

# Treating Adults with Physical Disabilities: Access and Communication

A Training Curriculum for Medical Professionals  
on Improving the Quality of Care  
for People with Disabilities

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Developed by



**WORLD INSTITUTE ON DISABILITY**

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In collaboration with

Center for Health Care Strategies

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The World Institute on Disability (WID) is a nonprofit research and public policy center promoting the civil rights and full societal inclusion of people with disabilities. WID's work focuses on four areas: employment and asset development; accessible health care and personal assistance services; inclusive technology design; and international disability and development. As over half of the Board of Directors and staff are people with disabilities, WID brings a diverse disability perspective to improving public policy and civil rights.

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## Introduction

Social and political gains of the disability rights movement culminating in the *Americans with Disabilities Act of 1990* are changing the ways that the medical system views people with disabilities. Medical professionals in all types of facilities must now understand disability as more than physical, cognitive or emotional dysfunction. A new model must be envisioned which takes into account the range of barriers, including environmental, architectural, logistical, societal and cultural, which define and impact the health of disabled individuals, as much as their biologic impairments. (National Institute of Disability Rehabilitation and Research, 2002, and Institute of Medicine, 1999). Economics is also influencing the increased focus on this population. Providers are becoming aware that appropriate care at the outset can avoid unnecessary emergency room visits, costly case mismanagement and dangerous secondary conditions.

The new disability paradigm results from decades of research and advocacy growing out of the Disability Rights and Independent Living movements. Healthcare professionals will benefit from becoming more aware of community resources including peer counseling, mutual support groups, independent living, advocacy, and recreational services available to disabled people and their families. The expanding knowledge of the provider, as well as improved communication between patient and provider are key in the delivery of quality medical care.

This curriculum and video offers practitioners, including physicians, dentists and nurses, as well as social service and support staff, an introduction to crucial issues that affect the quality of care for patients with physical, sensory and communication disabilities. This program offers a focus on physical disability including mobility, vision, hearing and communication impairment. It does not address the unique needs of people with cognitive disability, such as mental retardation, traumatic brain injury or psychiatric disability, nor does it address care of children with disabilities. These populations deserve separate attention in their own right.

This program emphasizes access and communication as the fundamental components of quality care for people with disabilities. The accompanying video illuminates the perspectives of people with disabilities and expert providers, discussing access and communication issues that often arise in the clinic setting, and the requirements of the ADA in addressing these issues. The curricular materials offer a case-based training exercise which challenges viewers to put knowledge into practice for nine patients with various physical, sensory and communication disabilities. This exercise can be used immediately following the video, at subsequent training sessions, or for individual self-administration.

Also included in the curriculum are a list of top-rated searchable web sites related to disability, links to downloadable resource guides about *The Americans with Disabilities Act*, and an extensive bibliography for further study on clinical and research topics related to disability.

## **Training Goals**

The overall goals for this training program are to increase the capacity of health professionals and staff to deliver culturally sensitive, quality care to adults with physical and sensory disabilities, to solve related problems in their practices, and to comply with the requirements of the *Americans with Disabilities Act*.

### **Participants will be able to:**

- Gain a better understanding of health, wellness and care issues concerning people with physical disabilities,
- Recognize and address architectural, communication, attitudinal and economic policy barriers to quality health care, as addressed in the Americans with Disabilities Act,
- Acquire specific skills to increase good communication and rapport, which in turn enhances accurate assessment and delivery of quality care.

