National League for Nursing

NLN VISION STATEMENT

ADVANCING NURSING EDUCATION: DISABILITY ACCESS, RETENTION, AND CURRICULUM

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Advancing Nursing Education: Disability Access, Retention, and Curriculum

MISSION

The National League for Nursing (NLN, 2026) promotes excellence in nursing education to build a strong and diverse nursing workforce to advance the health of our nation and the global community.

CORE VALUES

The NLN (2026) implements its mission guided by four dynamic and integrated core values that permeate the organization and are reflected in its work: Caring, Integrity, Diversity and Inclusion, and Excellence.

INTRODUCTION

In September 2023, the National Institute on Minority Health and Health Disparities (NIMHD) formally designated people with disabilities (also referenced as disabled people) as a population with health disparities, as supported by the National Institutes of Health (National Institutes of Health [NIH], 2023). This federal recognition underscores a critical truth: disability inclusion is a national health care equity imperative that demands coordinated action across academic institutions, accrediting bodies, and clinical systems.

Disability intersects with structural inequities related to race, ethnicity, gender identity, sexual orientation, socioeconomic status, immigration status, and age. These intersections shape who experiences compounded barriers in education, employment, and healthcare access. Disabled students and faculty of color, LGBTQIA+ disabled individuals, immigrants with disabilities, and people with disability living in poverty often face overlapping systems of exclusion, particularly racism and ableism (see Table 1), which frequently operate together. Because people hold diverse relationships to the concept of disability identity (Schuck et al., 2025), this vision statement employs both identity-first and person-first language (see Table 1), without privileging one approach.

In December 2025, the National Council on Disability (NCD, 2025b) issued a Request for Information on Disability Clinical Care, marking a federal acknowledgment of the urgent

national crisis caused by inadequate disability education for healthcare providers, including nurses. This call highlights widespread deficiencies in training, clinical preparedness, diagnostic accuracy, communication skills, and the ability of clinicians to deliver equitable care to individuals with disabilities and chronic conditions. NCD's request makes clear that insufficient disability education is a systemic failure and not an isolated or program-specific issue. This vision statement directly responds to this federal priority by affirming the need for comprehensive, competency-based disability curricula; robust faculty development; and system-wide redesign to ensure that every nurse is fully prepared to provide high-quality, patient-centered care for disabled people. Advancing disability equity in nursing represents a professional obligation and a national imperative.

Disability is a universal part of the human experience, present across every demographic group and woven into nearly every individual, family, and community across the lifespan. Because of this, disability inclusion is not a specialty concern but a shared responsibility across nursing education, clinical practice, research, and leadership. Most nurses will personally experience disability or support family members, colleagues, or patients with disabilities at some point in their lives. Disability, therefore, influences how nurses understand human development, physical and mental health, chronic illness, and wellness across the lifespan. Yet nursing education and clinical practice continue to exclude disabled people through outdated, discriminatory technical standards (a focus on "how" a student completes a task or skill while not accounting for the use of reasonable accommodations) (see Table 1) and policies, inaccessible environments, and restrictive assumptions that define who can be a nurse and the role of nurses. Disability content in nursing curricula is still treated as peripheral, optional, or nonexistent. These barriers are not accidental; they reflect long-standing structural practices that frame disability as a deficit and nursing as a purely physical occupation rather than a professional discipline grounded in competencies, evidence-based care, and clinical judgment (Velez et al., 2025).

BACKGROUND

Disability

Disability is one of the most common yet least acknowledged dimensions of human diversity. In the United States, 1 in every 4 adults, over 71 million people, identifies as having a disability, making disabled people the nation's largest marginalized group (Centers for Disease Control and Prevention, 2024). Globally, 1 in 6 individuals lives with a disability (World Health

Organization [WHO], 2024), and an estimated 5% to 14% of U.S. children have a disability (Hagerman & Houtrow, 2021).

Disability Definitions

Determining disability identity ultimately resides with each individual. For the purposes of this document, the following two definitions (i.e., American with Disabilities Act, WHO) among many offer complementary perspectives that help ground a shared working concept of disability. Together, they highlight disability as both a protected civil rights category and a lived experience shaped by social, environmental, and structural forces.

The Americans with Disabilities Act (ADA) (1990) defines disability using a three-pronged civil rights framework that determines who is protected under the law:

1. A physical or mental impairment that substantially limits one or more major life activities,
2. A record of such an impairment, or
3. Being regarded as having such an impairment.

This definition is intentionally broad. It ensures that people are protected not only based on actual impairments but also from discrimination rooted in assumptions, stereotypes, or misperceptions. As a federal civil rights law, the ADA identifies a wide class of individuals who are entitled to equal access, nondiscrimination, and reasonable accommodations in employment, public services, and public accommodations.

