

REALTIME TEXT FILE

DISABILITY AND HEALTH PROGRAM
DISABILITY COMMUNITY PLANNING GROUP WEBINAR
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Edited File

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>> CLAUDIA FRIEDEL: Hello, everyone. Thank you again for joining us and for your patience.

[Background noise].

>> CLAUDIA FRIEDEL: If everyone can mute their phones. Thank you again for joining us, for our Disability Community Planning Group Quarterly Webinar.

Today we're happy to have Lesa Lorusso on our call, she worked with our program to provide site accessibility assessments for healthcare facilities throughout the state. Lesa is a licensed interior designer and MBA with over 15 years' experience in workplace, education and healthcare design. She maintains a consultancy providing design solutions and design thinking workshops while pursuing a Ph.D. focused in healthcare design from the University of Florida's College of Design Construction and Planning. The title of her presentation is "Assessing physical environmental barriers in healthcare facilities: Designing for the accessibility needs of patients."

We're glad to have Lesa on our call. Before we begin, just a little housekeeping. Everyone is on mute, so as questions come up, please type them into your chat box. And Bryan will read them out at the end of the presentation for Lesa to answer. And thanks again for joining us.

And shortly we'll have Lesa share her screen.
I believe, Lesa, there is a button where you can click "show your screen."

>> LESA LORUSSO: Okay.

>> CLAUDIA FRIEDEL: The panel. There it is.

>> LESA LORUSSO: Can you see it?

>> CLAUDIA FRIEDEL: Yep, we see it.

>> LESA LORUSSO: Great.

>> CLAUDIA FRIEDEL: And we'll -- yeah, perfect. Wonderful. Well, thanks again for joining us. And Lesa, welcome!

>> LESA LORUSSO: Okay. Great. Can you see the GoToWebinar control panel? Should I minimize that?

>> CLAUDIA FRIEDEL: I can't see that, just your slides.

>> LESA LORUSSO: Okay, cool. I pushed it away.

Well, hello! Hello, everybody!

This is a presentation of a project that I did with a colleague of mine, Julie Emminger, who is not able to join us today but she worked with Claudia and her team that was funded by the CDC to look at how can we help or improve accessibility for patients to access to care throughout the state of Florida.

So, a lot of my research works with people who are older, and so what Julie and I did was we looked at a series of outpatient geriatric healthcare facilities.

So the title of the project is assessing physical environmental barriers in healthcare facilities and designing for the accessibility needs of patients.

So, here we go.

So, just in summary, the purpose of what we did was we worked together on this project funded by the CDC, with the UF Disability and Health Program, I partnered with Julie and we're both Ph.D. students at UF, to look at physical environmental barriers to healthcare facilities.

So, we looked at access in terms of architectural design and for elders within Central Florida.

So, we visited four different healthcare clinics in the Central Florida region, so a couple were up in Gainesville related to Shands, one was in Orlando, which was Florida Hospital for Seniors, it was an outpatient professional services clinic. And then one in Melbourne, which is the HealthFirst Aging Services Institute.

So, for all of the four different sites, what we did was we assessed them in sort of a mixed-methods format.

We used with all of them the ADA checklist, which I'll get into more in a minute, where we did on-site evaluations. Julie and I have this checklist and walked through each space from entering from the parking lot all the way through to the intricacies like the interior.

The second thing was we did was face-to-face workshops with staff and patients which

were invited, but only a couple actually attended the workshops. It was mostly staff. And I'll explain more what the design workshops are later as well.

And the last was patient surveys. So that mixed methods approach, we were hoping that would give us a well-rounded input of data to really identify gaps from different perspectives, which would then help us, as design students and designers, give each facility recommendations on how they could enhance access for their clients. And we were hoping that they would be scalable; hopefully that they were readily achievable.

So the outcomes that we had were, interestingly, patients indicated a greater need for access within an existing facility that already met 90% of the minimum ADA standards, which really doesn't come as a surprise to people that do a lot within the ADA world.

Because those minimum standards are just that. So, you can always go above and beyond; just because you meet the minimum standards doesn't guarantee best access to care.

So, as designers, for us it's really critical to understand the needs. What are the needs of patients, caregivers, and medical staff that maybe aren't being met currently by the minimum standards.

The findings overall suggest that there really were quite a bit of little to no cost, easy achievable design solutions, that could really impact allowing patients greater access to care.

So, the study setting which we talked about, we had four sites, two in Gainesville, one in Orlando, one in Melbourne. The key people included staff, physicians, receptionists, social workers, everybody who was at the actual site, administrative staff, and patients and caregivers.