### **The components of this training curriculum guide are:**

- Suggestions for teachers and trainers about disability issues
- Workshop Facilitator's Guide
- Video: "Access to Medical Care: Adults with Physical Disabilities"
- Workshop Handouts
- Cases for Discussion, with stimulus questions and case considerations for discussion or individual study.
- Online Resource Guide: Fifteen searchable disability-related web sites, for use in treatment management, referral, and consumer information.
- Recommended Downloadable Comprehensive Guides on disability and *The Americans with Disabilities Act*. These include comprehensive strategies for communication with disabled people, planning for programmatic access and accommodation, architectural access issues, medical education, consumer/patient perspectives, and Medicaid policy barriers and issues, each which include extensive bibliographic references for further study.
- Bibliography of Pertinent Articles on disability issues
- Evaluation Form

## **Suggestions for Teachers and Trainers about Disability Issues**

Training medical providers about disability requires sensitivity and knowledge of a range of complex social, personal, and medical, as well as technical knowledge of political and legal issues. This section offers suggestions for teachers and trainers to optimize the quality of the training workshop experience for participants.

### **Recommended Qualifications of Trainers**

It is recommended that at least one of a team, but preferably all of the trainers have the following key qualifications:

- Sufficient experience with personal, social and cultural issues for people with disabilities to be able to answer common questions about disability access, legal and social issues, and to challenge common stereotypes about people with disabilities,
- Thorough knowledge of the Title III of the Americans with Disabilities Act, Public Accommodations,
- A working knowledge of community and academic literature related to disability,
- Direct personal experience with disability issues, such as having a disability, or experience as a parent, offspring or sibling of a person with a disability.

These qualifications are designed to enlist knowledgeable trainers who have a "disability positive view" as well as technical knowledge essential to the content of this program. In some settings, medical professionals may be the most appropriate facilitators, where, for example, professional credentials are significant for credibility and professional criteria, such as CMEs. It is essential nonetheless, to remember that the most fundamental challenge to disability stereotyping comes from participants interacting with people with disabilities in a peer or leadership role. Non-disabled medical professionals can involve at least one co-trainer who is a person with a disability and who possesses the above qualifications. A recommended training format is included in this packet. Additional training suggestions are included, below.

### **Panel Presentations**

A panel presentation of people with disabilities is an excellent way to offer exposure to personal experiences and points of view about disability within a manageable time frame. Panel members can be chosen on the basis of their ability to effectively communicate their own experiences. In considering candidates, use care not to exclude people because of limited education, class background, communication disabilities or stereotyped notions of "presentability". Diversity of disability, level of education, race and gender will greatly enhance the impact and applicability of the panel presentation.

Panel members can be instructed to develop a brief presentation of approximately ten minutes, in which they share personal stories of their life and medical experiences which should illustrate points consistent with the objectives of the training. Inexperienced panel members may need assistance with this process, in framing their stories concisely and downplaying blame of professionals. Individuals interviewed in the video model clear, assertive, positive suggestions to providers.

Personal stories of negative or discriminatory experiences can be most effective when conveyed with:

- an attitude that discriminatory treatment is a result of lack of information and appropriate exposure to and positive interaction with people with disabilities,
- positive expectation that discriminatory treatment can be reversed with training, experience and knowledge of appropriate legal, ethical and social guidelines.

The above points can be stated directly by the trainer in private coaching sessions with panel members, as well as in the training event itself.

Panel members can be recruited from disability rights organizations, such as Independent Living Centers, from patients advocacy groups, and from a practitioner's own patients where appropriate.

### **Training Apprentices**

People with disabilities can acquire some helpful training and consulting qualifications, which can serve training programs such as this one. People with experience may be included in an "apprentice" role or assistant leader role. This is an effective way to expand the cadre of leaders and resource people, thereby expanding the impact of this work. Using people with disabilities as panel members, or even as workshop assistants who handle registration, etc. is an excellent way to train new trainers and increase exposure to disability for workshop participants.

### **Inviting People with Disabilities into the Training Audience**

Where possible and appropriate, a training workshop for medical professionals can be greatly enhanced by the presence of people with disabilities and/or their family members who may be invited to join the training audience. An atmosphere of open dialogue about disability issues should be fostered. The rigid line between "professionals and patients" is transcended when disabled and non-disabled people are allowed to interact as peers and citizens. Invitees can be consumers of the trainee medical agency or members of the local community.

