or possible? For example, for a patient whose caregiver staffing does not cover overnight hours, or who cannot get to a bathroom quickly, can you arrange a planned hospital admission for prep, or help with the insurance approval for one?
51. If a patient needs extra recovery time or overnight observation because of their disability, can that be arranged, and who handles the insurance approval?

52. What is your policy for going home after sedation? Who may take the patient home, and does someone need to stay with them afterward?
53. Can patients bring their own supplies or equipment? For example, a personal lift sling, disposable pads, wipes, or disposal bags? Which of these does your site stock?
54. Is there an accessible bathroom close to the prep and recovery areas, and what help is available for patients who need assistance getting to or using the bathroom quickly?
55. How long is a screening order or referral valid at your site, and how far in advance should a patient who needs accommodations schedule?
56. Who is the best person to speak with about positioning, transfers, or sedation questions? For example, an endoscopy nurse, charge nurse, or clinical manager? (Write down their name and contact details.)

Technical follow-up questions

These questions are best asked of a technologist, imaging lead, or clinical manager, not front-desk staff. They may require a callback or written follow-up. Document answers separately from the main call record.

For mammography staff

57. What is the lowest height, in inches, that the mammography breast platform or image receptor can lower to? *(Note: The standard is continuous adjustability from 26 inches to 42 inches above the floor.)*
58. Do patients approach the machine from the front or rear, from the side, or can they pass through from one end to the other?
59. Is there wheelchair space at the machine that is at least 36 inches wide?
60. Does the patient approach from the front or the rear?

61. If so, is the clear depth at least 48 inches?
62. Does the wheelchair space lets the patient enter at one end and exit at the other?
63. If so, is the clear depth at least 40 inches?
64. If side entry is needed, is the clear depth at least 60 inches?

For cervical cancer screening staff

65. What is the lowest height, in inches, that the table lowers to?
66. Is there a bariatric table available, and if so, what is its weight capacity?
67. Can a portable floor lift fit under the base of the table or equipment? (Note: The standard clearance is at least 39 inches wide, 6 inches high, and 36 inches deep measured from the edge of the exam surface.)
68. If your site uses a ceiling lift instead of a portable floor lift, is the equipment labelled as not compatible with portable floor lifts?

For DXA/radiology staff

69. For your standard hip/spine DXA, how high is the scanner table from the floor?
70. Is there at least 30 by 48 inches of clear floor space adjacent to the transfer side of the table, and if a lift or stretcher is needed, is there additional room?
71. Can a portable floor lift fit under the base of the table or equipment? (Note: The standard clearance is at least 39 inches wide, 6 inches high, and 36 inches deep measured from the edge of the exam surface.)
72. If your site uses a ceiling lift instead of a portable floor lift, is the equipment labelled as not compatible with portable floor lifts?
73. Who determines which scan type or scan site is appropriate? Is it the ordering provider, radiologist, DXA technologist, endocrinology, or another department?

74. If you offer forearm DXA, is it the 33% radius / one-third radius site used for diagnosis, or another peripheral forearm/wrist measurement?
75. If you offer heel QUS or another peripheral test, how do you use the result? Is it for screening/triage only, treatment decision support when central DXA is not feasible, or referral for central DXA?

For endoscopy / colorectal screening staff

76. What is the weight capacity of your procedure stretchers or tables, and what is the lowest height they reach?
77. What transfer equipment is available? For example, a slide board, gait belt, portable or ceiling lift? Are staff trained and allowed to use it? Can a patient bring their own sling for your lift?
78. What positioning supports can you provide for patients who cannot get into or hold the side-lying position on their own? For example, wedges, straps, or additional staff to support the patient's legs during the procedure?
79. Is there at least 30 by 48 inches of clear floor space beside the stretcher in prep and recovery bays for a wheelchair or lift?
80. Can a portable floor lift fit under the base of the table or equipment? (Note: The standard clearance is at least 39 inches wide, 6 inches high, and 36 inches deep measured from the edge of the exam surface.)
81. If your site uses a ceiling lift instead of a portable floor lift, is the equipment labelled as not compatible with portable floor lifts?
82. Who decides the sedation plan? Is it the gastroenterologist, an anesthesia provider, or both?
83. Is anesthesia support available on site for patients who need it?
84. If a complete colonoscopy is not possible for a patient, how do you communicate with the ordering provider about alternatives such as CT colonography or stool-based screening?

About Screening for All

Screening for All is an initiative funded by the Centers for Disease Control and Prevention (CDC)'s National Center on Birth Defects and Developmental Disabilities (NCBDDD) to address the significant barriers people with disabilities face in accessing preventive health screenings.

Developed by MCD Global Health, this project provides patients and healthcare providers with evidence-based tools and resources to make preventive health screenings accessible to all patients. Questions or comments can be sent to ScreeningForAll@mcd.org. More resources are available at mcd.org/screening-for-all.

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