Welcome! We will begin at 12:00pm PT

- Microphones and cameras will be disabled upon entry.

- Use the Q&A function to submit questions.

- Accessible materials, including presentation and recording, will be made available on https://nwadacenter.org/oha-healthcare/

- To enable Communication Access Real-time Translation (CART) services, select "Closed Captions" or "CC" in the Zoom toolbar.

- American Sign Language (ASL) Interpretation will be provided.

ADA and Healthcare Webinar Series

- Collaboration between the Oregon Health Authority and the Northwest ADA Center

- NW ADA Center provides information and training on the Americans with Disabilities Act to residents of Oregon, Alaska, Idaho, and Washington

- For more information on and recordings of this webinar series, go to https://nwadacenter.org/oha-healthcare/

Today's Learning Objectives

1. Understand the difference between implicit and explicit disability bias

2. Learn about the prevalence of disability bias among healthcare providers today

3. Become aware of disability bias embedded in common language and in medical chart notes

4. Explore ways to implement access check-ins

5. Gain tips on how to practice disability allyship from the professional and personal experiences of healthcare providers and disabled patients

Agenda

- Briefly review latest research on disability bias among healthcare providers

- Explore the ways ableism and disability bias show up in healthcare interactions

- Review strategies to increase access to healthcare

- Moderated Q&A with panel of providers and patients

- Q&A with audience

Key Barriers to Accessing Healthcare for People with Disabilities

- Inaccessible healthcare facilities

- Inaccessible healthcare equipment

- Inadequate anticipation of accommodation needs

- Absence of disability perspectives in decision-making spaces

- Negative perceptions of and assumptions about people with disabilities

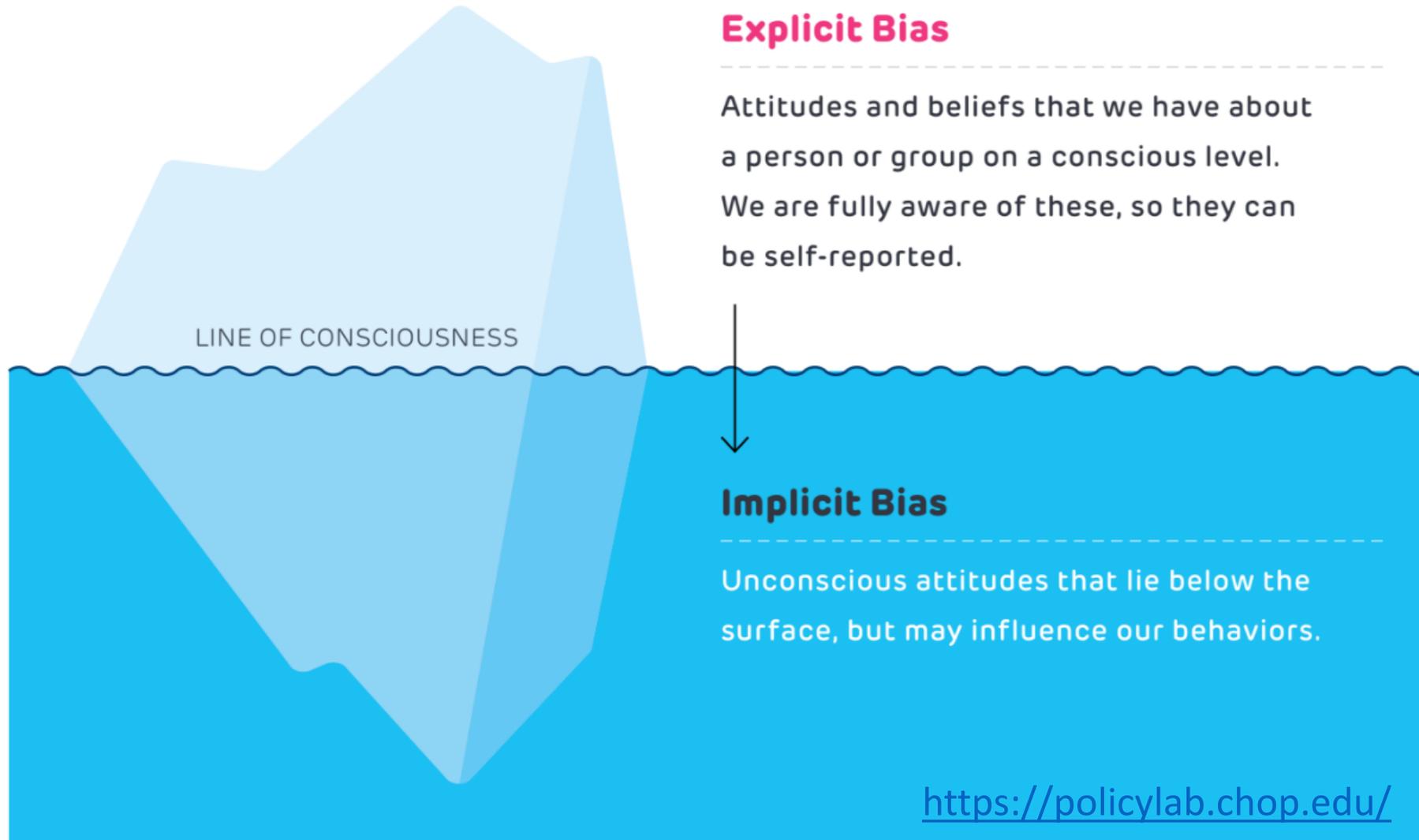# Implicit and Explicit Disability Bias

Ableism

- A form of discrimination that includes an assumption that able-bodiedness is the 'norm' or the 'ideal'

- Leads to differential and inequitable treatment based on actual or presumed non-typical function (i.e., discrimination)

- Pervasive across policies, the built environment, social attitudes, and practices

- Intersectional and rooted in other 'isms' (racism, sexism, etc.)

Explicit and Implicit Bias

Explicit Bias

Attitudes and beliefs that we have about a person or group on a conscious level. We are fully aware of these, so they can be self-reported.

LINE OF CONSCIOUSNESS

Implicit Bias

Unconscious attitudes that lie below the surface, but may influence our behaviors.

https://policylab.chop.edu/
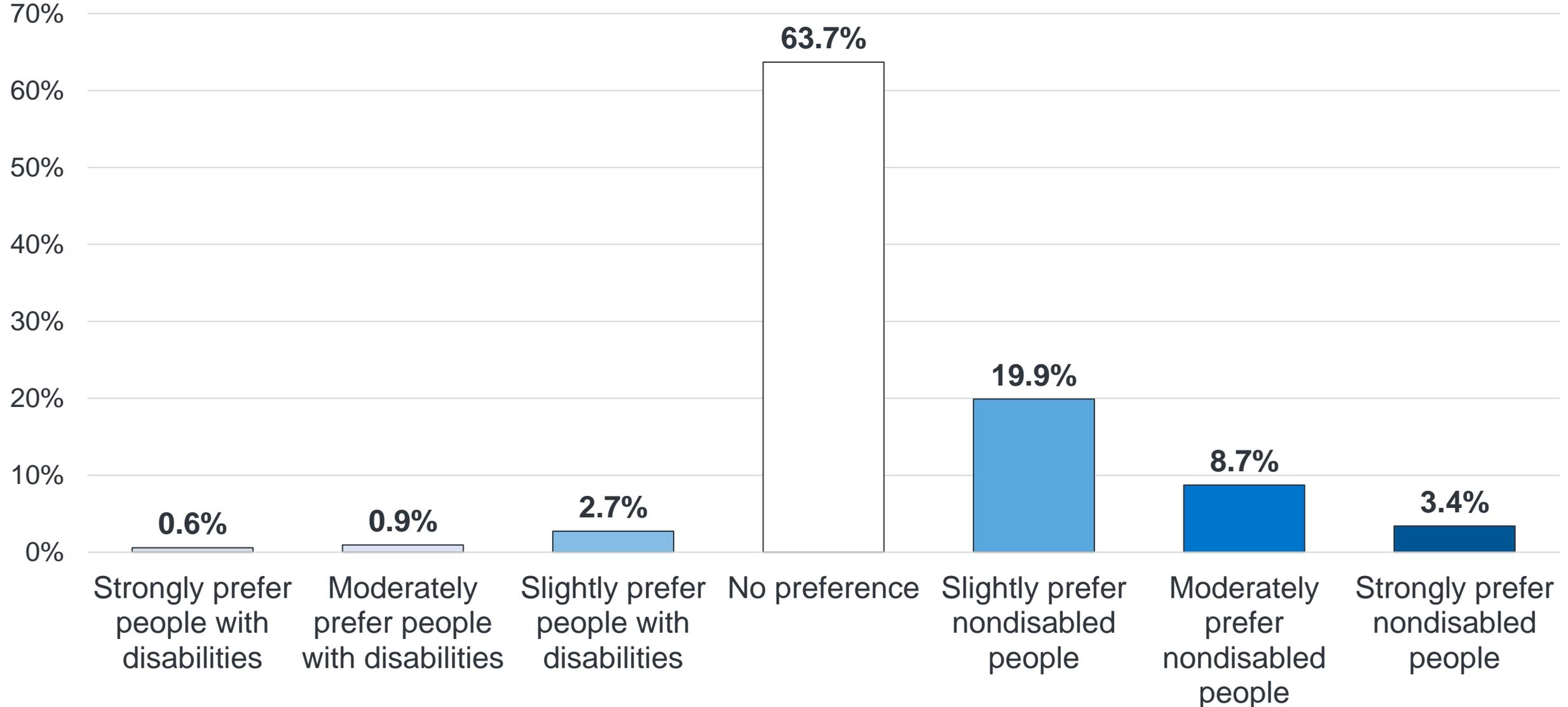
Past Research with Healthcare Providers