### **Handling Emotionally Charged Issues**

Disability training can raise sensitive issues for people with disabilities, as well as for medical and human service professionals. On occasion, some workshop participants may feel defensive or argumentative and express these feelings during the training. The trainer can state calmly that he or she is sorry if a comment has made anyone feel personally or professionally criticized. It is helpful to state simply that the goal of the workshop is not debate, but sharing of information, where there can be room for differing views and disagreement.

## **Workshop Facilitator's Guide**

### **Facilitator Preparation**

To prepare for a training workshop presentation, a facilitator must:

- familiarize him or herself fully with the training materials and the video
- arrange for appropriate audio-visual equipment
- prepare handouts for distribution, including:
  - cases (to be printed and cut apart for the exercise) and case questions
  - workshop handouts
  - evaluation forms

### **Workshop Agenda**

Suggested Format for Ninety Minute Workshop for Twenty-five Participants is below. Each segment can be flexibly timed as appropriate for the audience and time available.

#### **1. Introductions (5 minutes)**

If time permits, invite participants to introduce themselves and briefly pose one priority question about disability. This will give the facilitator a sense of the audience's familiarity with disability and level of training needs, and break the ice on the topic of disability.

OR:

For a larger group, invite participants to introduce themselves to a few others in the conference room, sharing something about their interest in the topic. Introductions may not ordinarily be a part of medical education and training, but we strongly recommend creating an atmosphere of dialogue and interaction. Changing practice requires more than learning facts; it includes change in attitudes and values, and benefits from open discussion.

**2. Goals Statement (5 minutes)** The facilitator states goals for the training (See Goals, page 5) and disseminates hand-outs, which summarize and reinforce key points for participants.

#### **3. Video and Questions (35 minutes)**

View the 23 minute video and invite questions and discussion. Participants may share reactions to the presentation and ask questions for clarification or content.

**4. Case Exercise in Small Break-out groups (10 minutes)** explores case examples. The cases challenge participants to apply their knowledge about accommodating people with disabilities in the clinic and puts into action their understanding of the requirements of the ADA. Participants are asked to break into groups of two or three people. Each small group is given one case to consider, along with stimulus questions. Participants are instructed to read the case aloud, then together address the accompanying stimulus questions. Participants brainstorm potential access needs of the case and develop a list of access and accommodation recommendations to report back to the large group.

**5. Case Report Backs and Discussion. (15 minutes)** Participants then return to the group to present recommendations for discussion. The time available and the size of the overall group, determines how many participants may report their answers. (Recommended: 3-5 minutes per small group of two or three) The facilitator will include report-backs on as many cases as time allows.

Each case raises crucial access and accommodation concerns for people with various disabilities. Following each small group's recommendation, the facilitator refers to and reinforces the appropriate ADA requirements. The facilitator offers clarification and if necessary, correction of participant's misconceptions, as they arise with the small group's case recommendations. Use the **Case Considerations** as stimulus for further discussion and clarification of participant case recommendations.

**6. Attitudinal Awareness (15 minutes)** It is useful for participants to focus attention on the complex social, personal, attitudinal-related issues which so profoundly underlie discrimination against people with disabilities in our society. Health care professionals are not immune from the same kinds stereotyping which confuses nearly everyone else in our society about disability. Participants can be asked in small groups or large discussion, to consider such questions as:

- a. Are there factors from your past, family, or cultural background that might affect your own attitudes about disability or disabled people, in positive or negative ways?
- b. How might experiences in education or training, or experiences with former disabled patients have influenced your current interactions with patients with disabilities?

**7. Closing (5 minutes)** The facilitator refers to materials in the packet to highlight articles and resources of interest and requests that participants fill out and submit *evaluation forms*.

