EXHIBIT A

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EXHIBIT B

# PRE-PHYSICAL BARRIER ACCESS SURVEY REMEDIATION PRIORITIES SCHEDULES[1]

## A. Non-BIMC Petrie Subject Facilities

1. Remediations to Perform at Non-BIMC Petrie Subject Facilities Within 3-6 Months of HCH Internal Evaluation:

    a. Train local building staff to periodically survey and move furniture, trash cans, and other movable objects to accommodate wheelchairs in hallways, circulation paths, and waiting areas
    b. Train local building staff to place existing accessible medical equipment in existing accessible exam rooms according to layout that preserves accessible amounts of space
    c. Secure floor mats
    d. Where the accessible route/circulation path is not the main route/circulation path, provide signage from the main route to an accessible route where possible/available, or implement policy solution where no accessible route is possible/available
    e. Provide signage outside inaccessible public bathrooms pointing to the nearest substantially accessible public bathroom
    f. Provide signage on how to request accommodations at major public areas like help/welcome desks, check-in desks, billing areas, in patient handbook, and on web site
    g. Remove clutter on accessible counters
    h. Develop policy solutions to architectural problems, such as emergency room check procedures for flashing alarm systems and clipboards for counters
    i. Place temporary cane-detectable objects (like cones) beneath hazards other than telephones and Purell dispensers protruding more than 4" from the wall with leading edges above 27" and less than 80".

2. Remediations to Perform at Non- BIMC Petrie Within 6-12 Months of HCH Internal Evaluation:

    a. Add Braille tape to signage where it is not already provided
    b. Adjust existing door closers
    c. Insulate pipes under sinks in substantially accessible bathrooms
    d. Remove high-pile, low-density carpeting
    e. Acquire temporary ramps at entrances where needed and feasible; train staff in how to use them

[1] Plaintiffs agree that they will not unreasonably withhold their consent to the extent the timeline for any of the remediations listed in this Agreement needs to be adjusted, taking into account that the proposed remediation schedule has been under discussion since February 2016. The Parties acknowledge that HCH has already implemented certain of the remediations listed herein at various Subject Facilities.

**B. BIMC Petrie Subject Facilities**

1. For units/floors in the BIMC Petrie Subject Facilities that have already been closed/are no longer in service and/or do not contain patient care spaces, no HCH Internal Evaluations or remediation work will be undertaken.

2. For units/floors in the BIMC Petrie Subject Facilities that are substantially empty, are in the process of being emptied/closed, and/or will be closed within the next year, the following interim remedial efforts shall be completed within 3-6 months of the HCH Internal Evaluation:

    a. Train local building staff to periodically survey and move furniture, trash cans, and other movable objects to accommodate wheelchairs in hallways, circulation paths, and waiting areas
    b. Train local building staff to place existing accessible medical equipment in existing accessible exam rooms according to layout that preserves accessible amounts of space
    c. Where the accessible route/circulation path is not the main route/circulation path, provide signage from the main route to an accessible route where possible/available, or implement policy solution where no accessible route is possible/available
    d. Provide signage outside inaccessible public bathrooms pointing to the nearest substantially accessible public bathroom
    e. Provide signage on how to request accommodations at major public areas like help/welcome desks, check-in desks, billing areas, in patient handbook, and on web site
    f. Remove clutter on accessible counters

3. For units/floors in the BIMC Petrie Subject Facilities that are slated to be emptied or closed within the next twelve (12) to twenty-four (24) months, in addition to the preceding items, the following interim remedial efforts shall be completed within 3-12 months of HCH Internal Evaluation

    a. Insulate pipes under sinks in substantially accessible bathrooms
    b. Remove high-pile, low-density carpeting
    c. Adjust existing door closers
    d. Acquire temporary ramps at entrances where needed and feasible; train staff in how to use them
    e. Add Braille tape to signage where it is not already provided
    f. Secure floor mats if needed and possible/practicable
    g. Develop policy solutions to architectural problems, such as emergency room check procedures for flashing alarm systems and clipboards for counters
    h. Place temporary cane-detectable objects (like cones) beneath hazards other than telephones and Purell dispensers protruding more than 4” from the

wall with leading edges above 27” and less than 80” if said protruding hazards have not been relocated or will not be relocated within 3 months.