The WHO (2003) defines disability through the International Classification of Functioning, Disability and Health (ICF), offering a multidimensional, global public health perspective. Within the ICF, disability encompasses:

1. Impairments in body functions and/or structures,
2. Activity limitations and participation restrictions, and
3. Environmental factors.

This framework emphasizes that disability does not reside solely within an individual. Instead, it emerges from the dynamic interaction between a person's functional capacities, bodily

structures, and the physical, social, and attitudinal environments in which they live. Contextual intersectionality factors, including age, race, gender, socioeconomic status, culture, and personal attributes, shape how disability is experienced and how barriers or supports are encountered.

Together, these two definitions underscore a central principle of disability justice: disability is not a deficit to be fixed but a natural part of human diversity. Understanding disability through both civil rights and public health lenses is essential for building equitable nursing education and clinical practice.

Disability and Nursing

Nursing education prepares safe, competent, entry-level professionals who develop specialized expertise over time within specific practice settings. This preparation is grounded in the concept of the undifferentiated student (see Table 1), which recognizes that entry-level graduates are educated and assessed on foundational, transferable professional competencies across all potential specialty clinical practice settings, rather than on the ability to perform "differentiated" specialty-specific or task-specific functions for a particular future clinical practice setting. Michael Reichgott (1996, 1998) articulated this concept in the period following the passage of the Americans with Disabilities Act, in response to health professions programs that attempted to use undifferentiated performance expectations and accreditation standards to exclude students who could not perform in every possible skill in any practice setting. Reichgott's (1996, 1998) work challenged both educational institutions and accrediting bodies, including medical accrediting authorities, for conflating professional competence with physical task performance and for using accreditation as a shield for discriminatory practices.

For nursing, this history matters because failure to critically examine the undifferentiated student concept has contributed to the profession's long-standing reliance on rigid technical standards developed and enforced by nursing programs themselves, which assume all graduates must be capable of all physical tasks in all settings. These assumptions are misaligned with contemporary, team-based nursing practice and have resulted in persistent, systemic exclusion across healthcare education, not only within nursing. Entry-level competence does not require independent performance of every task without support or reasonable accommodations. Rather, it requires sound clinical judgment, communication, patient safety, and professional accountability within differentiated roles of care.

Shifting from prescribed task methods to competency-based outcomes is therefore essential for nursing. When professional standards are incorrectly framed as physical task requirements, such as manual patient lifting or independent performance of all procedures, they exclude qualified disabled students and nurses, reinforce outdated, unsafe models of solo nursing task performance, and ultimately undermine patient safety rather than improve it. Competency-based standards, by contrast, focus on safe outcomes, support team-based care and reasonable accommodations, and reflect how nursing is actually practiced today. Clarifying entry-level expectations around foundational, transferable competencies allows nursing education to uphold rigorous standards while removing structural barriers that have historically limited who may enter, remain in, and contribute to the profession.

The National Academy of Medicine's *Vital Directions for Health and Health Care* initiative describes four broad spheres of care: health promotion and prevention, acute illness and injury, chronic conditions, and hospice and palliative care, each requiring distinct competencies, workflows, and team structures (Lipstein et al., 2016). Competence is defined by the ability to meet professional needs within a specific context, not by adherence to a narrow set of physical tasks. Long-standing curricular choices that marginalize disability care in nursing education perpetuate these patterns across both the nursing workforce and patient care.

The continued use of outdated technical standards is rooted in historical views of nurses as task-doers rather than autonomous professionals and has systematically shut out disabled students, faculty, and nurses (Marks & Ailey, 2014). This exclusion compromises patient safety, diminishes workforce diversity, and contradicts the realities of contemporary professional nursing. It is no accident that disabled students and nurses consistently report stigma, disbelief, and pressure to leave the profession, while patients with disabilities experience inaccessible care and harmful assumptions about their quality of life (Jamal-Eddine, 2025; Neal-Boylan, 2014; Neal-Boylan et al., 2015; Neal-Boylan & Miller, 2020; Neal-Boylan & Smith, 2016; Smeltzer et al., 2012). What appear as isolated incidents instead reflect a system that has failed to recognize disability as a natural form of human variation and a vital source of lived expertise across nursing and the communities it serves. Long-standing curricular choices that relegate disability care to the margins of nursing education reinforce these outcomes.

Health Equity

The NCD's *2022 Health Equity Framework* identifies five priority areas central to advancing health equity and addressing persistent health disparities (see Table 1) experienced by disabled people:

1. Comprehensive disability clinical care curricula,
2. Designation of people with disabilities as a health disparities population,
3. Federal designation as a special medically underserved population,
4. Accessible medical diagnostic equipment, and
5. Standardized disability data collection.

