WELL Innovations Proposal

Universal Design

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OVERVIEW

Steven Winter Associates, Inc. (SWA) is pleased to submit this Innovations Proposal to the International WELL Building Institute (IWBI) for consideration. SWA has been an early supporter of the WELL Building Standard (WELL); particularly, to examine the relationship between WELL and the design of the built environment for people with disabilities. This document outlines the need for Universal Design to be incorporated into WELL, along with recommendations for implementation.

BACKGROUND

Disability and Health

There are approximately 57 million Americans living with disabilities in the United States; worldwide, people with disabilities make up 15% of our population.[i] Over the last decade, research has emerged that highlights the importance of promoting health within the disability community.[ii] The primary, often overlooked, connection between disability and health is that many of the issues targeted by public health initiatives (i.e., asthma, diabetes, heart disease, mental illness, etc.) qualify as disabilities under the Americans with Disabilities Act (ADA).[iii] Moreover, adults with disabilities are likely to experience worse health than those without disabilities; and are more likely to have diabetes, arthritis, asthma, and are more likely to experience obesity. In addition, people with disabilities are more likely to engage in unhealthy behaviors that put their health at risk, such as cigarette smoking and lack of physical activity.[iv]

Following this research, it can be surmised that people with disabilities are in greater need of targeted public health strategies than people without disabilities. This need becomes increasingly important for public health strategies that focus on the built environment, as it is widely recognized that people with disabilities are heavily influenced by their surroundings.[v] In fact, Healthy People 2020 lists the built environment as one of the main determinants of health for people with disabilities; and cites the design of the built environment as being critical to, “achieve growth, development, fulfillment, and community contribution” for the disability community.[vi] Given this information, it is paramount that any health initiative, specifically one which strives to impact the design, operations, and management of buildings, concertedly address the needs of the disability community.

WELL and Design for Disability

The WELL Building Standard addresses accessibility for people with disabilities in *Feature #72: ADA Accessible Design standards*, which identifies compliance with the ADA as a precondition for all building types. While this ensures a certain level of structural access, these design requirements are considered to provide “minimum” levels of accessibility.[vii] Moreover, the ADA remains largely silent on design strategies that would benefit users with non-physical disabilities; such as design for developmental or intellectual disabilities, sensory disabilities, and emotional and mental disabilities, among others. To address these design needs, one would need to go beyond what is required by federal law, looking to initiatives such as Universal Design to provide a more nuanced design approach for people with disabilities.

Universal Design and Health

While the origin of Universal Design is deeply rooted in creating inclusive environments for people with disabilities, as is highlighted by the Seven Principles of Universal Design: Equitable Use, Flexibility in Use, Simple and Intuitive, Perceptible Information, Tolerance for Error, Low Physical

Effort, and Size and Space for Approach and Use; the overall intent is to design equitable and usable spaces for people of all abilities and ages. As the concept evolved since its inception in the 1970s, Universal Design has broadened to address aspects of inclusion, health, and social equity, while continuing to champion the design of high performance spaces for people with disabilities. A more recent definition that has emerged for Universal Design is, "a process that enables and empowers a diverse population by improving human performance, health and wellness, and social participation".[viii] This new classification positions Universal Design strategies as simple, smart, and intuitive design concepts that create better environments for all building occupants.

At their core, Universal Design strategies strive to promote flexible, usable, and intuitive spaces; that in turn can contribute to reducing anxiety, promoting safety, and leading to overall healthier, more equitable, and more usable environments for all building occupants. In addition, aspects of universally designed environments can encourage social participation for people with disabilities, and contribute to avoidance of disease and prevention of injury. Examples of Universal Design strategies include, but are not limited to:

- **Physical Access**: Widening doorways and routes, flexible use of space, and increased usability beyond ADA requirements;
- **Developmental and Intellectual Health**: Applying strategies that use color, texture, and perceptible information to aide individuals with autism, learning disabilities, and cognitive disabilities;
- **Wayfinding**: Implementing strategies to help individuals navigate through spaces with ease, including signage, design elements, technology, and intuitive flow;
- **Inclusion**: Developing operational policies and procedures that are inclusive of people with disabilities;
- **Technology**: Offering accessible technology that encompasses the needs of people with disabilities; including audio and visual equipment, and web access; and
- **Safety**: Removing impediments to safety that cause anxiety, stress, and psychological harm to provide easy access to all features, elements, and spaces of buildings and communities.