4. For units/floors in the BIMC Petrie Subject Facilities that are not slated to be emptied/closed within the next two (2) years, those units/floors will be subject to the interim remediation proposals set forth in Section A herein.

EXHIBIT C

# POST-SWA PHYSICAL BARRIER ACCESS SURVEY REMEDIATION PRIORITIES SCHEDULES[1]

. **Remediations to Perform at Non-BIMC Petrie Subject Facilities Within 3-6 Months After Expert Survey is Completed at the Subject Facility**

**1.** All of the following items (from Section A.1 of the "Pre-Physical Barrier Access Survey Remediations Priority Schedule" document (Exhibit B)) to the extent not already accomplished pre-Physical Barrier Access Survey:

a. Train local building staff to periodically survey and move furniture, trash cans, and other movable objects to accommodate wheelchairs in hallways, circulation paths, and waiting areas
b. Train local building staff to place existing accessible medical equipment in existing accessible exam rooms according to layout that preserves accessible amounts of space
c. Secure floor mats
d. Where the accessible route/circulation path is not the main route/circulation path, provide signage from the main route to an accessible route where possible/available, or implement policy solution where no accessible route is possible/available
e. Provide signage outside inaccessible public bathrooms pointing to the nearest substantially accessible public bathroom
f. Provide signage on how to request accommodations at major public areas like help/welcome desks, check-in desks, billing areas, in patient handbook, and on web site
g. Remove clutter on accessible counters
h. Develop policy solutions to architectural problems, such as emergency room check procedures for flashing alarm systems and clipboards for counters

[1] This section describes priority and timing of remediations of architectural barrier issues identified by SWA, and does not seek to limit the items that must be remedied. SWA will perform verification inspections with respect to all remediations performed hereunder in accordance with the processes identified in the Global Settlement Agreement.

The timeframes set forth in this document apply to all of the Subject Facilities (other than BIMC Petrie Subject Facilities) that have not yet been surveyed. For Subject Facilities (other than BIMC Petrie Subject Facilities) that have already been surveyed, the timeframes set forth herein will begin to run as to each such Subject Facility once the parties have agreed upon a final remediation plan for said Subject Facility, to the extent that there are still remediations described in this section that are yet to be performed.

Plaintiffs agree that they will not unreasonably withhold their consent to the extent the timeline for any of the remediations listed in this document needs to be adjusted, taking into account that the proposed remediation schedule has been under discussion since February 2016. The Parties acknowledge that HCH has already implemented certain of the remediations listed herein at various Subject Facilities.

i. Place temporary cane-detectable objects (like cones) beneath hazards other than telephones and Purell dispensers protruding more than 4" from the wall with leading edges above 27" and less than 80".

**2.** Begin process of constructing or altering ramps at entrances where needed, feasible, and the parties have agreed that ramp construction is the appropriate solution

**A. <u>Remediations to Perform at Non-BIMC Petrie Subject Facilities Within 6-12 Months After Expert Survey is Completed at the Subject Facility</u>**

**1.** All of the following items (from Section A.2 of the "Pre-Physical Barrier Access Survey Remediations Priority Schedule" document (Exhibit B)) to the extent not already accomplished pre-Physical Barrier Access Survey:

a. Add Braille tape to signage where it is not already provided
b. Adjust existing door closers
c. Insulate pipes under sinks in substantially accessible bathrooms
d. Remove high-pile, low-density carpeting
e. Acquire temporary ramps at entrances where needed and feasible; train staff in how to use them

**2.** Replace (inaccessible) door handles that require tight grasping, pinching, or twisting of the wrist that are identified in SWA's survey reports with accessible door handles (that do not require tight grasping, pinching, or twisting of the wrist) unless not readily achievable or the door to which the identified knob/handle is attached will otherwise be replaced with a door that has an accessible door handle within 12 months of SWA survey completion.

**3.** Place permanent cane-detectable objects beneath hazards other than telephones and Purell dispensers protruding more than 4 from the wall with leading edges above 27" and less than 80" if said protruding hazards have not been relocated or will not be relocated within 6 months of SWA survey completion.

