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ADA compliance for healthcare facilities and services

By Kristin Ahr and James Fetter

The Americans with Disabilities Act (ADA) is a comprehensive statute passed over 30 years ago with the goal of removing unnecessary and discriminatory barriers preventing people with disabilities from fully participating in all aspects of society.[1] To achieve this laudable goal, the statute imposed many requirements on public entities and private businesses that are deemed public accommodations. As relevant here, a public entity is defined as "any department, agency, special purpose district, or other instrumentality of a State or States or local government." ADA Title II thus covers public hospitals and other healthcare facilities.[2] Both hospitals and professional offices of healthcare providers are specifically listed as public accommodations covered under ADA Title III.[3] The ADA applies to all healthcare entities open to the public, from the large state-run hospital to the local pharmacy or doctor's office. And the ADA's requirements touch all aspects of the healthcare industry, from the physical layout of healthcare facilities to policies regarding communication with patients to the design of healthcare websites.

Though we do not discuss the Affordable Care Act (ACA) here, it is important to note that ACA Section 1557, which applies to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance." 42 U.S.C. § 18116(a)applies more stringent regulations to private healthcare facilities than would otherwise apply to private entities under ADA Title III. In a nutshell, this means that private healthcare facilities subject to the ACA must follow the regulations concerning disability access that apply to entities which receive federal funds.[4]

Though the ADA's requirements are numerous and seemingly daunting, they begin to make sense when one considers a basic question: What is required to ensure that people with disabilities—whether physical or sensory—have meaningful access to every part of or service provided by a healthcare facility? To take an obvious example, a doorway that is too narrow for a standard wheelchair to fit through creates an impassible barrier for a person who uses a wheelchair to ambulate. To take a somewhat more complicated case, a website or app that is not properly designed can be inaccessible to blind people who use screen readers (i.e., software that converts the text on the screen into speech or braille). As a result, blind people cannot perform otherwise simple tasks, such as

independently booking a COVID-19 vaccine appointment for themselves.[5] Failure to comply with the ADA may also result in avoidable and expensive litigation, after which a court may decide what your organization must do to come into compliance. Without a doubt, then, it is better to be proactive rather than reactive in ensuring that your healthcare organization is ADA compliant across the board.

In what follows, we address what we believe to be the three most significant areas in which a healthcare entity should evaluate its compliance with the ADA. These are physical access, policies concerning patient communication, and web accessibility. The first two areas have been critical to ADA compliance since the statute was enacted in 1992. Still, litigation continues against healthcare entities alleged to be noncompliant in these areas. Web accessibility—though not expressly mentioned in the ADA—is of growing importance due to the high and increasing volume of web accessibility litigation and the recent guidance from the Department of Justice (DOJ) to encourage and assist both public and private entities in making their websites accessible. Though it is always a good idea to consult an attorney or other expert on ADA standards before implementing a compliance plan, simply consulting with people with various disabilities is also a great way to identify obvious accessibility barriers.

Physical access

Ensuring people with mobility disabilities can access your healthcare facility is the cornerstone of any ADA compliance plan. In 2010, the DOJ released a comprehensive publication providing technical assistance to healthcare providers to ensure their facilities are accessible to people with mobility impairments.[6] This document describes multiple measures that every healthcare facility should take, such as ensuring that new construction of and alterations to buildings meet the requirements in ADA regulations. But the publication goes further, describing both structural and procedural means of providing access to people with disabilities in the healthcare context. For example, it notes that patients who use wheelchairs should generally not be examined while in their wheelchairs, and healthcare facilities should have accessible examination tables available to these patients. Likewise, it recommends that when a disabled patient brings a companion to a medical appointment, healthcare providers should *always* address the patient rather than the companion when asking the patient questions. And expecting a patient to bring a companion to an appointment is *never* an appropriate accommodation.