Workshop Handout:

## **Medical Care and Disability Awareness: Key Points**

- 1. People with disabilities require the same quality of medical service** and preventive care as any patient, but may be under-served and receive less than quality care.
- 2. Defining “health” as the absence of disability or chronic illness** negatively affects people with disabilities. Many lead active, fulfilling lives, which include work and community, sexual relationships and parenting, or could achieve these with appropriate community resources. Fortunately, many disabled people consider themselves healthy and well, which likely enhances their quality of life.
- 3. While a disability doesn’t necessarily imply illness, some disabilities may lower the threshold to an array of secondary conditions. Preventive care and early intervention can reduce complications.**
- 4. Listen for accurate assessment.** Listen attentively to your patients with disabilities to understand their background and functional needs. Avoid stereotyped assumptions. Avoid unnecessary referrals to specialists. A team approach works best to accommodate complex medical needs.
- 5. Barriers to care include physical/architectural barriers, communication barriers, attitudinal barriers and social/economic policy barriers.** Understanding these barriers and obtaining accessibility training is helpful for both medical and support staff. (See appendix materials for technical information and social perspectives.)
- 6. Medical facilities and practitioners are required by the Americans with Disabilities Act to provide access for people with disabilities to health care services.** The law requires *reasonable accommodations* –meaning those that are *readily achievable* and do not present an *undue hardship* on the facility. Practitioners and facilities need to learn about and provide specific accommodations for people with the full range of disabilities.
- 7. Advance access planning** in the clinic can save time and improve quality of care.
- 8. Check accessibility** when referring patients to diagnostic testing and specialty clinics. Check that referred-to-providers accept the patient’s insurance.
- 9. Some people with disabilities have an expertise** in their conditions, which should be respected and reinforced. Others, particularly newly disabled people need training and support to become active partners in their care.

## Workshop Handout

### **Definition of a Person with a Disability from the *Americans with Disabilities Act*:**

A disabled person is someone with a physical or mental impairment that substantially limits one or more major life activities (as well as someone with a history of such an impairment or someone currently regarded as such.) This includes people with obvious, visible disabilities, as well as the majority of people with disabilities who have hidden conditions such as arthritis, diabetes, or hearing impairment.

#### **Barriers to Health Care:**

- Physical barriers
- Communication barriers
- Attitudinal barriers
- Social Policy barriers

#### **When treating a person with a disability remember to:**

- talk to the patient, not someone who accompanies them
- avoid making assumptions
- ask, "How can I help you?" and respect the answer
- ensure that educational materials are easily accessible
- allow time for history taking & exam

#### **When treating a person who is blind or visually impaired, provide written material**

- in an auditory format
- on computer disc
- in Braille or large print

#### **When treating a person who is deaf or hard of hearing:**

- ask how to best communicate
- provide written educational material
- look at the person while speaking
- avoid shouting
- minimize background noise
- provide interpreter, if necessary for effective communication
- patients cannot be charged for interpretation
- family members should not be pressured to interpret to save time or expense

#### **When treating a person who is a wheelchair user:**

- provide access to exam areas
- provide assistance if necessary (for a full and complete exam, even if it requires more time or assistance)
- respect personal space, including wheelchairs & assistive devices
- avoid propelling wheelchair unless asked
- obtain adjustable exam tables for your facility, if possible

Workshop Handout:

## **Case Questions: Applying Access Information and Rapport Skills**

### **1. Access to the Facility**

- a. What access issues might arise for this patient at the clinic? Consider:
  - transit to and from the appointment
  - structural barriers in the facility
  - the exam, diagnostic procedures, and follow up or referral
- b. What difficulties might arise for clinic staff in meeting this patient's access needs?
- c. What information could assist the clinic in advance, and how might this be obtained?
- d. What auxiliary aids or services might be required to facilitate access?
- e. What assistance or safety precautions might be required from staff or the patient's companion or personal assistant, and how would this be arranged?

### **2. Attitudinal, Social and Policy Barriers**

- a. What stereotypes or social barriers might this person encounter in a medical situation?
- b. What issues regarding dignity, privacy, or autonomy might arise?
- c. Could this person's care or wellness potentially be compromised by limitations in Medicaid/Medicare coverage?