**B. <u>Remediations to Perform at Non-BIMC Petrie Subject Facilities Within 12-18 Months After Expert Survey is Completed at the Subject Facility</u>**

**1.** Install automatic door openers where other door alterations or policy solutions are not sufficient and where financially viable, with first priority going to doors in high-traffic main paths of travel

**2.** Reposition televisions, telephones, racks of informational materials, and other wall-mounted objects at compliant heights

**3.** Lower inaccessible counters in rooms that are otherwise being remediated/renovated, where practicable and possible and previously implemented policy solution of providing clipboards is not sufficient.

**4.** In accessible bathrooms, lower mirrors, coat hooks, toilet paper dispensers, paper towel dispensers, and toilet controls, where possible.

**5.** Lower coat hooks and/or install accessible coat hooks in other accessible rooms.

EXHIBIT D

# MOUNT SINAI BETH ISRAEL/MOUNT SINAI BROOKLYN

Administrative Policy and Procedure Manual
Policy No. 2002

**POLICY TITLE:** Patient Complaints and Grievances including ADA/Section 504 Grievances Procedure, Centralization and Management

**POLICY:** Patients' complaints and grievances are resolved promptly in accordance with New York State law and other federal and regulatory requirements. It is both a fundamental value and the policy of the hospital not to discriminate on the basis of disability. Mount Sinai Beth Israel (MSBI)/Mount Sinai Brooklyn (MSB) has adopted an internal grievance procedure providing for prompt and equitable resolution of grievances alleging any action prohibited by the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 ("Section 504") and regulations of the U.S. Department of Health and Human Services implementing Section 504. Section 504 prohibits discrimination on the basis of disability. Section 504 and the regulations may be examined in the office of the Section 504 Disability Coordinator who has been designated to coordinate the efforts of MSBI to comply with Section 504.

**PURPOSE:** A patient, or his or her representative, may voice a complaint or grievance, or recommend service delivery changes, to any member of the hospital staff without being subject to coercion, discrimination, reprisal or unreasonable interruption of care, treatment, and services. These issues, concerns or requests will be investigated and responded to in a non-judgmental and timely manner. Information gathered from the aggregation and trending of complaint/grievance data will be used for system evaluation and improvement.

**PROCEDURE:**

**Notification of Procedure For Non ADA/Section 504 Grievances**

1. The complaint/grievance process is communicated to patients and their representatives in material in the admitting packet, on Patient's Bill of Rights posters throughout the hospital, on free patient education TV channels, and by all employees to whom patients may express their dissatisfaction. These documents are to be available in alternative formats (i.e., large font), if requested.

2. The staff is educated regarding this procedure by means of the Patient Representative presentation at New Associate Orientation and via annual Core Competency training.

**Management of Complaints**

A complaint is defined as an issue raised verbally by a patient/surrogate//healthcare proxy which is resolved promptly by staff present and to the patient/surrogate/healthcare proxy's satisfaction.

- Staff present includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e., nursing, administration, nursing supervisors, patient advocates, etc.) to resolve the patient's complaint.

# MOUNT SINAI BETH ISRAEL/MOUNT SINAI BROOKLYN

Administrative Policy and Procedure Manual
Policy No. 2002

A grievance is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's surrogate/healthcare proxy, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations

## A. Management of Grievances

- If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements. A complaint is considered resolved when the patient is satisfied with the actions taken on their behalf.

- Billing issues are not usually considered grievances for the purposes of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 is considered a grievance.

- A written complaint is always considered a grievance. This includes written complaints from an inpatient, an outpatient, a released/discharged patient, or a patient's representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with CoPs. For the purposes of this requirement, an email or fax is considered "written."

- Information obtained from patient satisfaction surveys usually does not meet the definition of a grievance. If an identified patient writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance. If an identified patient writes or attaches a complaint to the survey but has not requested resolution, the hospital must treat this as a grievance if the hospital would usually treat such a complaint as a grievance.

- Patient complaints that are considered grievances also include situations where a patient/surrogate/healthcare proxy telephones the hospital with a complaint regarding the patient's care or with an allegation of abuse or neglect, or failure of the hospital to comply with one or more CoPs, or other CMS requirements. Those post-hospital verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.