This article further explains that, under ADA Title III, even facilities built before the ADA's effective date must remove architectural barriers where such removal is readily achievable.[7] The code offers the following examples of readily achievable barrier removal: "(1) Installing ramps; (2) Making curb cuts in sidewalks and entrances; (3) Repositioning shelves; (4) Rearranging tables, chairs, vending machines, display racks, and other furniture; (5) Repositioning telephones; (6) Adding raised markings on elevator control buttons; (7) Installing flashing alarm lights; (8) Widening doors; (9) Installing offset hinges to widen doorways; (10) Eliminating a turnstile or providing an alternative accessible path; (11) Installing accessible door hardware; (12) Installing grab bars in toilet stalls; (13) Rearranging toilet partitions to increase maneuvering space; (14) Insulating lavatory pipes under sinks to prevent burns; (15) Installing a raised toilet seat; (16) Installing a full-length bathroom mirror; (17) Repositioning the paper towel dispenser in a bathroom; (18) Creating designated accessible parking spaces; (19) Installing an accessible paper cup dispenser at an existing inaccessible water fountain; (20) Removing high pile, low density carpeting; or (21) Installing vehicle hand controls." Though not listed here, putting braille signage on rooms, especially when rooms have room numbers, is both readily achievable and very helpful for blind people who cannot read print signage.

Courts have similarly required healthcare facilities to implement readily achievable accessibility fixes, including repaving portions of and adding wheelchair ramps to parking lots to create an accessible path of travel, wrapping

pipes to prevent burns, lowering a toilet or urinal, and rearranging or removing furniture as needed to create accessible routes for patients using wheelchairs.[8] Therefore, even if your facility was constructed before the ADA came into effect, it is not exempt from all ADA requirements.

As crucial as it is to ensure physical access to people with mobility disabilities, physical access to healthcare facilities is not limited to this. In our post-COVID, increasingly contactless world, compliance professionals should also look for inaccessible devices, particularly kiosks or terminals for patient check-in, that prevent people with disabilities from accessing the facility. In a recent case, a court held that a diagnostics laboratory had to provide blind customers accessibility to check-in kiosks. The court rejected the lab's argument that blind customers should rely on phlebotomists to assist them with checking in because the lab, in that case, had an unattended waiting room, and phlebotomists generally did not know that a patient had arrived unless the patient used the kiosk to check in.[9] Thus, it is important to ensure that kiosks or similar devices that patients are expected to use without staff assistance have features that make them accessible to the blind.

Effective communication

The ADA requires covered entities, including healthcare organizations, to communicate effectively with people with disabilities. This means, among other things: ensuring that American Sign Language (ASL) interpreters or equivalent remote interpreting services are available when needed, providing written patient education and billing materials in accessible formats, and training staff to be respectful toward people whose speech may not be clearly audible due to a speech-related disability. Broadly speaking, ensuring effective communication means nothing more—or less—than ensuring that communications with people with disabilities are as clear and comprehensive as communications with people without disabilities.

In 2014, the DOJ released a technical assistance publication to help covered entities comply with ADA regulations regarding effective communication.[10] Although this publication is not specific to the healthcare industry, it provides a cornucopia of helpful advice that will likely decrease your organization's litigation risk if followed. For example, it advises that covered entities may use video remote interpreting (VRI) services to provide real-time interpretation for conversations between hearing and deaf people. However, it states that VRI services must meet specific criteria, such as having a reliable internet connection and always showing the interpreter's hands.

Indeed, much of the ADA litigation related to effective communication could have been avoided simply by following these criteria when procuring and setting up a VRI system. The United States Court of Appeals for the Eleventh Circuit recently held that deaf patients had an effective communication claim that could go to trial because they presented evidence that the VRI machines at the hospital where they sought treatment routinely malfunctioned and hindered their ability to communicate with hospital staff.[11] It did not matter that the patients could not point to any instances in which they received substandard medical care because of communication failures. The court explained: "The ADA and RA [Rehabilitation Act] focus not on quality of medical care or the ultimate treatment outcomes, but on the equal opportunity to participate in obtaining and utilizing services."[12]

Another court held that a hospital may have failed to communicate effectively with a deaf patient because its VRI system constantly froze and failed to work correctly.[13] And even though the patient's daughter was present and could interpret, a covered entity cannot require a person with a disability to bring a companion to help them communicate. It also didn't matter that the patient had some ability to communicate by reading and writing notes because the patient also had limited English proficiency and had difficulty writing due to his injuries.