The overall question was how might we design better clinics to enhance accessibility in healthcare in elder patients and their caregivers?

So, what we did first was we inquired about the environment itself. So, what we looked at here, it says 10% of the assessed criteria are in need of improvement. So, we had the physical environment, people with disabilities perspective and the staff perspective.

Areas that were frequently shown in need of improvement, we had a lot of inaccessibility entrances, lack of properly-placed signage, lack of or improperly placed signage, obstructions to clear floor space and reach, lack of van accessible parking space, tripping hazards, and opening and closing and securing of doors.

So, within our project, what we looked at, is we had three tiers to really look at and be able to give an estimate of finance feasibility, all of the non-complaint criteria that we collected through our checklist were categorized in the three-tiered system based on the impacting of the existing structures.

The first tier is minor renovations, low to no cost, installing moving signage, replacing and adjusting minor hardware.

Two was moderate renovation, a little more expensive, still not exorbitant, maybe \$200-1,000, replacing toilets and installing and replacing major door hardware.

Third was significant renovation, anything above \$1,000, moving walls or reorganizing corridors and different things like that can get expensive.

When we first started the project, we were looking for a validating tool and I reached out to -- I used to work in the Facilities Department at Wellesley College up in New England and I reached out to the disability advisor Jim Weiss when I was on the team up there and he recommended to me I use an ADA checklist for existing facilities to use, and that's what we did.

So, it's based on the 2010 ADA standards for accessible design, and it was really good, because what it did for us was it gave us a really robust checklist for us to go through and use as a tool.

So, what Julie and I did was we put this on our iPads and we walked through the space with our iPads and went step-by-step-by-step.

So, you know, just for you to know, this is based on the 2010 ADA standards. It was created in partnership by the ADA network and also the Institute for Human Center Design, which is based up in Boston.

Just a quick note, state and local governments, ADA applications for program accessibility, if you wanted to look them up, they're in the Department of Justice's ADA Title to Regulations 28CFR part 35.15.

So, most of us know, the ADA requires state and local governments, businesses and non-profit organizations to provide goods, services and programs to people with disabilities on an equal basis with the rest of the public.

So, some people think that only new construction and alterations need to be accessible and that older facilities might be grandfathered in, but, really, that's not the case.

Because ADA is a Civil Rights law and not a building code, older facilities are often required to be accessible as well to ensure that people with disabilities truly have an equal opportunity to engage with the environment.

Sometimes it's a greater obligation than what's known as, you can put it in quotes, "readily achievable barrier removal," so sometimes it is more than you'd think, but in this study, you'll see they were mostly readily achievable.

So, a little more about the checklist. So, if you look up here, requirements for places of public accommodation, the study, this study examined professional offices of healthcare providers, so those fall under the six categories which is what is considered a place of public accommodation. So that's why we focused and sort of moved in on this.

But in general, businesses, non-profit organizations that serve the public must remove architectural barriers when it is readily achievable as well.

In other words, when barrier removal is easily accomplishable and able to be carried out without much difficulty or expense is a requirement.

The decision of what is considered readily achievable, you can look at the overall size type and finance of the public accommodation, what is the nature? What might the cost be of the improvements that are needed? If the barrier, when removable, is difficult, it may be readily achievable in the future, if the organization does get more monies in the future.

And that's how we approach our checklist for each facility.

So, the checklist itself has these four priorities. We've got accessible approach and entrance, access to goods and services, toilet rooms, and then other items that sort of is a catch-all for things, like water fountains and public telephones and things like that.

We started outside, like an arrival point where somebody is being dropped off. What was the sidewalk, a couple of these were larger than others, so I just walked throughout the entire parking lot and, you know, started where somebody might actually either pull up in their car or be dropped off in the front and really looking at access, from the parking lot forward.

We did take extensive notes on the actual checklist and we had -- we were taking photographs and tape measures throughout each space.

Just so you know, the checklist itself is based on the 2010 ADA standards for accessible design. It's not exhaustive, though, it does not include all sections of the 2010 standards.

For example, there are no questions within it about patient rooms that are located in hospitals where you might actually -- somebody might actually be staying for a long period of time or guest rooms and hotels and things like that.

So, if you do want to use this checklist -- and it's free if you Google it, it comes right up, ADA checklist for existing facilities -- and you're trying to assess a site that has things within it that aren't in the click, just refer back to the full 2010 ADA standards.

So, overall, full compliance is required only for new construction and alterations.

