CNIB Response to

the Accessibility for Ontarians with Disabilities Act (AODA) Health Care Standards

– Initial Recommendations

July 2021



## Introduction

In 2017, the Government of Ontario committed to identifying and addressing accessibility barriers in the health-care sector and established the Health Care Standards Development Committee under the Accessibility for Ontarians with Disabilities Act (AODA). The Committee was tasked with developing recommendations for a new accessible health care standard across the province.

In October 2017, [CNIB responded to the government’s initial survey](https://cnib.ca/sites/default/files/2021-07/Accessible%20Healthcare%20Report%202016.docx) on what should be included in the AODA Health Care Standard. In May 2021, the Committee submitted the initial recommendations to the Ministry of Seniors and Accessibility, and CNIB is pleased to provide feedback on these standards as part of the public consultation process.

CNIB commends the Ontario government for taking the initiative to develop accessible health care standards, which are long overdue, especially in hospitals, patient relations and complaints, education and training, awareness and outreach, and emergency or pandemic situations.

In addition to the feedback that will be gathered by the Committee, CNIB sought additional, detailed feedback from Ontarians who are blind or partially sighted.

We carefully reviewed the recommendations and deployed a survey, hosted focus groups, and conducted personal interviews to get an in-depth, qualitative response on the topic of accessibility in health care from community members. This report is CNIB’s response to the AODA Health Care Standard – Initial Recommendations.

## CNIB's response to the recommendations:

**Recommendation 1: Accessibility planning and engagement with persons with disabilities.**

The wording used in the recommendation does not specify actionable steps, which creates ambiguity and a lack of accountability, for example “consider the needs of persons with disabilities” and “formal mechanism”. The recommendation also does not list the contents of the multi-year accessibility plans and who is responsible for developing them.

The recommendation is only reflective of permanent disabilities. However, disabilities are episodic, situational, and progressive. Therefore, having accessible spaces, tools, devices, etc., is beneficial to all, including people without any disabilities but with accommodation needs.

**Recommendation 2: Consultation on procurement or facilities**

The preamble of this recommendation only speaks to people with disabilities. However, this excludes people with accessibility needs who require accommodation that is not due to a disability.

**Recommendation 3: Access to equipment**

The intent of this recommendation focuses on training and education instead of access to equipment. To better align the intent of the recommendation and the recommendation itself, the intent should specify how the hospitals will be committed to providing requested equipment to people with disabilities and people with accommodation needs.

**Recommendation 5: Coordination of accessibility accommodations**

Part a. of this recommendation states that “health care providers must proactively offer persons with disabilities an opportunity to identify their individualized accommodation needs”. This excludes people who do not identify as having a disability but still require accommodation. The recommendation also does not account for differences in disabilities, assuming health-care providers can identify visible and non-visible disabilities.

**Recommendation 6: Electronic Health Records**

Disclosing accessibility needs in the Electronic Health Record (EHR) does not consider patient’s privacy, so the Committee needs to integrate privacy acts and other acts for the recommendations to be functional.

Mandating the disclosure of accessibility needs in the EHR section induces stereotypes about people before they visit the health-care provider. The recommendation assumes that everyone with a disability wants to identify as having a disability and wants this information to be in their EHR. It also assumes the patient’s caregiver or visitors will not have needs to disclose.

The recommendations also assume that all patients with disabilities know their accessibility needs before their appointments and that these needs do not change, when they could be determined by the health-care environment, procedures, health-care setting, urgency, etc.

**Recommendation 8: Communication accommodation and respect for capacity**

It is assumed that just because an accessibility need is demonstrated by a patient, or is communicated to the health-care provider, that it will be met. Our consultations have revealed cynicism about accommodations being met. To change perceptions about accessibility, health-care providers and policymakers need to overtly state their commitment to accessibility and meet those needs.

The assumption that health-care providers or hospitals will know when people will require information in alternate formats also categorizes people. For example, not everyone who is partially sighted benefits from large print or braille documents.