Explicit Bias

- Levels of explicit bias vary, but tend to be lower among health professions students compared to other professions

- Explicit bias tends to improve throughout health professions education

- Differences within disciplines (i.e. PT students shown to have less favorable explicit attitudes compared to OT students)
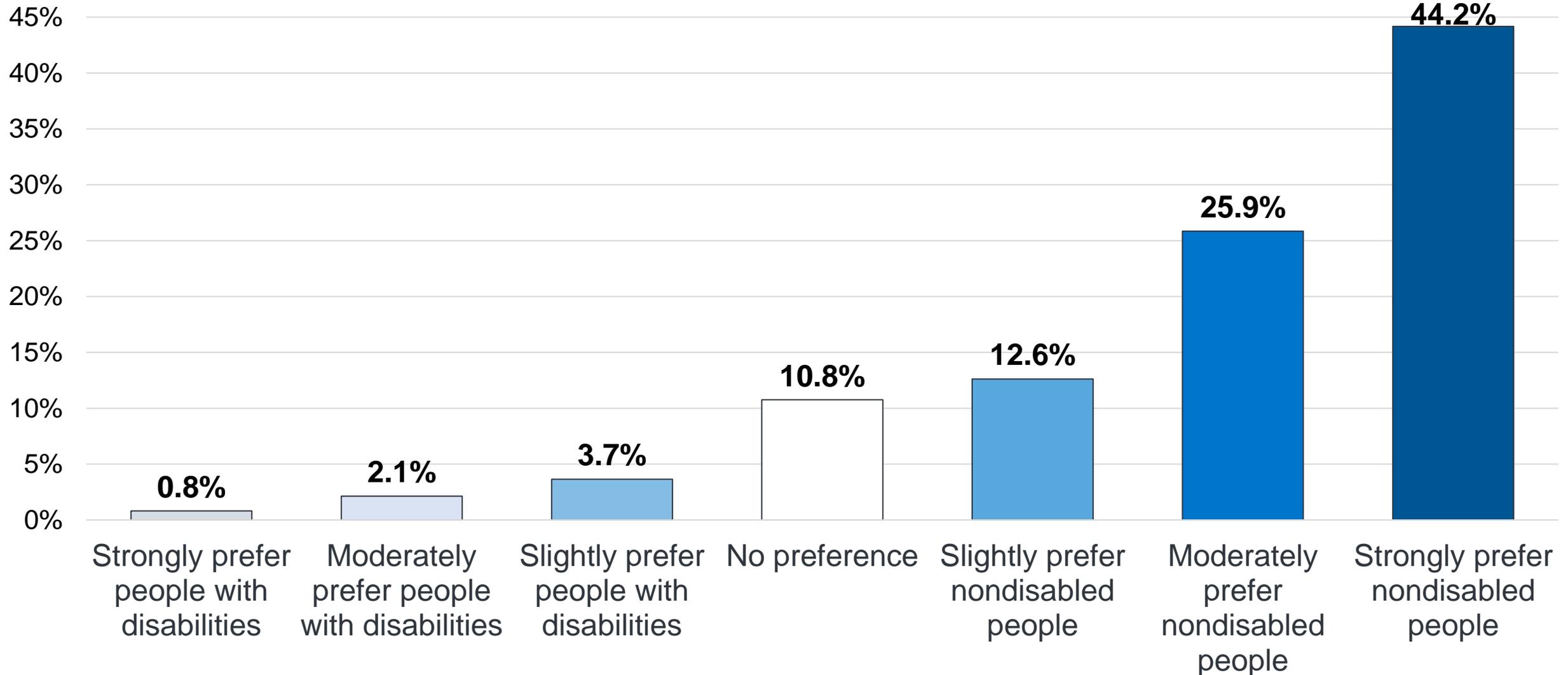
Implicit Bias