### **3. Rapport and Interview**

- a. What issues might arise in communication or in establishing rapport?
- b. What medical history questions need to be answered about this individual's disabling conditions to adequately address presenting symptoms?
- c. What safeguards or reassurance could be offered to help engender an atmosphere of trust and safety that this patient would not be exploited as a guinea pig, or disrespected as a person with a disability?

### **4. Exam, Diagnosis and Treatment**

- a. What access or rapport issues might arise in diagnosis or treatment?
- b. What factors for this patient might need to be addressed to improve adherence and treatment compliance?
- c. What assistance or accommodations might be appropriate in administering medications?

### **5. Referral**

- a. What referrals might be useful for this patient? What stereotyped assumptions might lead to inappropriate referral of the patient to a specialist?
- b. What are clear indicators that a specialty referral would be appropriate?
- c. In referring the patient for diagnostic testing, what access, insurance coverage, HIPPA, confidentiality or privacy, Electronic Health or Medical Records-related difficulties might arise?
- d. Can crucial information be flagged in the chart? How?

### **6. Follow-up Care**

- a. What barriers might arise for this patient in obtaining follow-up care?
- b. In informing the patient of diagnostic test results?

## Cases

These case examples are presented as a basis for discussion. They are designed to emphasize establishing rapport and developing appropriate access and accommodation for a clinical exam.

Workshop participants may also be encouraged to offer their own case examples in addition, or be notified in advance of the workshop to prepare and bring case examples.

**For case discussion in the workshop small group exercise**, cases can be printed out on a separate page and cut apart, to be distributed one each to the small break out groups, along with a copy of the stimulus questions on the preceding page.

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1.

Ron T. is a 39 year old man with a C6 spinal cord injury. He is employed as a computer software designer. He drives his own van, and uses a powered wheelchair. He has just joined his company's new health plan, which referred him to your clinic for an annual physical.

-----

2

Sarah M., is a 31 year-old legally blind woman. She is married and the mother of a four-year-old, whom she brings along to the appointment. She presents with a skin rash on her arms and abdomen, complaining of itching. She indicates that her sighted husband described the appearance of the rash to her. She is concerned about contagion of the rash to her child, as well as being able to monitor the rash's healing.

-----

3

Jake B. is a 57 year-old paraplegic man with post-polio from childhood; he uses a wheelchair. He is employed as a dispatcher for a trucking company. He complains of irritation in the anal area and occasional blood on the toilet paper. He is not sure if he has ever had hemorrhoids. He is unable to stand.

4

Lin P. has severe rheumatoid arthritis. She is 49 years old, lives alone and walks with two canes, occasionally uses a manual wheelchair for longer distances. She presents with a fever of 99.1 and reports nausea and vomiting the previous night.

-----

5

Pema L. is a 68 year old woman with right hemiplegia from an aneurysm, five years post incident. She has a significant degree of dysarthria; she ambulates using a four point cane. She complains of mild breathing difficulties keeping her up at night, especially when she is lying down. She has a history of allergies.

-----

6

Darrel J. is a 62 year-old Deaf man, who grew up in a family with two Deaf parents and one hearing sister. He works as office manager in a mail order business. He complains of abdominal pain. He lip reads fairly well and uses a notebook to briefly jot down his thoughts, but requests an interpreter if he will be required to undergo any diagnostic tests because he is afraid of not fully understanding what might be happening.

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7

Maria T. has achondroplasia. She is 3 foot, 9 inches tall, 46 years old, and ambulates independently. She works as an administrator in a community college. She presents with joint pain in her shoulder, saying it is interfering with her computer work.

8

Jan F. is a 29 year old man with Becker's Muscular Dystrophy. He is married with two children, and describes himself as a disability activist, and works in an Independent Living Center. He says he has had headaches and difficulty sleeping for two months.

---

9

Michael S. is a thirty-one year old full time graduate student with moderately severe cerebral palsy, including significant dysarthria and mobility impairment. He is able to walk but comes into the clinic in his manual wheelchair, which he uses sometimes. He lives in the accessible student dorm on campus. He complains of a sore throat and fatigue, which has bothered him for the last ten days.