**Recommendation 10: Effective communication and informed consent**

The recommendation refers to the need to express informed consent for people with disabilities. However, the issue is not that they are unable to express their consent but that they encounter barriers to accessing information that they need to consent to.

The recommendation does not list the contents of policies and procedures as to how it will be accessed by someone who is having trouble consenting. Moreover, the recommendation does not state who will create and mandate these policies.

The healthcare patient management systems can be inaccessible to staff with disabilities and pose barriers for patients who need electronic access to complete forms or information. However, no recommendation has been made on this issue.

Some recommendations in the report assume that all individuals with disabilities have trouble expressing consent. The recommendation does not consider differences and severity of disabilities.

**Recommendation 11: Development of education and training in hospitals and colleges**

The recommendation does not list how the training will be different from the current AODA training and the topics that will be covered. There is also no reference of mechanisms to ensure that health-care professionals are trained sufficiently or that they are implementing or utilizing their training.

Moreover, there are existing professional development courses for the healthcare professionals and staff members, but not all these courses are accessible. Recommendation 11 does not comment on the accessibility of the course and the Committee should list ways to ensure all training courses are accessible.

It is also important to note that healthcare providers can live with a disability. If the training is not accessible, healthcare providers with disabilities may not be able to benefit from it. Moreover, utilizing healthcare providers with disabilities as a resource to facilitate care for people with disabilities is not mentioned in the recommendation.

**Recommendation 13:** **Training resources and core competencies**

While training and education are important, they are not sufficient to tackle certain barriers such as wayfinding. The recommendation does not mention ways for employees and volunteers to comply with the policies, procedures, and practice. Expecting people to remember verbal instructions about policies and procedures is overly optimistic.

Additionally, the recommendation does not explicitly state whether a new form of training that addresses core competencies will be conducted or if the existing training, which is based around customer standards and is not sufficient, will continue.

Point 4 of the recommendation only lists people who are partially sighted, excluding people who are blind. Some of the recommendations put some people with disabilities into categories. For example, the way recommendations are worded puts all people with hearing loss in the same category and assumes everyone who is hard-of-hearing, deafened or Deaf share the same experience and need the same accommodation.

**Recommendation 15: Hospital declaration of values**

The recommendation only refers to individuals’ hesitancy in making complaints and suggests no ways to deal with patients’ unawareness of their accessibility rights or their inability to make a complaint.

**Recommendation 16: Accessible patient relations process**

Hospitals should recognize people of all ages, disabilities, races, creeds, etc. use the healthcare system, so there should be mechanisms, systems, practices to meet the needs of the diverse population. Moreover, requesting something in an accessible format puts the responsibility in the hands of people who require them, when the hospital should consider these requirements from the start. Failing to acknowledge that accessibility and universal design are for everyone, and by creating recommendations from this implicit bias, the health-care standards perpetuate stigma around disabilities.

**Recommendation 17: Accessible complaint process**

The recommendation does not state how the responses to the complaints will be accessible.

**Recommendation 20: Enforcement strategy and framework- hospital accessibility standards**

The word “accessible format” has been consistently used in the report, but “accessible formats” has not been clearly defined.

**Recommendation 22: Accessibility and disability during a pandemic or emergency**

The recommendations exclude people with multiple disabilities, immigrants, and rural populations. Moreover, there are no recommendations on the accessibility of other formats of medical consultation (e.g., telehealth conference).

The recommendations do not refer to the inaccessibility of appointment-booking systems and how they should be addressed.

## Suggested Improvements to Recommendations

**Recommendation 1**

A Chief Accessibility Officer (CAO), who is directly accountable to the CEO, should be appointed. The CAO should oversee an Inclusion, Diversity, Equity, and Access (IDEA) portfolio.

Words such as “formal mechanism”, “accessible formats”, “fully accessible”, “consultation” need to be clearly defined to remove ambiguity and misinterpretation.