RECOMMENDATION

SWA recommends incorporating Universal Design strategies into WELL to directly address the health needs of people with disabilities and to contribute to WELL's overall mission to create healthy, equitable, and safe environments for all building occupants. SWA has provided two options for implementing this recommendation, which could either be applied singularly, or, more preferably, in combination.

Option 1: Revise Feature 72

Feature 72: ADA Accessible Design Standards should become, *Feature 72: Universal Design* with three parts:

Part 1: Environmental Access
a. Buildings comply with current ADA Standards for Accessible Design*
b. Buildings offer increased levels of accessibility beyond the ADA, where feasible**

Part 2: Perceptible Information
a. Wayfinding tools are incorporated such as maps, signage, and technology
b. Company website complies with Section 508 of the Rehabilitation Act of 1973

Part 3: Inclusion

a. Establish policies and procedures that accommodate visitors, guests, and employees with disabilities
b. Conduct training annually on the nondiscrimination policies and procedures of the ADA

**The ADA Standards could be replaced with a recent version of the International Building Code (IBC): Chapter 11 on Accessibility, which outlines accessibility requirements that are similar to the ADA. Unlike the ADA, the IBC is an international standard which could be more applicable given the global reach of WELL Certification.*

***WELL could offer references such as The Universal Design Guidelines New York City 2 to assist the project team with achieving this subpart.*

Option 2: Incorporate Universal Design into existing Features

Revise current WELL Features to include elements of Universal Design. This would require an in-depth review of each feature; some examples could include:

- Feature 85: Integrative Design could include the addition of an accessibility or universal design consultant as critical to the stakeholder charrette group.
- Feature 86: Include a question related to the ease of maneuvering, operability, and inclusion for people with disabilities.
- Feature 87: Include design strategies incorporating color, texture, and senses for developmental and intellectual disabilities.

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[i] World Health Organization [and] The World Bank. World Report on Disability. 2011, http://www.who.int/disabilities/world_report/2011/report/en/.

[ii] Andresen, E.M., Lollar, D.J., and Meyers, A.R. "Disability outcomes research: why this supplement, on this topic, at this time?" National Institutes of Health. Archives of Physical and Medicine and Rehabilitation 2000 Dec; 81(12 Suppl 2):S1-4.

[iii] "Who has a Disability under the ADA." Illinois Legal Aid Online. https://www.illinoislegalaid.org/legal-information/who-has-disability-under-ada.

[iv] Boslaugh, S.E. and E.M. Andresen. "Correlates of Physical Activity for Adults With Disability." *Preventing Chronic* Disease 3.3 (2006): A78. Print.

[v] "Chapter 6: Disability and the Environment." *Enabling America: Assessing the Role of Rehabilitation Science and Engineering,* edited by Ed. Edward N. Brandt, Jr. and Andrew M. Pope. 1997, pp. 147 – 169. https://www.nap.edu/read/5799/chapter/8.

[vi] "Disability and Health: Overview." *Healthy People 2020*. U.S. Department of Health and Human Science Services: Office of Disease Prevention and Health Promotion. https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health

[vii] *2010 ADA Standards for Accessible Design.* [Washington, D.C.]: U.S. Department of Justice, 2010. https://www.ada.gov/regs2010/2010ADAStandards/2010ADAstandards.htm

[viii] "What is UD?" UniversalDesign.Com. Steinfeld and Maisel, 2012. http://www.universaldesign.com/what-is-ud/