## Case Considerations

(To be used in case feedback discussion, following the small group's access and accommodation recommendations.)

### **For Mobility-Impaired Patients, Consider:**

- Is there accessible parking, including wheelchair **van** parking, which means room for the lift or ramp to deploy, not just car-width spots?
- Is there an accessible entrance to the facility? Is it clearly marked?
- Are exam rooms accessible to wheelchair users?
- Are reception area, medical assistants and medical staff educated to be non-patronizing and to assume that a wheelchair user is potentially fully employed, competent and knowledgeable about self-care?
- Is there an adjustable exam table to allow a full exam?
- Is there a policy regarding provision of personal assistance for transfer to exam table and dressing and undressing assistance? If so, are disabled patients informed of this policy?
- Are medical staff adequately informed of this condition, for example, spinal cord injury-related concerns such as dysreflexia, skin care, bladder and bowel care and personal assistance services?
- Is a sexual history taken? (often neglected due to the stereotype of asexuality.)
- Medication: Is the pharmacy able to supply medication in easy-to-open containers accessible to quadriplegic individuals?
- If referral for diagnostic testing is made, can the chart be flagged to inform specialists or diagnosticians of wheelchair access needs?

### **For Blind or Visually Impaired Patients, consider:**

- Are there Braille markings on elevators?
- Are resource people available in the lobby to assist blind people? Are they trained to assist in orienting a blind person to locate specific areas in the facility?
- Are reception area, medical assistants and medical staff taught to be non-patronizing and to assume that a blind person can be, for example, a competent parent, fully employed, and an independent individual?
- Are medical and non-medical staff trained to verbally explain procedures?
- Are patient education materials available in alternative format, such as large print, audio cassette, Braille or computer disk?
- Attitudinal: Don't assume or expect a sighted child accompanying a blind parent to be a guide or guardian in any way.
- Does the pharmacy have Braille labeling capability, and if not, who is available to verbally instruct the patient?

**For speech Impaired patients, consider:**

- Are medical and non-medical staff trained to be respectful and non-patronizing?
- Are medical and non-medical staff trained to be patient, not complete sentences for or second guess the patient?
- Is there sufficient time allowed for speech impaired persons to communicate verbally or via a word board or computer display?
- Is there adequate time scheduled in the appointment for the patient to adequately communicate without pressure to hurry?
- Do staff know to directly the address the patient and not a companion? (unless the companion is indeed a guardian, which should be clearly determined, not assumed.)

**For Deaf or hard of hearing patients, consider:**

- Are medical and non-medical staff aware of facility policy, community resources and contact information regarding interpreter services?
- Are staff familiar with TDDs (Telecommunication Devices for the Deaf) and available communication relay systems?
- Are interpreter services appropriately contacted and scheduled?
- Are medical and non-medical staff aware that they may not charge the patient for interpretation, nor should family members be pressured to interpret to save time or expense?
- Are medical and non-medical staff trained to be patient, respectful and non-patronizing, not complete sentences or second guess the patient, directly the address the patient and not a companion or sign language interpreter?
- Are staff ready to provide auxiliary aids and services? These include visual aids, written instruction or communication via writing if necessary.

## **Downloadable Comprehensive Guides and E-Courses on Disability Issues, Cultural Competence and The Americans with Disabilities Act**

The three downloadable guides listed below provide excellent resources for training and individual instruction in:

- Essential cultural competence issues for providers serving patients with disabilities,
- Meeting the requirements of the *Americans with Disabilities Act*,
- Extensive bibliographies on pertinent research and training materials

### **Tips and Strategies to Promote Accessible Communication**

#### **The North Caroline Office on Disability and Health**

This comprehensive guide addresses disability awareness, communication aids and alternative formats, including print materials, computer access and use of a TTY, media issues, and a useful glossary. <http://www.fpg.unc.edu/~ncodh>

