Access Ready Healthcare Legal Foundation

Healthcare Technology and Disability Civil Rights

Americans with Disabilities Act

Title II of the Americans with Disabilities Act (ADA), covering all state and local government activities, was enacted in 1990. Section 504 of the Rehabilitation Act, covering all recipients of federal funding has been in place since 1973. These laws are unequivocal: they require covered entities, including public healthcare providers and public health agencies, to ensure their communications are equally effective for people with disabilities as for people without disabilities. The Department of Justice has made clear that Title II requires all services, programs, and activities of public entities, including those provided through the internet or other technology, to be accessible. The Department of Health and Human Services has made clear that Section 504 requires digital healthcare technology used in and by healthcare providers to be accessible. See https://www.hhs.gov/sites/default/files/ocr-guidance-electronic-information-technology.pdf.

Title III of the ADA covers private healthcare providers, including doctors' offices, hospitals, clinics, pharmacies, and health insurers, and Section 504 also applies to private providers that receive federal financial assistance, such as Medicaid and Medicare. Therefore, private healthcare providers must comply with Title III's requirement that communications with individuals with disabilities be accessible.

Public and private medical providers now frequently use technological means to communicate with patients, caregivers, and members of the public in a variety of contexts, including websites, online registration and appointments, electronic health records, kiosks, and telemedicine systems. These forms of communication must meet the ADA's "effective communication" standard.

Effective communication generally means people with disabilities can access or acquire the same information, engage in the same interactions, and enjoy the same products and services that the healthcare institution offers its non-disabled participants with substantially equivalent ease of use. To be effective, online or information and communications technology (ICT)-based healthcare communications must be provided in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability. These requirements apply to both communications the provider makes to members of the community and communications it receives from the community.

The only defenses available are when the provider documents in advance, and can prove, that, using all its available resources, it is too difficult or too expensive to accomplish accessible communication or it would fundamentally alter the nature of the communication or program to make it accessible. Even if one of those defenses applies, the provider is required to do everything it can to provide accessible communication up to the point where the burden becomes too great. This is a high bar.

If a person with a disability is denied equally effective communication in healthcare, he or she can file a case in court or a complaint to a federal agency. Either way, the discriminating provider can be required to make its technology accessible, adopt policies to ensure accessibility going forward, and undertake any other steps necessary to remediate the problem. Public healthcare providers can also be required to pay damages for any extra expenses, time, or other burdens the complainant incurred, as well as damages for the harm of being obstructed in accessing his or her healthcare and of experiencing discrimination. Both public and private providers can also be required to pay the complainant's attorneys' fees and costs. Finally, and significantly, under Section 504, the provider can be required to give up its federal funding.

So, if a public or private healthcare provider is offering information or services via the internet or ICT, or if it is receiving information, registration, appointments, and the like from patients, prospective patients, caregivers, and the community via the internet or ICT, it ignores the accessibility of those communications at its own peril.

Section 1557 of the Affordable Care Act

The regulations implementing Section 1557 of the Affordable Care Act specifically provides that health programs or activities provided by covered entities through electronic or information and communications technology must be accessible to individuals with disabilities unless doing so would result in undue financial and administrative burdens or fundamental alteration of the health program.

Although a healthcare entity that deploys inaccessible ICT may meet its legal obligations by providing an alternative accessible way for people with disabilities to use the programs or services, such as a staffed desk or telephone information line, these alternatives must provide equal access to the benefits of the ICT, such as hours of operation, the range of options and programs available, privacy, and convenience.

Accessibility of Healthcare Technologies to Members of the Public

In the bygone era of just paper records and paper-and-pencil forms, equally effective communication generally meant providing large print, Braille, or audiotaped records to a blind patient and a scribe to fill out forms. However, these approaches

are often expensive, unreliable, time-consuming, and simply inadequate in today's technology-driven world. Some of these approaches also undermine privacy and independence, as well as the flexibility, portability, and convenience that are key benefits of healthcare technology.

Online and information and communications technology-based healthcare tools offer greater opportunities to access information, communicate health histories and symptoms, and collaborate. Nowadays, most people with vision disabilities have access to screen reader software, magnification software, or Braille displays that can translate a web page or electronic document into large print, computerized speech, or Braille. A website can, therefore, be made accessible to blind and low vision people simply by ensuring it will work with such assistive devices and software programs, that certain standards are met for images and other visual information, and that input and navigation can be achieved through keyboard commands as well as mouse commands. Now, captioning for video and audio information is readily available for people with hearing disabilities. A video or audio presentation or meeting can be made accessible to people who are deaf or hard of hearing simply by providing real-time captions. However, if healthcare software is not designed to interact with assistive technology, or if ICT equipment (such as kiosks or telemedicine systems) relies exclusively on visual input (e.g., touchscreens) and output (text or video) and is not designed to have tactile and audio input and output, the benefits of the new technologies are lost for people with disabilities.

Recognizing the advent of both digital communication and digital assistive technology, the regulations implementing the ADA provide that accessible electronic and information and communications technology is a type of auxiliary aid or service required by the law, and the Section 1557 regulations specifically require accessibility of services offered through electronic and information and communications technologies.

Provider and Employee Access

As patient and public-facing healthcare information has moved into technology, so have providers' employee-facing systems. Doctors, nurses, administrators, and other provider employees are protected by Title I of the ADA. The ADA does not specifically require providers to ensure their employee-facing technology is always accessible. However, any provider that does not ensure its technology is accessible will most likely fail to meet its legal obligations.

If a healthcare provider uses existing technology that is inaccessible, it theoretically has two options - 1) make the technology accessible or 2) if it is too expensive or difficult to make the technology accessible, provide a work-around for the employee with a disability (e.g., a staff person or contractor to function as a reader, scribe, or

interpreter). If, on the other hand, the provider has purchased or developed employee-facing technology since the ADA was enacted, it is less likely to be able to succeed in making an undue hardship defense. That is because, if an accessible version of the technology was available or it was not difficult to make the technology accessible when it was developed, then it would not have been an undue hardship to use accessible technology. The cost of remediating a new technology should have no bearing if the technology could have been accessible from the beginning.

In addition, workarounds for inaccessible technology are inefficient, expensive, and often fail to provide equal access for employees with disabilities. For example, when a healthcare technology or records database is readily available on-demand to employees without disabilities as they perform their duties, but an employee with a disability must await the availability of a part-time reader in order to access it, the employee with a disability is being denied an equal opportunity to perform his or her job.

Eve L. Hill

Inclusivity Consulting