- Levels of implicit bias in health professions mirror implicit bias in the general population and are generally high

- Implicit bias tends to remain stable throughout healthcare education

- Many providers believe they are not biased but demonstrate consistent differences in clinical interactions

- Overall, less research on implicit bias comparatively

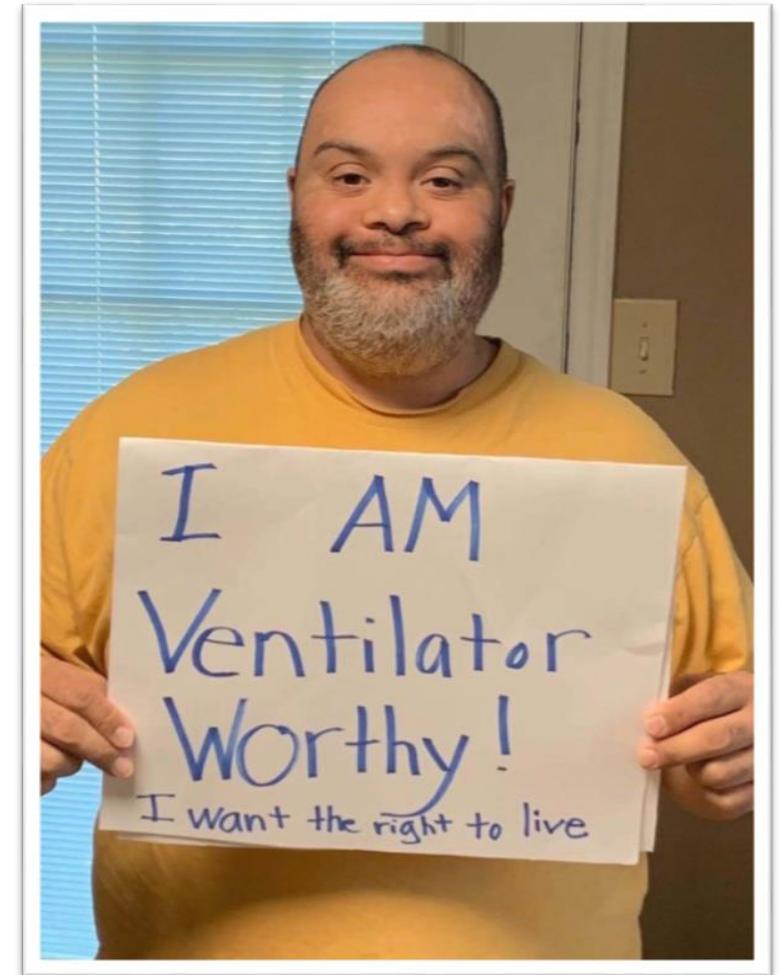Healthcare professionals: Explicit Disability Attitudes

Healthcare professionals: Implicit Disability Attitudes

Bar chart showing:
- Strongly prefer people with disabilities: 0.8%
- Moderately prefer people with disabilities: 2.1%
- Slightly prefer people with disabilities: 3.7%
- No preference: 10.8%
- Slightly prefer nondisabled people: 12.6%
- Moderately prefer nondisabled people: 25.9%
- Strongly prefer nondisabled people: 44.2%

Consequence of Disability Bias: Health Disparities for People with Disabilities

- Significant health disparities exist for disabled patients due to a complex interaction of factors- most of these are not related to a specific health condition

- Biased or ableist provider beliefs and attitudes (explicit or implicit) influence patient encounters, referrals for care, and clinical decision-making

- Through the lens of the ICF, provider beliefs and attitudes are a significant environmental factor that must be addressed to improve healthcare outcomes

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Ways Ableism Shows Up in Healthcare Interactions... Tensions and Assumptions

- Making assumptions about patients' goals or desires (e.g., that a patient wants to look or function as "normally" as possible)

- Equating "learning about" to "living with" a particular condition (i.e., relying on simulation experiences for insight)

- *Telling* patients what their priorities should be rather than *inquiring* what they are

- Perpetuating the stereotypes that disabled people have a lower quality of life than nondisabled people

- Treating health conditions as being isolated from patient identities

What can we do about it?
What the research tells us....