**Recommendation 2**

There should be a roving accessibility specialist who works with hospitals. The specialist can work with the hospitals to ensure all hospitals have the same standards.

**Recommendation 5**

Since disabilities can be episodic, situational, and progressive, patients should be able to modify their accommodation needs when necessary. Allowing them to change their needs, when necessary, reduces inequity and enhances the patient experience.

The recommendation should state how healthcare providers, staff members, volunteer members are asking people about their accessibility needs and meeting those needs. It should also state the consequences for hospitals, healthcare providers, staff members and volunteer members if they do not follow the health care standards.

**Recommendation 6**

TheEHR should not be the sole place for people to disclose their disabilities as it will deprive people of the chance to communicate their needs to the healthcare providers in other ways. Moreover, since it is not guaranteed that healthcare providers see a patient’s EHR, it is essential to give people multiple opportunities to disclose their accommodation need as they see fit.

**Recommendation 7**

To ensure that hospitals, health-care providers, staff members and volunteer members are committed to accessibility and follow related procedures, the recommendation should state how hospitals will manage employee compliance. This can include developing formal policies, explaining why these policies are necessary, making policies easily accessible, and other methods to ensure employees’ compliance.

**Recommendation 10**

Everyone should have equal access to the information so people with disabilities can understand the information and express consent accordingly.

The recommendation should also specifically list who is responsible to create and mandate policies and procedures around informed consent. Lastly, steps should be listed to describe how people with disabilities will be made aware of these policies.

To ensure accountability, the Committee needs to state how these recommendations connect to the AODA, Excellent Care for All Act information and other privacy legislation.

**Recommendation 11**

It should be mandated that regulatory schools have a disability and accommodation policy for staff and students. This will ensure an attitudinal change in new professionals, instilling a culture of accessibility and inclusion.

**Recommendation 16**

We think using the term “patient relations process delegate” is not intuitive and people with disabilities or people who have accommodation/accessibility needs may not decipher that this delegate is exclusively available for them. A better term to use is “Equity, Accessibility, Diversity & Inclusion representative.

Along with the contact information of the representative, the process of the selection of the patient relations process delegate should be made accessible, usable, and available. This information should also be broadcasted to the public, so they are aware of the role of the delegate.

**Recommendation 19**

Volunteer-patient interactions should be audited as well, and the audit should be submitted either as part of the compliance report or in an internal report.

**Recommendation 20**

A list of accessible formats should be created, and it should be mandated for the documents to always be available in these formats. Some examples of accessible formats include large print, LSQ, ASL, real-time captioning, information in plain language, an e-document formatted to be accessible to be used with a screen reader, braille documents, etc.

**Recommendation 21**

Information about accessibility tailored for the health-care providers should also be broadcasted, as it may increase awareness about the topic, keep health-care providers accountable, and inform people with disabilities about their rights and what to expect when they visit a healthcare provider.

The government should have both short-term and long-term plans for accessibility. Currently, the system is inaccessible for people with disabilities and people without disabilities needing accommodation. Even though these standards are helpful in the short-term, the aim should be to make the hospital system accessible for all. This includes components such as modifying the education system and giving opportunities to professionals with disabilities to be a part of the health- care system as well as other areas that do not deal with patients.

These standards should not be limited to hospital settings and the scope of these standards should be extended to other healthcare settings, pharmacies, labs, etc.