And the checklist is really not intended to determine compliance for new construction or facilities being altered, it's more of a guide or a tool to be used for improvements.

Elements and facilities built or altered before March 15, 2012 that comply with the 1991 ADA standards are not required to be modified to the new standards.

So, that's just some things to keep in mind. Sometimes facilities, you know, if you're a designer and you're working with them and you say you want to go around with a checklist, they get nervous, because they're afraid that it's going to be very expensive.

So, the sites that we worked with, we assured them that we have a checklist, we're not, you know, we weren't necessarily, you know, out to get them, and they were very collaborative and eager to know, what could they do to make the space better for their

clients.

So, this is just a picture version of the different priorities. So the first one, priority one, approach and entrance, it gives you a good glimpse into what the checklist is. So each priority starts with this and then as you go through it, it has images and then a checklist on the right. You know, does it measure within this range, check yes or no, and if not, there's a little place for a no, and then it says how to provide possible solutions and what those might be. Access to goods and services, that really helped us within the lobby areas. There's a lot of reception desks and things of that nature.

Toilet rooms are always a big -- especially for people with disabilities, the elderly and people with dementia, you know, we really zoomed in on those toilet rooms, because there's some unique needs there within that population. And then additional access. That, for us, was water fountains.

So, just to see the overall results, what we had, low versus high cost solutions, we see that in the tiers related to costs that we talked about earlier.

Seventy-five percent of the non-complaint issues could be addressed with little to no cost solutions. So, that was a good thing, because the less they cost, the more easily achievable they are.

Our survey that we put out, the patient accessibility experience survey, it was a ten-item questionnaire and we gave it to patients and their caregivers during the clinic visit.

So, 23 patients completed the survey. And it has five point Likert-type questions to rate their satisfaction and easy of accessibility, like parking and entering the building, opening doors, the waiting rooms, moving throughout and navigating the buildings, check in, check out spaces, toilet rooms, and exam rooms.

So, people were, on the whole, satisfied, which was good. Several people, you know, really felt like things were excellent or adequate.

A small amount were completely dissatisfied. And there was sort of an equal amount saying hey, there is some improvement that are needed.

The design thinking element of what we did was we then, you know, we got direct feedback from patients and their caregivers and we wanted direct feedback from staff as well.

So, design thinking is sort of a problem-solve mindset, so it comes from the world of industrial design, actually, and is an approach where you, as the designer, say hey, I don't have all the answers here, and it puts the client really in the driver's seat. So, in that sense, it's considered human-centered or patient-centered.

So, what we did was we set up different workshops with physicians and staff. Patients were invited; a couple patients came.

But we did creative exercises. They get people to collaborate together, to work a little bit outside of their box. There was chocolate involved, because it helps the creativity,

and helps people loosen up.

And what we were looking at was, you know, what are the overlaps between desires, what's feasible, and then what's actually viable.

And within that center there, that's the human centered design solution.

So, what do people want? What's really feasible? And then what's fiscally viable?

For this project, we really worked with staff, clinicians, and site administrations to brainstorm the barriers to accessibility and quality of care and those were the main questions when we worked together with the teams within these activities.

We did two exercises and we were conducting one called stakeholder mapping and one called affinity mapping.

So, we'll get a little bit more into this in a second.

You can see, stakeholder mapping here, it looks like a whole bunch of colorful spaghetti, but what we did was have them sit down and say okay, map out who are all the different stakeholders are, stakeholders being people who are involved in this system, this healthcare system that makes this particular -- each particular facility operate.

You can see Hospice, nurses, physicians, transportation, family caregivers, medical equipment, rehab. I mean, it's just a wide web of people who go into this complex healthcare system.

And you can see by the results and the complexity, it's very complex.

The connections and interactions between stakeholders varied. So, what does that tell us as designers? That the process itself is really difficult to streamline.

The most complex relationship are really internal, between staff and support organizations. You had social workers, everything seemed to go back to the social worker, which you can see is sort of at the top circled in yellow.

The role of the social worker was one of the most intense and over utilized within that system.

So, those are really important take-aways.

The complexities to the overall system and its impact on patient care, ADA related gaps pertaining to the physical space, which we'll get to in a minute, the perception of ADA needs within the physical space observed by staff, aligned with and expanded upon those that we identified during the site visit.

So, that was a great step towards validating our findings within the checklist.

They really started to align.

It also showed us that the local staff was really well aware of the needs of the patients and how the building itself impacts their access to care.