### **Removing Barriers to Health Care**

#### **The Center for Universal Design**

This guide addresses architectural access issues for health facilities, including design standards established by the *Americans with Disabilities Act*. <http://www.design.ncsu.edu/cud>

### **Access Equals Opportunity: Outpatient Medical and Health Care Facilities: FAQs on The Americans with Disabilities Act** **King County Office of Civil Rights**

In question-answer format, common questions about the ADA are answered succinctly for health providers. <http://www.metrokc.gov/dias/ocre/medical/htm>

### **A Family Physician's Practical Guide to Culturally Competent Care**

While not specifically focused on physical disability, this e-learning course from the Office of Minority Health addresses essential principals of care that are central to provision of quality care for people with disabilities, including those from multi-cultural backgrounds. <http://thinkculturalhealth.org>.

## **Online Resource Guides for Providers Serving People with Disabilities: Healthcare, Legal and Training Web Sites**

These searchable online resource guides provide a wealth of information on specific disabling conditions, sub-constituencies and disability issues. They offer relevant medical, disability rights and Independent Living resources, listed by category: Health Care; Legal Issues and *The Americans with Disabilities Act*; Training Programs and Materials.

### **HEALTH CARE**

#### **Medline Plus: Disabilities**

<http://www.nlm.nih.gov/medlineplus/disabilities.html>

A service of the U.S. National Library of Medicine and the National Institutes of Health, provides extensive links to national resources, specific conditions, treatment management, patient/consumer and provider organizations, directories, law and policy, statistics, recent articles, adults, women and children.

#### **Health Promotion Resource Guide**

<http://www.fpg.unc.edu/%7Encodh/pdfs/Health%20Resource%20Guide.pdf>

This guide provides health educators, service providers, and program planners a carefully selected collection of resources that address disability-related accessibility, communication, and topic-specific health promotion. From the North Carolina Office on Disability and Health.

#### **A Provider's Guide for the Care of Women with Physical Disabilities & Chronic Medical Conditions, Dr. Sandra Welner**

<http://www.fpg.unc.edu/~ncodh/Provider.pdf>

This guide is designed for clinicians to improve their knowledge and practice in providing care to women with physical disabilities and chronic medical conditions. Includes information on access to general medical care, removing common barriers, and comprehensive reproductive health care. From the North Carolina Office on Disability and Health.

#### **National Women's Health Information Center – Women with Disabilities**

<http://www.4woman.gov/wwd/index.htm>

This federal website puts information centralized for women with disabilities, caretakers, health professionals, and researchers. The site offers information and resources on different types of disabilities, abuse, access to health care, breast health, financial assistance, older and minority women with disabilities, parenting, reproductive health, and substance abuse. There is also a toll-free information and referral hotline.

**Oral Health Care for Persons with Disabilities**

<http://www.dental.ufl.edu/Faculty/Pburtner/Disabilities/frtitle.htm>

An online continuing education course by the College of Dentistry, University of Florida, with information on how to provide oral care to people with various types of disabilities.

**U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administration**

<http://www.mentalhealth.org/>

Adults and children, mental health links to resources, directories, suicide prevention, depression, specific conditions, newsroom and current articles, conferences and events calendar.

**Depression and Disability; Dr. Karla Thompson**

<http://www.fpg.unc.edu/~ncodh/pdfs/DpressBk.pdf>

This guide provides health educators, service providers, and program planners a carefully selected collection of resources that address accessibility, communication, and specific health promotion topics. North Carolina Office on Disability and Health.

**Sex Information and Education Council of the United States**

<http://www.siecus.org/pubs/biblio/bibs0009.html>

Sexuality and Disability annotated bibliography, presenting a cross section of available resources on physical and mental disability as well as chronic illness.

**Sexual Health Network Home Page**

<http://www.sexualhealth.com/>

The Sexual Health Network is dedicated to providing easy access to sexuality information, education, mutual support, counseling, therapy, healthcare, products and other resources for people with disabilities, illness, or general changes throughout the lifecycle and those who love them or care for them.