Lack of quality healthcare continues to produce profound and preventable health disparities for the large and growing population of disabled people. Ableism is documented across the healthcare spectrum (Christakis & Iezzoni, 2023; Lagu et al., 2022), including within nursing (Smeltzer et al., 2025), and is a significant contributor to these disparities (Lundberg & Chen, 2024). Rooted in the medical model of disability, ableism frames disability as a deficit or defect within the individual, ignoring the social and environmental forces that shape health (Borowsky et al., 2021; Friedman et al., 2024). It manifests through prejudice, discrimination, stereotyping, and social oppression (Bogart & Dunn, 2019).

Dismantling ableism in nursing requires more than isolated interventions. It demands a system-wide culture change that recognizes and values the expertise, leadership, and lived experiences that disabled people bring to nursing education and clinical practice. These efforts align with broader societal commitments to address structural inequities and eliminate disability-related disparities for disabled people.

Ableism and Structural Inequities

Ableism, discrimination, and social prejudice against people with disabilities rest on the belief that non-disabled people are inherently superior, and that disabled people are "less than" or in need of being "fixed" (Dorsey Holliman et al., 2023). Patients with disabilities experience the greatest disparities (see Table 1) when disability intersects with racism, gender bias, ageism, or limited economic opportunity (Langmann & Webel, 2023). Confronting ableism is

essential to combating discrimination on all fronts and to advancing equitable health outcomes.

Nursing education plays a critical role in addressing these health disparities. As the largest healthcare profession in the U.S. and worldwide, nurses are uniquely positioned to recognize and respond to intersecting forms of structural bias. Nursing curricula, policies, didactic content, and clinical experience shape whether disparities are reinforced or disrupted through intentional design. Yet two longstanding structural failures continue to impede progress:

1. Exclusion and discrimination targeting disables students, faculty, and nurses.
2. Lack of disability-related content and experiences in nursing curricula.

Exclusion and Discrimination Targeting Disabled Students, Faculty, and Nurses

For decades, disabled individuals have faced persistent barriers to entering, thriving within, and advancing in nursing education and clinical practice. These barriers are not the result of individual limitations but of structural decisions embedded in policies, norms, and institutional cultures. For disabled students, common barriers include:

- **Institutional reliance on restrictive technical standards** that privilege traditional ways of moving, seeing, hearing, touching, learning, and communicating core nursing competencies such as clinical judgment, communication, and leadership (Marks & Sisirak, 2022; Ailey & Marks, 2020; Marks & Ailey, 2014; NCD, 2025).
- **Stigma, bias, and resistance to provide accommodations** signal to students that disability is incompatible with nursing (Jamal-Eddine, 2025).
- **Disclosure pressures** that force students into a double bind in needing to appear "disabled enough" to qualify for support while simultaneously "not too disabled" to be judged unfit for practice.
- **Failure to center students' own assessments** of their needs, instead assuming that others know what is best for them.
- **Reliance on individually granted accommodations** that require costly diagnostic documentation, mandatory self-disclosure, and navigation of complex, stigmatized institutional processes.
- **Narrow assumptions about what a nurse must be able to do**, rather than recognition of the wide range of roles, skills, and practice environments across the nursing profession.

These practices have produced a nursing workforce that does not reflect the diversity of the populations it serves. They also compel many nurses with nonapparent disabilities to conceal their disabilities, limiting role diversity, innovation, and equity in patient care.

Exclusionary dynamics also affect individuals who acquire disabilities after admission or hire. Although federal courts and federal enforcement agencies have affirmed the right of disabled students and professionals to receive reasonable accommodations to access postsecondary and professional education, inequities and discrimination persist across nursing programs. The relative absence of nursing-specific litigation reflects not a lack of exclusion but the limitations of legal remedies in transforming educational practice and culture.

Nursing programs benefit from proactively developing supportive, transparent processes that prioritize retention, flexibility, and continued academic or professional progression when disability emerges during training or employment. Such approaches strengthen the profession, expand the talent pipeline, and advance equity for both patients and providers. Implementing the American Nurses Association's (ANA, 2021) safe nursing care guidelines, including evidence-based staffing ratios, safe patient handling practices that eliminate manual lifting, and healthy work environments, is not merely a best practice—it is a matter of patient and workforce safety, as well as healthcare equity. When these standards are ignored, preventable injuries rise, disabled nurses are pushed out of the profession, and students are taught both implicitly and explicitly that their safety is negotiable and that they are expendable. Full implementation of ANA guidelines protects all nurses and expands the ability of nurses with disabilities to thrive, while directly challenging the entrenched belief that nursing is defined by physical endurance rather than clinical judgment, communication, and teamwork.

Integration of these guidelines into nursing education is a necessary corrective to decades of exclusion and affirms that nurses have both an ethical duty to provide high-quality care and a fundamental right to a safe, accessible workplace. Addressing the harm caused by unsafe, exclusionary practices depends on the profession's commitment to dismantling the structures that have kept disabled people out of nursing education and employment. This requires a shift toward competency-based education (CBE) (see Table 1), the adoption of Universal Design and Universal Design for Learning (UDL) principles (see Table 1) (Nuss, 2026), and the intentional elevation of disabled nurses and students as leaders in shaping the future of the

profession. Strategies are needed to reduce bias when using CBE evaluation methods (Sokolowich, 2025).