- All verbal or written complaints regarding abuse, neglect, patient harm, or hospital compliance with CMS requirements are considered grievances for the purposes of these requirements.

- Discharge Appeals are managed according to Admin P&P 4004 which outlines the patient's right to appeal their discharge, the role of the QIO in the process, and the established procedure to follow.

- Whenever the patient/surrogate/healthcare proxy requests that his or her complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital, the complaint is considered a grievance and all the requirements apply.

- Hospital staff will strive to respond to a grievance as soon as practicable. If the grievance is complex and it is determined that resolution will take longer than 7 days, the Hospital shall promptly notify the patient/representative in writing or by telephone that the grievance has been received, the hospital is still working to resolve the grievance and will follow-up with a final written response within four weeks from the date the grievance was received. If the matter requires additional time beyond the four week period, the patient/representative will be notified in writing and this letter will include a revised date of completion.

- Responses may include meetings with staff and telephone calls, but all grievances must receive written responses from the Department/Administrator involved or from the Patient Representative Department detailing the steps taken to investigate the grievance, the results of the investigation, any corrective action taken, the date of completion and the name of a contact person.

- Data collected regarding patient grievances, as well as other complaints that are not defined as grievances (as determined by the hospital), must be incorporated in the hospital's Quality Strategy Advisory Group (QSAG).

**Actions Taken:**

1. The Patient Representative will make appropriate referrals to Quality Improvement, Risk Management, and Utilization Management, if the situation warrants such referral.

2. All grievances and the nature of the action taken and resolution are entered in the Patient Representative database for tracking and trending and are reported monthly to the Patient Safety/Grievance Committee. All paper correspondence will be copied to the Patient Representative Department for the Central File.

3. Aggregate reports summarizing patients' complaints/grievances are compiled and provided to the Patient Safety/Grievance Committee and to appropriate departments as necessary. Results are used to identify opportunities for improvement. Aggregate reports are reviewed by the committee, senior administration and the Quality Strategy Advisory Group (QSAG) semi-annually to evaluate ongoing compliance with the grievance policy. The QSAG

reports to the hospital wide Quality Performance Improvement Committee (QPIC) and QPIC reports to the Board of Trustees at least semi-annually.

4. If the complainant is not satisfied with the hospital's response to the complaint/grievance, he or she will be provided with the New York State Department of Health hospital complaint telephone number and/or address.

5. Complaints/grievances relating to physician behavior or quality are managed in coordination with the Chief Medical Officer. Complaints/grievances relating to physicians are also forwarded to the Chairs for review in the appointment and reappointment processes.

**B. ADA/Section 504 Grievances Policy and Procedure**

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. The grievance may also be filed on behalf of the aggrieved person by a family member, friend, or other advocate. Consistent with MSBI/MSB's policies and the law, MSBI/MSB will not retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

**Procedures:**

1. Grievances must be submitted to the ADA/Section 504 Disability Coordinator within thirty (30) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

2. The grievance may be made in any of the following forms:

   - In a written document mailed, emailed, faxed, or otherwise delivered to the ADA/Section 504 Disability Coordinator.
   - In a telephone call to the ADA/Section 504 Disability Coordinator.
   - Orally to a Department Manager or facility supervisor.

   The Director of the Patient Representative Department is the ADA/Section 504 Disability Coordinator. The Director can be reached at:

   MSBI: Telephone Number: (212) 420-3818; or via Fax: (212) 420-5606.
   MSB: Telephone Number (718) 951-3005; or via Fax: (718) 951-2726

3. The grievance should include the following information:

   - the name, address, telephone number, email address, and/or other contact information of the person filing it; and

- a statement of the problem or action alleged to be discriminatory, including supporting details and the requested remedy or relief.

4. The ADA/Section 504 Disability Coordinator (or her/his designee) shall conduct an investigation of the complaint. The investigation will include interviews, which may be telephonic, of the aggrieved person and witnesses. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The investigator will be mindful of the right of the aggrieved person to confidentiality and privacy of the information obtained during the investigation consistent with the conduct of a reasonable investigation of the grievance. The ADA/Section 504 Disability Coordinator (or her/his designee) will maintain the files and records of MSBI/MSB relating to such grievances.