## Further general considerations

### **Education and Training**

* **Standardization of AODA training:** The format, content, length of the current AODA training is not standardized, preventing their comparison between hospitals. One of our community members indicated the need for a standardized AODA training, so that when someone says, “I have an AODA training”, you understand what kind of training they have”.
* The AODA training should have awareness training, which includes interaction and respectful communication, pre-conceptions, stereotypes about disabilities, and how to avoid them.
* Employees in hospitals should have consistent communication standards and all employees should draw on their training when communicating with patients with disabilities.
* **Separate training:** To ensure that staff members fully retain AODA training, it should be carried out separately from other training, and it should be engaging and memorable (e.g. instead of completing online training, simulations or on role-playing has a better chance of being retained. Also, an experiential style of training will better prepare the staff to deal with real-life situations.
* **Accountability:** The training should be mandated, and hospitals and employees should be held accountable if they do not complete the training.
* **Contents of training modules:** Training modules should cover etiquette, communication style, sighted guides, and the handling accessibility requests. Staff and healthcare professionals should also be trained to ask people about their accommodation needs and put procedures on hold until those needs are met.
* **Training and education for everyone:** By training everyone in the healthcare setting, miscommunication should be rare. It also ensures awareness, understanding, and coordination. Many participants in the focus groups commented that physicians were better at communicating with people who have sight loss or hearing loss, but other staff members of the hospital do not know how to communicate or help people with disabilities. Thus, training should be completed by health-care professionals, both new and practicing, full-time and part-time staff, contractors, and volunteers. This ensures an attitudinal change in the health-care system and shows commitment to accessibility. For a specific reference, see recommendation 14.
* **Everyone in hospitals should know of the inventory of assistive devices** and where they are placed.
* **Accessibility-related competencies should be listed and assessed regularly** using an accessibility lens. Each competency should be assessed on whether it embeds accessibility and inclusion.
* **Regulatory colleges should have committees** that consist of representatives from the public and healthcare professionals with disabilities to map specific disability-related competencies that each health professional should have.
* **Accessibility and availability:** Online training modules should be made screen reader compatible, with the option of an audio component.
* **The process of requesting accessible, alternate formats** should be made accessible and usable as well.

### **Consultations**

* **Consult with people who have disabilities and with service users.** Since people with disabilities are diverse and have different needs, it is important to actively involve them in the decision-making process. It is not sufficient to only consult them in the planning stage. The process should be iterative and individuals with disabilities should be part of the entire process.
* **Consult with people who have studied disability management and accessibility.** Professionals with degrees/diplomas in disability studies should also be consulted as they understand how the lives of people with disabilities are shaped by injustice, exclusion, social and cultural norms, etc.
* **Consult with agencies or organizations that advocate for accessibility.** Agencies such as CNIB or Vision Loss Rehabilitation Ontario work with people with disabilities and host consultations regularly. These agencies should be consulted to understand and identify barriers that people with disabilities face and to implement solutions to mitigate those challenges.
* **Consult with healthcare providers with disabilities.** Healthcare providers and other individuals with disabilities should be a part of the senior leadership team. By sponsoring and mentoring leaders with disabilities, there will be a stronger top-down commitment, along with positive peer pressure. Employing healthcare professionals with disabilities can also help to remove the notion that people with disabilities cannot be high-functioning people, or have less talent compared to those without disabilities. Not all individuals who have a disability need help from another individual to function. Moreover, consulting with healthcare professionals with a disability can also instill a clear understanding of what accessibility is.

It should be mandated that regulatory schools have a disability and accommodation policy for staff and students. This will ensure an attitudinal change in the new professionals, instilling a culture that sees disability and accessibility as normal.

## Conclusion

In general, we are supportive of the AODA health care standard recommendations that have been put forward and appreciate the government’s commitment to building an accessible Ontario. We hope to see these recommendations implemented into other healthcare settings beyond hospitals.

However, even though these recommendations cover a broad range of barriers and suggest improvements, many recommendations lack specific, actionable steps, which will prevent the recommendations from being implemented. Moreover, because of the lack of specificity, hospitals will not be held accountable if these recommendations are not followed as intended.

CNIB has made numerous suggestions to improve these recommendations and to consider the implicit biases in some of the recommendations. It is crucial to remove the stigma attached to disability and tackle systematic and attitudinal barriers to build a fully accessible healthcare system. We hope that the Committee considers our recommendations.

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