Cultural attitudes within nursing, whether implicit, explicit, or reinforced by institutional norms, continue to shape how disability is perceived and valued. Many nurses and faculty hold unexamined assumptions about safety, competence, communication, and professionalism when working with colleagues with disabilities or caring for patients with disabilities (Wood & Marshall, 2010). These beliefs do not remain abstract; they influence who is recruited, who is admitted, who is supported, who is evaluated fairly, and who is pushed out. They also shape the quality of care disabled patients receive.

Transforming nursing requires confronting these attitudes. Structured faculty development, reflective practice, and disability-led and disability-affirming education are essential. Nursing cannot claim a commitment to equity while perpetuating ableist norms that harm both providers and patients. A profession that prides itself on advocacy extends that advocacy inward toward its own members, ensuring that disabled nurses and students are not merely included but empowered.

Lack of Disability-Related Content and Experiences in Nursing Curricula

Most nursing students graduate with little or no formal preparation to care for disabled people across the lifespan, despite encountering disabled individuals in nearly every care setting, which leaves the entire nursing workforce underprepared. This gap reflects a long-standing pattern of curricular exclusion that treats disability as peripheral rather than as a core dimension of health equity. Faculty frequently report limited training, experience, or confidence in teaching about persons with disabilities and often lack a foundational understanding of disability as a sociopolitical identity, not merely a medical condition (VanPuymbrouch et al., 2020; VanPuymbrouch, 2021). These gaps are compounded by implicit bias, which shapes how disability is taught, understood, and valued.

Many faculty believe they already "cover" disability because they reference ADA requirements, teach mobility-related skills, or briefly mention disability within modules on chronic illness or end-of-life care. But these limited approaches reinforce a narrow, deficit-based view of disability and fail to prepare nurses for equitable, patient-centered practice. Teaching wheelchair transfers without addressing communication, diagnostic overshadowing (see Table 1), intersectionality, or structural barriers reduces disability to a technical task rather

than a lived experience shaped by social and political forces. This is not disability education; it is a missed opportunity that reinforces exclusion and inadequate preparation.

The assumption that disability is already adequately integrated often goes unexamined in nursing programs. Systematic, critical curriculum mapping helps identify where disability is meaningfully included and where it is absent. Comprehensive disability education prepares graduates to recognize and challenge ableism, understand disability as a form of diversity, and provide affirming, accessible, equity-grounded care.

Emerging assistive technologies, including AI-enabled tools, offer powerful opportunities to strengthen disability inclusion in nursing education while improving learning and efficiency with more flexible, accessible learning environments for all students and faculty. These tools provide adaptive supports, enhance communication and learning, and reduce administrative burdens that disproportionately disadvantage students and faculty with disabilities. Integrating such technologies is not merely innovative; it is a concrete step toward dismantling barriers and expanding access.

Preparing clinicians to care for one of the largest and most diverse patient populations is essential to professional responsibility and ethical practice. Disability education provides a necessary foundation for high-quality, inclusive care. National bodies, including the NCD (2025a), U.S. Surgeon General (Office of the Surgeon General, 2005), WHO (2024), and Alliance for Disability in Health Care Education (2019), have unequivocally called for comprehensive disability curricula across health professions. Parallel initiatives from the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and The Joint Commission further reinforce a growing national consensus: disability clinical care and competency training are not optional enhancements. They are essential to educational quality, patient safety, and health equity across healthcare systems.

Yet despite years of national recommendations, the gaps remain profound. Nursing programs continue to graduate clinicians underprepared to care for one of the largest and most diverse patient populations in the country. Excluding individuals with disabilities from nursing education and failing to teach disability as a core component of health equity undermines the profession's ability to meet contemporary practice demands and perpetuates preventable health disparities (Marks & McCulloh, 2016). Preparing nurses to deliver accessible, patient-centered care to people with disabilities requires integrating disability-related content and

clinical experiences across nursing education and fully including disabled students, nurses, and faculty as leaders in workforce preparation.

Nursing Education Curricula

Nursing curricula require treating disability as a natural and expected part of human diversity rather than an exception, a deficit, or a special topic. This requires explicit grounding in the legal responsibilities established under the ADA and Section 504 of the Rehabilitation Act, as well as the integration of multiple models of disability, including social, biopsychosocial, and other relevant frameworks. Nursing students learn how disability intersects with the social determinants of health, communication, assessment, and clinical skills across various types and severities of disabilities. Without this foundation, graduates are unprepared to deliver equitable care to disabled people and those living with chronic conditions.