5. The Section 504 Disability Coordinator will issue a written decision on the grievance no later than 30 days after its filing, which will be available in alternative formats.

6. The person filing the grievance may appeal the decision of the Section 504 Disability Coordinator by writing, telephone or fax to the Chief Compliance Officer within fifteen (15) days after receiving the Section 504 Coordinator's decision. The Chief Compliance Officer shall issue a written decision in response to the appeal no later than thirty (30) days after its filing, which will be available in alternative formats.

   The contact information for the Chief Compliance Officer is:
   Telephone Number: (212) 523-2162

7. The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights, or with an appropriate state or local agency.

8. MSBI/MSB will make appropriate arrangements to ensure that disabled persons are provided other reasonable accommodations, if needed, to participate in this grievance process. The ADA/Section 504 Disability Coordinator (or her/his designee) will be responsible for such arrangements.

9. In case of questions or concerns, please contact:

   The Director of the Patient Representative Department (the ADA/Section 504 Disability Coordinator) who can be reached at:

   MSBI: Telephone Number: (212) 420-3818 or Fax (212) 420-5606

**MOUNT SINAI BETH ISRAEL/MOUNT SINAI BROOKLYN**

Administrative Policy and Procedure Manual

Policy No. 2002

MSB: Telephone Number (718) 951-3005 or Fax (718) 951-2726

Originating Department: Patient Representative

AP 2002 Revised: 08/01, 08/03, 4/05, 4/09, 4/11, 8/12, 7/13, 5/14, 4/15, 12/15, 11/16

Reviewed: 4/05, 1/07, 1/09, 4/09, 4/11, 8/12, 7/13, 5/14, 4/15, 12/15, 11/16

# MOUNT SINAI BETH ISRAEL/MOUNT SINAI BROOKLYN

Administrative Policy and Procedure Manual

Policy No. 2024G

**POLICY TITLE:** Use of Service Animals by Persons with Disabilities

**PURPOSE:** To assist staff in providing reasonable accommodations for patients and/or visitors requiring the use of service animals.

**POLICY:** Consistent with Mount Sinai Beth Israel and Mount Sinai Brooklyn's commitment toward providing a barrier-free environment for people with disabilities, the Medical Centers supports the use of service animals within its facilities.

**COMPLIANCE WITH LAW:**

Mount Sinai Beth Israel and Mount Sinai Brooklyn (MSBI/MSB) have developed these Policies and Procedures to ensure full compliance with the obligations, terms, and conditions consistent with relevant Federal, State, and City laws including the revised final regulations implementing the Americans with Disabilities Act (ADA) for title III (public accommodations and commercial facilities).

**DEFINITIONS:**

1. An “individual with a disability” means a person who has a physical or mental impairment that substantially limits one or more major life activities including, but not limited to, walking, talking, seeing, breathing, or hearing.

2. Service animals are dogs that have been individually trained to do work or perform tasks for a person with a disability. Examples of such work or tasks include, but are not limited to, guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post-Traumatic Stress Disorder during an anxiety attack, or performing other duties. A service animal does not have to have a license or certification. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

3. Miniature horses that have been individually trained to do work or perform tasks for the benefit of an individual with a disability shall be permitted to accompany patients or visitors to the Medical Center. The Patient Representative Department or the Nursing Supervisor should be called to facilitate accommodation with the ADA Coordinator based on the following considerations.
    (1) Whether they are housebroken;
    (2) Whether they are under the owner’s control;
    (3) Whether the Medical Center can accommodate the horse’s type, size, and weight;
    (4) Whether the horse’s presence compromises legitimate safety requirements necessary for the safe operation of the Medical Center.

4. Direct Threat: A significant risk to the health or safety of others that cannot be eliminated or mitigated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services. The existence of a direct threat needs to be made on a case-by-case basis.

5. Fundamental Alteration: A modification that is so significant that it alters the essential nature of the services offered.