Effective communication is not limited to providing interpretation services to deaf patients, however. Patients

with visual impairments or who are blind often require materials in an alternative format, such as braille or large print. This is particularly important to keep in mind when providing written materials related to medications and billing. It will not play well in court if a healthcare facility routinely forgets or refuses to provide bills in an accessible format to a blind person, thus resulting in bills going unpaid and being sent to collections.[14]

The best practice is to ensure that your healthcare facility is ready to communicate effectively with disabled patients and others, particularly those with sensory and speech disabilities. If VRI rather than an in-person sign language interpreter is used, ensure that the VRI system works properly and doesn't prevent the patient from seeing the interpreter's hands. And if a blind or visually impaired person requests materials in an accessible format, be prepared to provide them on time. Indeed, it is best whenever possible to grant a reasonable request for an accommodation related to communication because federal regulations require that "primary consideration" be given to the requests of people with disabilities.[15]

Web accessibility

As important as it is to ensure physical access and effective communication, it is hard to overstate how important it is to ensure that your healthcare organization's website is accessible to people with disabilities. For one thing, the field of prospective plaintiffs is much larger. Anyone with a relevant disability who visits a healthcare organization's website could bring a claim based on an accessibility barrier, so long as they allege that they plan to use its website or services in the future.[16] Thus, a website with obvious accessibility barriers is a ripe target for one of the growing number of web accessibility lawsuits. As a recent study noted: "Since 2018, website and mobile app accessibility lawsuits have made up roughly a fifth of all ADA Title III filings in federal courts, which now consistently exceed 10,000 lawsuits annually."[17] And although it remains unclear whether mobile apps are covered, creative plaintiffs and their attorneys are also beginning to target these.

Despite this growing wave of litigation, the DOJ has yet to issue regulations establishing the standards that covered entities, including healthcare organizations, must follow to avoid web accessibility litigation. It has, however, released very recent guidance describing some of the most common accessibility barriers and pointing to accessibility standards that, if followed, are likely to make a website ADA compliant.[18] In brief, websites must be structured so that a user can interact with them solely using the keyboard because people with certain disabilities, such as blindness and motor impairments, cannot use a mouse. Graphics and images on websites must be labeled with alternative text, so that a screen reader can access them. And videos should have captions and, ideally, audio descriptions so that deaf and blind people can fully access the information they convey.

As the DOJ recommends, the best practice is to ensure that your organization's website complies with either the Web Content Accessibility Guidelines (WCAG) 2.0[19] or the guidelines applied to federal agencies under Section 508 of the Rehabilitation Act.[20] The United States Court of Appeals for the Ninth Circuit has also held that, though an organization cannot be held liable for failing to meet a specific web accessibility standard, a court can nevertheless require a business to comply with WCAG 2.0 if a court finds that its website fails to comply with the ADA.[21]

The best approach for guaranteeing that your organization's website will be and remain accessible is to incorporate the WCAG or Section 508 standards into the website development process so that web accessibility is simply part of your organization's culture rather than an afterthought following an expensive lawsuit. To do this, ensure that your web development team is familiar with WCAG 2.0 or the Section 508 standards; consider hiring an outside expert to perform an accessibility audit on your website. Having people with disabilities test your website is also an option, as proficient users of screen readers or other assistive technology will likely be able to find accessibility barriers without much difficulty.

Conclusion

Complying with the ADA requires a serious investment of time, effort, and, most of all, planning. But the effort is worthwhile not only because ADA litigation can result in significant—and avoidable—expenses and intrusive judicial management of your organization but also because healthcare facilities should be accessible to all who need their services. And once a healthcare organization considers the perspectives of people with disabilities who wish to access its facilities, communicate effectively with staff while receiving treatment, and use its website to book appointments and the like, the various requirements imposed by the ADA and its enabling regulations begin to make sense and form a coherent picture.

Takeaways

- When developing an Americans with Disabilities Act (ADA) compliance plan, consider the perspective of people with disabilities and consult them whenever possible.
- Be proactive, not reactive. Don't wait to be sued; instead, take actions now to comply with the ADA.
- Be on the lookout for barriers to physical access, effective communication, and the accessibility of your organization's website.
- Physical access goes beyond wheelchair access, and effective communication includes but goes beyond providing interpretation services for deaf patients.
- Whenever possible, give primary consideration to the reasonable requests of people with disabilities to accommodate their needs.