For patients with disabilities, diagnostic overshadowing (see Table 1) occurs when clinicians attribute new or unrelated symptoms to a patient's existing disability. Diagnostic overshadowing is a well-documented source of preventable harm, delayed diagnosis, and inappropriate treatment. NCD (2025a) identifies diagnostic overshadowing as a major contributor to illness, injury, and early mortality among disabled people and calls for its elimination through comprehensive education, structural redesign, and accountability. Nursing education plays a pivotal role in this work by preparing students and faculty to recognize, interrupt, and prevent diagnostic overshadowing, ensuring safe, accessible, evidence-based, and patient-centered healthcare. Addressing diagnostic overshadowing is a moral and professional obligation central to safe, patient-centered healthcare.

Preparing graduates to understand, use, and advocate for accurate disability-related data is a crucial component of nursing education. Information about access barriers, communication needs, and the use of accessible diagnostic and durable medical equipment is essential for inclusive practice. These data inform accessible communication strategies, guide the use of accessible equipment, and support the development of universally designed learning and care environments. The NCD's (2025a) Health Equity Framework identifies accurate disability data as a cornerstone of health equity, making it a professional responsibility for nurses to understand and apply.

Addressing disability in nursing education extends beyond entry-level programs, from prelicensure, undergraduate to graduate and advanced practice education, to prepare future

clinicians, leaders, and faculty. Graduate programs play a critical role in developing nurse educators who can teach disability content with accuracy, depth, and cultural humility. Inclusive, community-based clinical experiences shaped by the voices, leadership, and lived expertise of people with disabilities provide a powerful framework for preparing nurses who can recognize and address health inequities wherever they practice.

The full integration of disability into nursing's educational mission strengthens professional preparation and the delivery of high-quality healthcare. Preparing nurses to care for people with disabilities is central to professional competence and ethical practice. In the context of persistent nursing shortages and national patient safety priorities, disability-inclusive nursing education is essential to expanding the workforce, reducing preventable harm, ensuring safe and equitable care for all patients, and sustaining the profession's long-term viability.

CALL TO ACTION

The NLN is committed to transforming nursing education, clinical practice, and leadership to mitigate and eliminate ableism, advance health equity, and ensure a diverse, inclusive nursing workforce prepared to care for all people. This transformation requires decisive and sustained action. It requires immediate, coordinated, and collective action across education from LPN/LVN to PhD, clinical practice, accreditation, and leadership so that no single group, especially disabled students, nurses, faculty, or patients, bears the burden of change alone.

Persistent ableism, diagnostic overshadowing, and exclusionary educational practices continue to harm disabled people across the nursing continuum. National bodies, including the NCD, have made clear that disability inclusion is foundational to achieving health equity (see Table 2). In addition, no U.S. state requires such standards for nursing school admission or graduation, underscoring that these practices reflect institutional preference rather than legal necessity (Velez et al., 2025). Addressing disability with the same urgency, rigor, and accountability applied to other recognized drivers of patient safety, healthcare quality, and health outcome disparities depends on full integration of disability across curricula, accreditation standards, licensure and certification requirements, leadership development, and workforce planning.

Because national disability competency initiatives have historically focused on medicine, leadership from nursing organizations and accrediting bodies is essential. Collaboration with the NCD, the National Organization of Nurses with Disabilities, and other national and

international partners is essential to ensure that disability clinical care and competency training are fully embedded throughout nursing education, accreditation, and clinical practice (Campbell & Rydberg, 2025).

This transformation requires (a) removing technical standards because they function as discriminatory entry or progression barriers; (b) developing universally designed, competency-based curricular frameworks that reflect the diversity of nursing roles and practice environments; (c) embedding disability models, principles, history, and clinical care across all levels of nursing education; (d) elevating disabled nurses, students, and faculty as leaders, advisors, educators, mentors, and co-designers of curricula, simulation, assessment, and policy; (e) mandating accreditation, licensure, and certification requirements that align with national and global disability-inclusive and health equity frameworks; and (f) redesigning nursing systems to value disabled individuals and ensure equitable access, retention, and professional success. Creating a nursing workforce that reflects the full heterogeneity of society is essential to achieving excellence in nursing and meeting national health equity goals. Disability inclusion is not a peripheral initiative; it is central to the future of the profession and to the health and dignity of nurses and to the communities that nurses serve.

RECOMMENDATIONS

For the National League for Nursing

- Lead national efforts to eliminate traditional technical standards that function as discriminatory entry or progression criteria in nursing education.
- Drive recruitment and retention initiatives that meaningfully include students and faculty with disabilities.
- Advocate for comprehensive disability-related content across all levels of nursing curricula.
- Ensure disability is recognized as a key demographic and structural determinant of health within workforce diversity initiatives.
- Promote and disseminate disability-related educational resources, including the *Core Competencies on Disability for Health Care Education* and NLN-developed materials.
- Support accreditation, licensure, and certification standards requiring programs to demonstrate how disability informs curriculum design, faculty development, and evaluation metrics.
- Model disability inclusion within NLN governance, leadership pathways, and professional development programs.