**PROCEDURE:**

1. Individuals with disabilities accompanied by service animals shall be allowed in all areas of the Medical Center that are unrestricted to inpatients, outpatients, or visitors (e.g. lobbies, waiting areas, standard patient rooms, cafeterias, and examination rooms) provided that the service animal does not pose a direct threat and that the presence of the service animal would not require a fundamental alteration to the provision of the Medical Center's policies, practices, or procedures.

2. A determination to exclude a service animal shall be based on an individualized assessment made by the physicians, nurses or other licensed health care providers with the ADA Coordinator based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain the nature, duration, and severity of the risk to health and safety the service animal poses; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk. Decisions may not be made on the basis of bias, stereotype, or assumptions about how a particular animal is likely to behave.

    a. Service animals are not allowed in areas in which a sterile environment is maintained such as operating rooms, surgical suites and other locations for invasive procedures where a sterile field is present, or the central sterile processing department and food preparation areas.

3. When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask if the dog is a service animal required because of a disability and what work or task the dog has been trained to perform.

4. Staff <u>may not</u> ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

5. Individuals with disabilities must keep their service animals under control at all times, including keeping their service animals on a leash or in a harness, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices, in which case the individual must maintain control of the animal through voice, signal, or other effective controls..

6. A person with a disability cannot be asked to remove his service animal from the premises unless (a) the dog is out of control and the handler does not take effective action to control it within a reasonable amount of time or (b) the dog is not housebroken.

7. When there is a legitimate reason to ask that a service animal be removed, staff must offer the person with the disability the opportunity to obtain services without the animal's presence.

8. The Patient Representative or Nursing Supervisor (evenings and weekends) will assist in arranging escorts for individuals with disabilities in the event that service animals are not permitted into a restricted area after an individualized assessment is made. Contact the Security Department if previous arrangements have not been made for the disposition of the service animal.

9. The animal's handler is responsible for making arrangements with family, friends, or accompanying persons to take care of the animal's physical needs (i.e., feeding, walking, grooming, etc.) and to clean up after the service animal. Staff members are not required to provide care or food for a service animal.

10. In the event someone in the area of the service animal has asthma, allergies to the animal, or a phobia about animals, the Medical Center shall modify its policies, practices, and procedures to permit a service animal to remain with a patient by, for example, moving the patient to another comparable room, changing staff schedules, or using other nondiscriminatory methods.

11. MSBI/MSB shall instruct and train all medical personnel and staff, including security personnel, on the provisions of this policy upon hire and annually.

12. A copy of this policy shall be provided upon request in an accessible format to every service animal user seeking access to MSBI/MSB as a patient or visitor.

Originating Department: Infection Control/Patient Care Services /Patient Representative
AP2024G Revised: 3/99, 4/02, 10/02, 2/03, 4/04, 8/11, 4/15, 1/16
Reviewed: 3/99, 4/02, 10/02, 2/03, 4/04, 9/03, 4/04, 5/05, 9/07, 2/09, 8/11, 2/13, 4/15, 1/16

**Mount Sinai Beth Israel / Mount Sinai Brooklyn**
Administrative Policy and Procedure
Policy No. 2024H

**POLICY TITLE:** Effective Communication for Patients Who Are Blind or Low Vision

**PURPOSE:** This policy sets forth a process to provide individuals with vision disabilities, as well as individuals who have other cognitive and/or communication-related disabilities, who may need alternative formats as necessary for effective communication. Under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act as amended, hospitals and medical facilities must provide effective means of communication for patients, companions or family members, and hospital visitors who are blind or visually impaired. The duty to provide effective communication includes, but is not limited to, access to information communicated through the MSBI website The State of New York (Chapter 92, Section 1, Subdivision 9 of Section 2803-I and 2803-t) requires hospitals to provide discharge plans and preadmission information as large print documents or, upon request of the patient or patient's representative – as an audio recording made available as a CD, an electronically transmitted digital file, or other recorded medium that the hospital provides, in addition to a written copy of the information. These documents and recordings are made available free of charge.

**PROCEDURES:**

1. Upon Admission, all patients who are blind or low vision will be provided a large print version of preadmission information, at the patient's or patient's representative request. The large print version of the preadmission packet is available on Forms on Demand.

2. Patients who are blind or low vision accompanied by service animals shall be allowed in all areas of the Medical Center as permitted by Administrative Policy and Procedure No. 2024G, "Use of Service Animals by Persons with Disabilities."