1. Establish Standards of Care for Patients with Disabilities

- At what points in the scheduling / intake / exam processes are patients prompted to request accommodations?

- When is it clinically appropriate to treat a person with disabilities in their chair versus transferring them to an exam table?

- How will you schedule and bill for the extra time that may be required to accommodate a disabled patient? (E.g., time associated with using an interpreter, making transfers from wheelchairs to exam equipment, providing after-care instructions in language plain enough that a patient with a cognitive or intellectual disability can understand them?)

2. Start and End Each Visit with an Access Check-In

- Begin each visit by asking "Do you have any accommodation needs that we should talk about before we begin to make sure we get the most out of your visit today?"

- Don't make assumptions about the priorities of disabled patients, ask what they want to address during the visit

- Listen, ask questions, double check for comprehension of what is discussed

3. Be Aware of Disability Bias in Language

- Avoid language that insinuates disability is a tragedy (e.g., confined to a wheelchair, bedridden, suffers from, is afflicted with…)

- Avoid language that minimizes or diminishes psychosocial disabilities (e.g., "my schedule is insane," "I am so OCD today," "someone needs to take their meds…")

- Use descriptive rather than value laden language in charting or medical record notes. (e.g., noncompliant, aggressive, disengaged, poor hygiene, etc.) Describe behavior, action, or appearance in neutral terms.

4. Examine Institutional Practices

- Ask if, or to what degree, disability is represented in your workplace, group, and leadership team(s)

- Include people with disabilities in diversity, equity and inclusion initiatives

- Remember: Simulations only reinforce stereotypical disability experience!

- Incorporate disability allyship trainings and opportunities into work activities (like this one!)

5. Review Accessibility of All Areas in Which Patients Will Be

- Are there seats that will work for people of all body types and sizes?

- Is the waiting room arranged in a way that it will accommodate power wheelchairs?

- Is there somewhere for people who use canes to position them while they check in?

- Will elevators accommodate power wheelchairs?

- Is there parking with space for a vehicle that uses a ramp or lift?

- Is there a relief area for service animals?

What can we do about it?
What providers and patients tell us...

Panelists

Heather A. Feldner
PT, PhD, PCS

University of Washington

- Assistant Professor, Rehabilitation Medicine: Physical Therapy
- Core Faculty, Disability Studies Program
- Affiliate Faculty, Center for Technology and Disability
- Director, IMPACT Collaboratory
- Associate Director, CREATE

Justice Chukwu

NW ADA Center

Technical Assistant Specialist

Questions from the audience for our panelists

Additional Resources

Additional Resources

- Iezzoni, Lisa I., Sowmya R. Rao, Julie Ressalam, Dragana Bolcic-Jankovic, Nicole D. Agaronnik, Karen Donelan, Tara Lagu, and Eric G. Campbell. "Physicians' Perceptions of People with Disability and Their Health Care: Study reports the results of a survey of physicians' perceptions of people with disability." *Health Affairs* 40, no. 2 (2021): 297-306.]

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- Friedman C, Owen AL. Defining disability: understandings of and attitudes towards ableism and disability. Disabil Stud Q. (2017) 37:2. doi: 10.18061/dsq.v37i1.5061

- Forber-Pratt AJ, Mueller CO, Andrews EE. Disability identity and allyship in rehabilitation psychology: sit, stand, sign, and show up. Rehabil Psychol. (2019) 64:119. doi: 10.1037/rep0000256

- Meeks L, Case B, Joshi H, Graves L, Harper D. Prevalence, plans, and perceptions: disability in family medicine residencies. Family Med. (2021) 53:338– 46. doi: 10.22454/FamMed.2021.616867

- Feldner HA, VanPuymbrouck L, Friedman C. Explicit and implicit disability attitudes of occupational and physical therapy assistants. Disabil Health J. (2022) 15:101217. doi: 10.1016/j.dhjo.2021.101217 55.

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- Doebrich A, Quirici M, Lunsford C. COVID-19 and the need for disability conscious medical education, training, and practice. J Pediatric Rehabil Med. (2020) 13:393–404. doi: 10.3233/PRM-200763

ADA & Healthcare Webinar Series

View all the webinar recordings at:
https://nwadacenter.org/oha-healthcare/

1) **Disability Foundations for Healthcare Providers**

2) **Physical Access and Telehealth**

3) **Effective Communication and Reasonable Modification**

4) **Disability Allyship in Healthcare: Practical Tips from Provider and Patient Perspectives**