- Develop and adopt shared disability-related competencies for nursing education and clinical practice, aligned with competency-based frameworks and assessed through observable outcomes across didactic, clinical, and simulation learning.
- Establish evaluation metrics to assess disability-related competencies, including learner outcomes, faculty preparedness, and their effect on patient experience and care quality.
- Prioritize research and innovation to evaluate disability-inclusive, competency-based, and AI-enabled nursing education models, including (a) effectiveness of instructional, clinical, and practice-based interventions grounded in universal design principles; (b) effect on nurses' and students' knowledge, skills, attitudes, and readiness to provide high-quality care to people with diverse disabilities; and (c) experiences and outcomes of disabled and non-disabled individuals pursuing nursing, with and without the implementation of this vision.
- Convene a national nursing conference in collaboration with other nursing organizations and nursing education programs to develop and implement strategies to address disability in nursing education.

For Leadership in Nursing Programs (Deans/Directors/Chairs)

- Discontinue restrictive technical standards that exclude entire groups of students from admission or progression.
- Implement universally designed environments and competency-based curricula that emphasize what students must know and demonstrate, rather than how they must physically perform tasks.
- Actively hire, support, engage, and value faculty with disabilities.
- Provide faculty development on disability, ableism, universal design, legal responsibilities, and inclusive teaching practices.
- Allocate resources for community-based clinical experiences, simulation redesign, and partnerships with disability-led organizations.
- Foster a culture that affirms disability as a form of diversity and expertise.
- Ensure experiential learning through direct engagement with disabled people, including their integration as paid educators, standardized patients, mentors, and curriculum co-designers.
- Promote collaboration among instructional designers, disability resource professionals, faculty, and centers for teaching and learning.

- Align nursing education with accessible clinical environments, including accessible exam tables, diagnostic equipment, and communication technologies.
- Collaborate with nursing organizations to develop and implement strategies to address disability in nursing education.
- Invest in sustained faculty development with protected time, professional development credit, and institutional accountability.

For Faculty

- Engage and value students and faculty with disabilities.
- Evaluate students based on competencies, not rigid expectations of physical task performance.
- Develop simulations featuring disabled individuals with lived experience to ensure authentic, innovative competency assessment
- Apply Universal Design for Learning (UDL) to instruction, assessment, course materials, and simulations.
- Assess personal and program-wide implicit bias and incorporate structured reflection into faculty development.
- Embed disability content throughout undergraduate and graduate nursing curricula, including models of disability, history, communication strategies, clinical care, and legal responsibilities.
- Engage disabled individuals as consultants, panelists, guest lecturers, standardized patients, and co-educators.
- Conduct curriculum mapping to identify and address gaps in disability education based on an established disability education framework.
- Promote advocacy skills so students understand their role in addressing disability-related health inequities.
- Use an array of existing available resources and seek funding and resources to ensure all faculty and students receive education about disability and high-quality nursing care of people with disabilities.
- Leverage assistive technologies and emerging AI-enabled tools to support learning, communication, assessment, and clinical preparation for all students, while ensuring ethical use, accessibility, and alignment with competency-based outcomes.

For Collaboration with Clinical Practice Partners

- Develop community partnerships that provide students with meaningful clinical experiences in diverse, inclusive, and real-world settings involving disabled people.
- Collaborate with interprofessional teams to improve care for disabled individuals across hospital, community, employment, home, correctional, school, and long-term care environments.
- Support clinical placements and work environments that employ, accommodate, and value students and nurses with disabilities.
- Improve disability-related data collection and integrate disability identifiers into healthcare workforce and patient datasets to evaluate inequities, curricular impact, and outcomes related to accommodations, assistive devices, and universal design strategies.

CONCLUSION

As the nation's largest, most trusted, and most essential healthcare profession, nursing holds both an ethical responsibility and a strategic opportunity to lead the next era of health equity by fully valuing people with disabilities in education, clinical practice, and leadership. This Vision Statement calls for a profession-wide culture shift to dismantle historical barriers, embed disability content throughout prelicensure, undergraduate and graduate curricula, and embrace disabled nurses and students as essential contributors to nursing excellence.

Preparing all nurses from LPNs/LVNs to PhDs to deliver high-quality, patient-centered care, including care for individuals with disabilities, is fundamental to advancing health equity for current and future generations. The future of nursing depends on systems designed for all of us, including those who live with disability today and those who will experience disability tomorrow.

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Table 1. Glossary of terms.