3. If the patient is deaf-blind, contact the Sign Language Program at 212-844-8445 and request a sign language interpreter who can communicate with patients who are deaf-blind.

4. If no alternative format is available that meets the patient's communication needs and preferences, hospital staff may read aloud any forms the patient is required to sign (i.e., consents, health care proxy, etc.). See Exhibit A of this policy - Instructions for Use of Readers.

   Upon discharge, all patients who are blind or low vision will be provided a large print version of the patient's discharge plan, or at the patient's or patient's representative's request, an audio recording will be made available in addition to the written copy. For patients with smart phones, a recording of the discharge instructions may also be made available using the recording feature of their phones. Digital voice recorders will be provided by the Patient Representative Department. During off-hours, contact the nurse supervisor on duty and request a digital voice recorder.

5. Assistive devices such as telephones with large numbers or magnifiers are available through the Patient Representative Department on a loaner basis. During off-hours, contact the nurse supervisor on duty and request these items as needed.

6. Patients who are blind or low vision access written communication in a variety of formats. Some persons who are blind or low vision have sufficient vision to read large print; others may not have this skill. Not all persons who are blind or low vision read braille. Some people who are blind or low vision:
   - Use specialized software to access the Internet ("screen reader software")
   - Use screen magnification software to enlarge the size of the text
   - Use software that speaks the content of the website aloud or renders in braille.

7. MSBI/MSB staff should consult with each individual patient to assess their communication needs and preferences. This is mandated by law.
   - Appropriate steps should be taken to ensure that all personnel having contact with a patient, companion or visitor are made aware of such person's vision disability so that effective communication is achieved.
   - MSBI/MSB may need to provide documents in alternative formats. **(See Exhibit A of this policy for guidelines on Alternative Formats.)** MSBI/MSB shall make documents in alternative formats available to patients with vision disabilities within a reasonable time frame to ensure effective communication.

8. Patients who are blind or have low vision have special needs for interpreting their environment. The following guidelines can help make their hospital stay as easy and comfortable as possible:

   - **Communication**
     a) Always verbally identify yourself when you approach and introduce other people in the room.
     b) Do not leave without letting the patient know.
     c) Introduce yourself and address the patient by name, so they know you are talking to them and not to another patient in the next bed.
     d) Introduce the patient to any roommates and ask him/her what assistance they need or how they would like to be assisted.
     e) Always inform the patient before starting any procedure, especially if the procedure requires physical contact. It can be very unnerving for a person who is blind to be touched without warning. Ask the patient if they have any questions.
     f) Never distract or touch a service animal without asking the owner.
     g) Be prepared to provide written materials in an auditory format, on computer disc, in Braille or large print.

   - **Orientation to the room**
     h) Mobile patients should be oriented to their room starting from a central point, such as their bed. Walk with the patient rather than giving only verbal directions. This helps them learn distances and pick up sensory cues, so next time they can make the trip independently.

i) Staff should be welcoming and describe the physical environment (doors, steps, ramps, bathroom location, etc.).
j) Tell the patient where personal affects (clothes or belongings) are in the room and do not move them without telling the patient.
k) Don't unnecessarily move the patient's belongings, the furniture, or equipment in the room. If items are moved, let the patient know their new location.

- **Meals**

l) Read aloud menu items and let the patient choose his/her meal.
m) Tell the patient when his/her meal has arrived, where the tray is placed, and the contents of it. You can either use the clock-face method (e.g., the meat is at 6 o'clock), or by saying, items are at the top, bottom, right or left side of the plate.
n) Ask the patient if he/she needs assistance with removing packaging from items and provide any hot drinks in non-spill containers and tell the patient where they are placed.