1 42 U.S.C. § 12101 .
2 42 U.S.C. § 12131(1)(B).
3 42 U.S.C. § 12181(7)(F).
4 Doe v. CVS Pharmacy, Inc., 982 F.3d 1204, 1208-09 (9th Cir. 2020), cert. granted in part, 141 S. Ct. 2882 (2021) and cert. dismissed sub nom. CVS Pharmacy, Inc. v. Doe, One, 142 S. Ct. 480 (2021). "Section 1557 of the ACA incorporates the anti-discrimination provisions of various civil rights statutes, and prohibits discrimination on the basis of … on the basis of disability pursuant to Section 504 of the Rehabilitation Act (29 U.S.C. § 794)."
5 U.S. Department of Justice, "Justice Department Secures Agreement with Rite Aid Corporation to Make Its Online COVID-19 Vaccine Registration Portal Accessible to Individuals with Disabilities," news release, November 1, 2021, https://www.justice.gov/opa/pr/justice-department-secures-agreement-rite-aid-corporation-make-its-online-covid-19-vaccine.
6 U.S. Department of Justice, "Access To Medical Care For Individuals With Mobility Disabilities," July 2010, https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm.
7 28 C.F.R. § 36.304(b).
8 See Theodore v. Lowell Gen. Hosp., No. 15-CV-11774-ADB, 2017 WL 1164486, at *4 (D. Mass. Mar. 28, 2017). This case lists readily achievable renovations and fixes that a pre-ADA hospital could make.
9 Vargas v. Quest Diagnostics Clinical Lab'ys, Inc., No. CV-19-8108-DMG-MRWX, 2021 WL 5989961, at *6-*7 (C.D. Cal. Oct. 15, 2021).
10 U.S. Department of Justice, "ADA Requirements: Effective Communication," January 2014, https://www.ada.gov/effective-comm.htm.
11 Silva v. Baptist Health S. Fla., Inc., 856 F.3d 824, 833 (11th Cir. 2017).
12 Silva, 856 F.3d at 834.
13 Bustos v. Dignity Health, No. CV-17-02882-PHX-DGC, 2019 WL 3532158, at *2 (D. Ariz. Aug. 2, 2019).

14 Bone v. Univ. of N. Carolina Health Care Sys., No. 1:18-CV-994, 2022 WL 138644 (M.D. N.C. Jan. 14, 2022).
1528 C.F.R. § 35.160(b)(2). "In determining what types of auxiliary aids and services are necessary, a public entity shall give primary consideration to the requests of individuals with disabilities."
16 Panarese v. Sell It Soc., LLC, No. 19-CV-3211-ARR-RML, 2020 WL 4506730, at *2 (E.D. N.Y. July 2, 2020). Report and recommendation adopted, No. 19-CV-3211-ARR-RML, 2020 WL 4505703 (E.D. N.Y. Aug. 5, 2020). "Plaintiffs allege that, despite several attempts to use and navigate the Website, they have been denied the full use and enjoyment of the Website as a result of accessibility barriers on a regular basis. Plaintiffs also allege that they genuinely wish to avail themselves of the goods and services offered on the Website, despite their dual motivation as 'testers' visiting places of public accommodation to assess their compliance with Title III of the ADA." (citations omitted).
17 Minh Vu, Kristina Launey, and John Egan, "The Law on Website and Mobile Accessibility Continues to Grow at a Glacial Pace Even as Lawsuit Numbers Reach All-Time Highs," *Law Practice Magazine*, January 1, 2022, https://www.americanbar.org/groups/law_practice/publications/law_practice_magazine/2022/jf22/vu-launey-egan/.
18 U.S. Department of Justice, "Guidance on Web Accessibility and the ADA," March 18, 2022, https://beta.ada.gov/resources/web-guidance/.
19 Web Accessibility Initiative, "WCAG 2 Overview," updated August 6, 2022, https://www.w3.org/WAI/standards-guidelines/wcag/.
20 U.S. Access Board, "About the ICT Accessibility 508 Standards and 255 Guidelines," *Revised 508 Standards and 255 Guidelines*, January 18, 2017, https://www.access-board.gov/ict/.
21 Robles v. Domino's Pizza, LLC, 913 F.3d 898, 907 (9th Cir. 2019). Holding that "the district court can order compliance with WCAG 2.0 as an equitable remedy if, after discovery, the website and app fail to satisfy the ADA."