Term	Definition/description
Ableism	A form of discrimination in favor of nondisabled people. Ableism examples include physical barriers, such as buildings without ramps, inaccessible websites, and lack of captions; attitudinal barriers such as telling someone they "don't look disabled," patronizing them, or questioning if they are "really" disabled; and systemic issues, such as hiring discrimination or failing to provide reasonable accommodations, all stemming from favoring non-disabled people and assuming disability is tragic or requires fixing (Eisenmenger, 2019).
Competency-Based Education	An educational model in which students advance by demonstrating mastery of specific skills and knowledge (competencies) rather than by completing "seat time" or courses, allowing for self-paced, personalized learning focused on outcomes rather than just content completion (Arbour et al., 2025; National League for Nursing Strategic Action Group, 2023). Seat-time requirements can disadvantage disabled students who may need flexible pacing, alternative formats, or nontraditional pathways.
Diagnostic Overshadowing	A cognitive bias where healthcare providers incorrectly attribute a patient's new or existing symptoms to a known, pre-existing condition (e.g., a mental illness, intellectual disability, or chronic disease) instead of investigating for a new, separate, or co-occurring illness, leading to misdiagnosis, delayed treatment, and poorer health outcomes. It is a form of implicit bias in which symptoms are "overshadowed" by the established diagnosis, leading clinicians to stop gathering information prematurely (Dell'Armo & Tassé, 2025).
Disability Disclosure	The voluntary act of informing others, typically an employer or school, about a disability or health condition to request necessary adjustments (accommodations) or to build

	understanding and support, focusing on functional limitations and needed supports rather than detailed medical specifics. It allows individuals to access legal protections (such as the Americans with Disabilities Act), receive reasonable accommodations, and reduce stress; however, the decision of when, how much, and how to share is personal (National Collaborative for Workforce and Disability for Youth, 2009; Pelleboer-Gunnink et al., 2017).
Disparities for People with Disabilities	In healthcare, a health disparity is a "preventable difference in health outcomes." The disparities result in noticeable and often significant differences or dissimilarities. These disparities manifest as higher rates of chronic diseases, such as diabetes, along with obesity and smoking, poorer health status, and greater unmet needs due to inaccessible health systems, ableism, poverty, and discrimination, leading to worse health compared to the general population.
Explicit Bias	Conscious attitudes that result in deliberate and calculating behaviors (VanPuymbrouck et al., 2020).
Identity First Language (IFL)	A person's disability as a core part of their identity (e.g., "autistic person," "disabled person"), contrasting with person-first language (PFL) ("person with autism," "person with a disability"), with preferences varying by individual, community, and context. IFL is popular in many disability rights movements to affirm disability as a natural identity, not a deficit, while PFL emphasizes the person first, with the key being to ask individuals their preference. IFL identifies the disability descriptor before the person, as in "deaf person," "blind person," or "wheelchair user." IFL affirms disability as a valid identity and part of a person's whole self, challenging the idea that disability is inherently negative (NIH, 2025).
Implicit Bias	Unconscious attitudes that result in spontaneous and unplanned behaviors (VanPuymbrouck et al., 2020).
Inequities for People with Disabilities	Systemic disadvantages and disparities, driven by ableism, that people with disabilities face in areas like employment,

	income, education, and healthcare, leading to higher poverty rates, worse health outcomes, and reduced life quality compared to non-disabled people. These inequalities stem from societal barriers, discriminatory policies (e.g. subminimum wages), inaccessibility, and social stigma, creating a cycle where disability worsens poverty and vice versa (Shandra, 2018).
LGBTQIA+	An inclusive acronym representing Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual (+). This evolving term promotes understanding, visibility, and acceptance for a broad spectrum of people within gender and sexual minority communities, highlighting contributions from all walks of life (Lee et al., 2025).
Person First Language (PFL)	A way of speaking and writing that emphasizes the individual's humanity before their disability or condition, focusing on the person rather than the diagnosis to promote respect, dignity, and inclusivity, using phrases like "person with autism" instead of "autistic person," though some communities prefer Identity-First Language (IFL). Instead of "the disabled" or "an epileptic" use "a person with a disability" or "a person with epilepsy." While PFL is widely encouraged, some disability communities, particularly the Autistic and Deaf communities, prefer Identity-First Language (IFL) (e.g., "Autistic person") because they see their disability as an integral part of their identity, not something separate (NIH, 2025).
Technical Standards	Admission requirements set by nursing programs that have not kept pace with legislative or technological developments. The standards for many nursing programs are available on the Internet and include the ability to observe required demonstrations and experiments, and to communicate with patients in speech and writing; sufficient motor function to carry out basic nursing techniques and to elicit diagnostic information through palpation, auscultation, percussion, etc. Technical standards typically rely on