Originating Department: Patient Representative
Revised: 01/14, 2/16
Reviewed: 4/10, 1/12, 1/14, 2/16

# Exhibit A – Guidelines for Providing Documents in Alternative Formats

## ALTERNATIVE FORMATS:

Definition: Braille, large print, audio, and electronic formats that provide effective communication of print information to individuals with disabilities

Appropriate Alternative Formats may include, but are not limited to:

- Accessible PDF
- Audio format
- Braille
- Descriptive or audio narration
- Electronic Format
- Large Print
- Written notes

## DOCUMENTS THAT MAY BE REQUIRED IN ALTERNATIVE FORMATS:

MSBI/MSB shall be prepared to provide patients with the following types of documents in alternative formats:

- Medication and prescription information, such as the name of the prescription, instructions for taking the medication, dosage, and side effects. Admissions instructions and paperwork.
- Obtaining informed consent for treatment.
- Advising about patients' rights and privacy protections.
- Explanation of procedures, tests, and treatments.
- Diagnosis and explanation of diagnosis or prognosis.
- Discharge and other follow-up instructions.
- Educational materials and services, such as brochures provided to patients.
- Descriptions of programs and/or services provided by MSBI/MSB.

## INSTRUCTIONS FOR USE OF READERS:

Consent forms and other information may be read to patients, consistent with their privacy rights. Any such information must be read to the person with a vision disability completely, effectively, accurately, and impartially. This information should also be offered in an alternative format for the patient's personal record keeping.

Mount Sinai

# Tips for Treating Patients with Physical and Sensory Disabilities

## *Remember to:*

- Speak directly with the patient, not to any companion that the patient may have.
- Avoid making assumptions about what assistance the patient needs. Offer assistance, wait for offer to be accepted and wait for instructions.
- Ask how you can help them and *respect* their answers.
- Presume that patients with disabilities are competent to handle their own medical care. If patients do not have anyone to assist them, do not ask them whether they brought an aide or a companion.
- Allow time for history taking and thorough exam.
- Use "person-first" language when referring to patients with disabilities (i.e. person who is blind, person who uses wheelchair, person with hearing loss) unless the patient asks to be referred to in another manner.
- Don't be afraid to ask the patient questions if you are unsure.

## *Blind or Low Vision Patients*

- Always verbally identify yourself when you approach and introduce other people in the room.
- Do not leave without letting the patient know.
- Ask before you help. Always ask how they would like to be assisted. Ask the person before you touch him/her to offer help.
- Be prepared to provide written materials in an auditory, tactile, or electronic format of the patient's preference (CD, Braille, large print).
- Verbally explain procedures before beginning treatment and ask the patients if they have any questions.

- Tell the patient where personal affects (clothes and other belongings) are in the room and do not move them without telling the patient.
- Staff should be welcoming and describe the physical environment (doors, steps, ramps, bathroom location, etc.).
- Never distract or touch a service animal without asking the owner.

## *Hearing Loss Patients*

- Ask how best to communicate.
- Be prepared to give written materials as long as they are not the primary form of communication.
- Inform patients that sign language interpreting and real-time captioning services are available.
- If requested, promptly provide sign language interpreting or real-time captioning service for effective communication.
- Do not talk at a distance from them or from another room.
- Look directly at the patient when speaking so they can see your mouth.
- Speak normally and clearly. Do not shout, exaggerate mouth movements, or speak rapidly.
- Minimize background noise and glare.

## *Deaf Patients*

- Ask how best to communicate.
- Inform patients that sign language interpreting and real-time captioning services are available.
- If requested, promptly provide sign language interpreting or real-time captioning service for effective communication.
- Family members should not be used to interpret.
- Address the patient, not the interpreter.
- Be prepared to give written materials as long as they are not the primary form of communication.

## *Wheelchair Users*

- Make sure there is a path of access to the room.

- Respect personal space, including wheelchair and assistive devices.
- Do not propel the wheelchair *unless* asked to do so.
- Provide accessible equipment as needed.
- Provide assistance as needed, such as by clearing obstacles from the path of travel or helping patients transfer to equipment if accessible equipment is unavailable.
- Do not separate patients from their wheelchairs.
- Do not examine patients while seated in their wheelchairs if the examination requires a person to lie down.

## *Questions*

- If you have any questions or need assistance in caring for patients with disabilities, please call:
    - Patient Representative Department at xxx-xxx-xxxx, or
    - Nursing Supervisor, xxx-xxx-xxxx

**References**

"Access to Medical Care: Adults with Physical Disabilities", World Institute on Disability, ISBN Number: 0-942799-08-0, Published 2011.