And this is the affinity mapping. So, the affinity mapping, you give everybody Post-It notes and we really -- we just asked them, okay, think of all of the problems that exist right now within your space.

And, you know, they worked together and just put down one -- the only rule was one

problem per Post-It note.

And then you can see in the picture on the top right, after they've had enough time to really get all of the problems out of their brains on the Post-It notes, we worked together and organized them into areas like -- you can see our outcomes here, small exam rooms, needed a more homey feel, the exam rooms weren't relaxing, which is a huge problem for people with dementia, small walkways and hallways, small office space for staff. Needed better music in the lobby, so the sensory element in the overall experience was really important, especially for the elder community. The parking lots were small, the doors themselves were often hard to open.

They needed more technology to implement education and training, needed better testing stations within the site, and equipment -- areas for equipment and sampling.

So, it was a really good way to, you know, to really hone in on specifics, things that we would never ascertain ourselves by walking around with a checklist; we really got a good deposition of input and information.

So, really, you know, looking at the design, the reason why we look at the design is as design researchers, we know that the built environment itself plays a role in patients' abilities to successfully engage in their environments and we wanted to gain key insights into access of care, specific mobility needs, and levels of satisfaction.

So, that's why we used the different sites across, why we used the multiple perspectives, sort of the checklists and the design thinking and the surveys, and then worked together to analyze the results to really give them guidance that they could apply to the interior design to benefit access to care.

So, when we're looking at design, here's a couple images of just -- this is the Florida Hospital for Seniors in Orlando, this was a bathroom on the top right and on the lower part was the waiting room.

So, at one site, you could see on the right, the paper towel dispenser was mounted at a height that was accessible to the recommended standards, but the location of the dispenser's handle you can see is all the way up to the right and it exceeded the height by six inches, so it was pretty awkward for anybody to actually reach up around and pull that lever down.

So, a lower-cost solution would be to plant maybe a bin or a tray filled with loose paper towels on the counter to increase reach itself, if they weren't able to. And the wall space was really small, so there wasn't a whole lot of other places that that particular dispenser could go. Or mounting just a single paper towel holder next to the sink might do the same thing.

So just bringing access and making it readily achievable, and better for everybody, really.

Seating in the lobbies are often arranged in such a way that the only available space for a person in a wheelchair to wait impeded upon the direct path of travel, so this creates a temporary obstruction on the space and creates a sense of burden and isolation for the

person in the wheelchair.

So that's easily achievable because that's space branding and arranging the furniture in a way that does not cause anybody to feel burdened or isolated, or that their physical location caused problems for anyone coming in the space, and a lot of our findings was similar to this. Easily achievable and a low cost solution that would have a big impact overall.

So, you know, the direct benefits of the study were determining the best fit design solutions, implementing them directly on-site, and then, you know, there is support that could be continually available, and then having the potential over time to evaluate the best fit solution.

So, in this study, just in conclusion, one out of 23 patients indicated a greater need for accessibility within an existing facility that already met 90% of the standards.

So, with an emphasis on creating environment and principles of universal design, it's really crucial for hospital managers and care managers to understand the needs of their patients.

So, in the meantime, with little to no financial investment, there are easily achievable design solutions that would help people with disabilities to create independent and value on return on investments, some things, you know, just like relocating signage, music, providing different, you know, seating arrangements, things like that, that seems small, but can make a major impact on the experience for a person with disabilities and their caregivers.

In addition to the quantitative investigational methods that we use, the checklist, further research into the impact of accessibility on healthcare for people with disabilities should, in the future, include feedback from medical staff and caregiver perception.

So, gaining more information from the people themselves.

When we did work with the people within the design thinking exercises, that really did give us a good well-rounded glimpse into what was going on and it allowed us as the researchers to look at, you know, first we use the validated tools, then we checked the reliability of the results through the direct impact from medical staff, they had an intimate understanding of the system and gave us information we never would have gotten by checklist alone.

So, the mixed methods approach was really valuable in producing thorough results and combined with the philosophy that encompassed universal design.

So, that is the end of that presentation.

[Pause].

>> CLAUDIA FRIEDEL: Well, thank you so much, Lesa. We have time for questions, so if anybody has any questions, please feel free to type them into the chat box.

I was with Lesa when we did one of the design thinking workshops and that was really fun, it was really fun to get to talk to all the folks that are there every day working in

these facilities.

And just seeing what they think about accessibility, what do they think it means, how can that site get there, and just thinking of all of the different stakeholders and what roles they play in that facility.

It was really interesting, so I was glad to be a part of that.