**Through the Looking Glass (Parents and Children with Disabilities)**

<http://www.lookingglass.org/index.php>

Through the Looking Glass (TLG) is a California-based community organization and national Research and Training Center which pioneered clinical and supportive services, early intervention, training and research, serving families, whether parent or child--with disability or medical issues.

**PACER (Parent Advocacy Coalition for Educational Rights) Center, ADA Q&A  
Health Care Providers**

<http://www.pacer.org/pride/health.htm>

A frequently-asked-question (FAQ) web page with a focus on needs of disabled children and their parents, addresses covered health care providers, resources, communication, auxiliary aids and services, barrier removal, and tax credits.

### **Registry of Interpreters for the Deaf**

<http://www.rid.org>

The Registry of Interpreters for the Deaf, Inc., (RID) is a national membership organization of professionals who provide sign language interpreting/transliterating services for Deaf and Hard of Hearing persons.

## **LEGAL ISSUES and THE AMERICANS WITH DISABILITIES ACT**

### **Disability Rights Education and Defense Fund**

<http://www.dredf.org/>

The Disability Rights Education and Defense Fund, Inc. (DREDF) is a national law and policy center dedicated to protecting and advancing the civil rights of people with disabilities through legislation, litigation, advocacy, technical assistance, and education and training of attorneys, advocates, persons with disabilities, and parents of children with disabilities.

### **National Association of the Deaf Law Center**

<http://www.nad.org/infocenter/infotogo/legal/ada3qa.html>

A frequently-asked-question (FAQ) web page from the National Association of the Deaf Law Center covering issues regarding Deaf individuals and access to health care, “ADA Questions and Answers for Health Care Providers.”

## **TRAINING PROGRAMS & MATERIALS**

### **World Institute on Disability**

<http://www.wid.org>

WID is a nonprofit disability research, training and public policy center in Oakland, CA, promoting civil rights and inclusion. WID offers a training video package and workshops for medical providers in improving the quality of medical care for adults with disabilities and chronic illness, as well as “Disability Benefits 101” a collaborative training and resource project on disability benefits and work issues.

### **Program Development Associates**

<http://www.disabilitytraining.com/>

PDA provides training materials for professionals and consumers regarding disability. Topics include: Disability Awareness, Advocacy, Developmental and Learning Disabilities, Special Education, Physical Disabilities, Mental Health, Assistive Technology and Vocational Rehabilitation.

Workshop Handout

**EVALUATION FORM**

1. After completing the training, did you gain a better understanding of the health care needs of people with disabilities?

\_\_\_\_\_ Yes      \_\_\_\_\_ Somewhat      \_\_\_\_\_ No

Comments:

2. Do you think the training adequately addressed essential issues and barriers to serving this population?

\_\_\_\_\_ Yes      \_\_\_\_\_ Somewhat      \_\_\_\_\_ No

Comments:

3. Do you feel more confident in addressing medical issues for patients with disabilities (select one)?

\_\_\_\_\_ Very confident

\_\_\_\_\_ Somewhat confident

\_\_\_\_\_ Not confident

\_\_\_\_\_ Have difficult working with this population

\_\_\_\_\_ Other (please explain) \_\_\_\_\_

4. After this training, do you think you have improved knowledge to facilitate the following: (select “yes” or “no”)?

- | Yes   | No    |  |
|-------|-------|--|
| _____ | _____ | conduct an adequate medical interview with a disabled person?  |
|       | _____ | provide reasonable accommodation to blind, deaf, mobility impaired or speech impaired patients in your facility? |
| _____ | _____ | assist other professionals and support staff with providing these?   |
| _____ | _____ | comply with the Americans with Disabilities Act requirements for medical facilities and practitioners?           |
| _____ | _____ | refer a patient with a disability to another specialist?   |

Comments:

5. What additional resources or training would you need to feel confident with any of the above?

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6. What suggestions do you have do improve the training workshop?

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Thank you!

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