	observation, communication, motor abilities, intellectual/conceptual, and behavioral/social skills that require degrees of sensory and motor function, effectively precluding many otherwise qualified applicants with physical and sensory disabilities from being considered for and admitted to nursing education programs. Increasingly, students, educators, and disability scholars note that these standards are unnecessarily restrictive, given the primary importance of cognitive qualifications and the decreasing importance of physical ones in contemporary nursing practice (Ailey & Marks, 2020).
Undifferentiated Student	A graduate of a health professions program who has not yet selected a specialty and is therefore required to acquire the knowledge and skills of all potential specialties; with reasonable accommodations students could become undifferentiated (Reichgott, 1996, 1998).
Universal Design	A framework for creating environments, products, and services usable by all people, regardless of age, ability, or situation, without needing special adaptation, making environments accessible and beneficial for everyone, not just those with disabilities, like curb cuts used by strollers and wheelchairs, or closed captions for all viewers (RL Mace Universal Design Institute, 2024).
Universal Design for Instruction (UDI)	An educational framework for proactively designing courses to be accessible and effective for the broadest range of learners, minimizing barriers by offering flexible methods for engagement, representation, and expression, benefiting students with diverse abilities, backgrounds, and learning styles, rather than designing for an "average" student. It moves beyond legal compliance by building in options for diverse needs from the start, encompassing all aspects of teaching from physical space to technology and assessment (Scott et al., 2003).

Universal Design for Learning (UDL)	An educational framework that designs flexible learning environments and materials to give all students an equal opportunity to succeed by proactively removing barriers, offering multiple ways for students to access information (Representation), engage with it (Engagement), and show what they know (Action & Expression) (CAST, 2024).

Table 2. National disability organizations and resources.

Category	Description
National disability organizations	• American Association on Health and Disability (AAHD). AAHD is dedicated to improving overall health for people with disabilities through health promotion and wellness. https://aahd.us/ • Association on Higher Education and Disability (AHEAD). AHEAD is the leading professional membership association for individuals committed to equity for disabled individuals in higher education. https://www.ahead.org/home • Developmental Disability Nurses Association (DDNA). DDNA supports nurses working with persons with intellectual and developmental disabilities their families and those individuals they supervise. https://ddna.org/ • National Organization of Nurses with Disabilities (NOND). NOND promotes equity for people with disabilities and chronic health conditions in nursing through education and advocacy. https://nond.org/ • National Council on Disability (NCD). Federal leadership on disability policy, health equity, and clinical care, including reports and calls to action addressing the inclusion of disability competencies in health professions education and practice. https://www.ncd.gov/

Resources	• American Nurses Association. (2022). *Intellectual and developmental disabilities nursing Scope and standards of practice* (3rd ed). Wolters Kluwer. • Blunt, E., & Smeltzer, S. C. (2012). Caring for people with disabilities: The nurse practitioner tool kit. https://www.villanova.edu/university/nursing/villanova-nursing-experience/college-in-the-community/disability-resource.html • Colbert, A., & Kronk, R. (2020). Equity access: Online nursing education on care for people with disabilities. *Journal of Nursing Education, 59*(6), 349–351 (www.equityaccess.org). https://doi.org/10.3928/01484834-20200520-10 • Developmental Disabilities Nurses Association. (2020). Practice standards of developmental disability nursing (3rd ed.). High Tide Press. • Drum, C. E., Krahn, G. L. & Bersani, H. (Eds.) (2009). *Disability and public health.* American Public Health Association. • Golisano Institute for Developmental Disability Nursing. (n.d.). *Educational modules.* https://learn.nursegrid.com/collections/golisano-institute-for-developmental-disability-nursing?srsltid=AfmBOoqjLPG4Y4nrlwfcWjZ-z7odcKX9kFMk0IURQ6pv44-dAmHRjVoC • Hewitt, A. S., & Nye-Lengerman, K. M. (Eds.). (2019). *Community living and participation for people with intellectual and developmental disabilities.* American Association on Intellectual and Developmental Disabilities. • National League for Nursing. (n.d.). *Advancing care excellence for persons with disabilities (ACE.D).* National League for Nursing. www.nln.org/education/teaching-

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Additional National and Cross-Sector Resources on Disability Competency and Clinical Care	• Association of American Medical Colleges (AAMC). Resources on disability inclusion, accessibility, and equity in undergraduate and graduate medical education. https://www.aamc.org/ • Accreditation Council for Graduate Medical Education (ACGME). Accreditation standards and initiatives addressing equity, diversity, inclusion, and competency-based medical education. https://www.acgme.org/ • The Joint Commission. Standards and guidance on patient safety, accessibility, effective communication, and equitable care for people with disabilities. https://www.jointcommission.org/en-us

NLN STRATEGIC ACTION GROUP
Vision Statement: Advancing Nursing Education: Disability Access, Retention, and Curriculum

This Vision Statement was developed by the NLN Strategic Action Group on Disability Access, Retention, and Curriculum, reflecting the collective expertise of disabled and non-disabled individuals, nurses and non-nurses, educators, researchers, advocates, and leaders. Central to this work is the recognition that lived experience with disability is a critical form of knowledge essential to advancing equitable nursing education and practice.

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