All right. We'll see if any questions have popped up. I don't see any. Bryan, do you see any?

>> BRYAN RUSSELL: No, nothing yet.

>> CLAUDIA FRIEDEL: Okay. Well, I don't know, Lesa, if you have your e-mail anywhere on the presentation? But maybe we can put that up in case anybody wants to e-mail you at a later time?

>> LESA LORUSSO: Hmm.... you know, I don't think I did. It's llorusso@ufl.edu. So, there's my last name, just put an L before it, and then @ ufl.edu.

>> CLAUDIA FRIEDEL: Okay, wonderful. We'll give it another minute, in case anybody thinks of anything.

[Pause].

>> CLAUDIA FRIEDEL: But we wanted to thank you so much for your time. And she will actually be presenting this work in a conference -- do you want to talk a little bit about APHA because we'll have you present on that on the third quarterly call.

>> LESA LORUSSO: Oh, sure, yeah. Yeah, so we're going to Atlanta in November for an APHA conference, and it's exactly this exact presentation, it's a stand-up PowerPoint presentation or podium presentation that I'll be giving there to the Disability Section of APHA. So that will be really exciting to present, on that stage and get feedback and be able to walk around and see what other people are doing within that field.

>> BRYAN RUSSELL: Hey, Lesa, this is Bryan. What day and time is the presentation?

>> LESA LORUSSO: Let me look. I know I fly out I think on the.... Monday the 5th.... um.... I can e-mail it to you. I fly up on Monday, I think I present on Tuesday, and then I come back down on the 8th. So, I can e-mail Claudia.

>> BRYAN RUSSELL: Yes, okay, great.

>> Well, I'm Ed Clark the evaluator for the disabilities coordinator, I'm asking because I have a presentation there, my presentation is going to be on the Monday around 5:10, so if there's not a conflict, I would like to see your presentation and see what you're doing when we're all there.

>> LESA LORUSSO: Oh, great! That would be awesome! Thanks.

>> That's wonderful.

>> CLAUDIA FRIEDEL: Go ahead, sorry.

>> Sorry, this is Susan Redmon, Lesa. I'm wondering if there's any plans to do follow-up within all of these facilities to see if any of the low-cost solutions could be put in place or have been put in place?

>> LESA LORUSSO: You know what? That's a great idea. Claudia and I should definitely talk about that and see if that's something that we can do, for sure.

[Pause].

>> CLAUDIA FRIEDEL: And then for I believe probably the third quarter webinar, Lesa will be come back to present from other talks, we'll probably have some highlights from this presentation as well, but she'll be attending other disability sections and presentations while APHA and will be kind of giving her participation for members and some take-aways from those presentations for our DCPG folks -- not everyone can go to APHA, it's a huge conference, but it's a great opportunity to be able to go. So, everyone can hear a little bit more about what's going on there. Yes?

>> This is Ed again. It's also on that Monday, if I'm not mistaken, I'm a part of a disability work group there with APHA and they're giving a tour of the Shepherd Center which is a rehabilitation center there regarding spinal column --

>> LESA LORUSSO: Oh, cool.

>> -- and they're providing shows from the event to the Shepard Center, it might be listed on their page but if not, I can forward you an e-mail that I received pertaining to that.

I think it's a good opportunity to see how people are actually doing that work on the ground.

My wife actually spent almost three months in that facility --

>> LESA LORUSSO: Oh, wow.

>> -- and they were very instrumental in helping her get her wits about herself and begin her role in recovery.

And I think it would be a great opportunity to see what people are doing and how they're doing it, and it's a state of the art what they have there.

>> Yeah, Shepherd is the gold standard.

>> Yeah, there's nothing like that on the East Coast. It sent me up for mental --

[Talking over one another].

>> LESA LORUSSO: Oh, no!

>> It's a wonderful place, though.

>> CLAUDIA FRIEDEL: Oh, wonderful. Well, yeah, definitely, send us that info and I'll pass it along to Lesa and hopefully she can attend on our program's behalf.

>> Okay.

>> CLAUDIA FRIEDEL: Well, hearing no -- or seeing no questions, we're going to go ahead and wrap up.

And just thank you all for joining us today. And to Lesa for presenting. And to all of our partners for attending.

So, thank you all so much.

We will send Lesa's presentation to the group, as well as with the CART notes, so look out for that.

And thank you for your time. Have a great day!

>> LESA LORUSSO: Great. Thanks, everybody.

>> BRYAN RUSSELL: Thank you.

[Concludes at 11:42 a.m.]

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