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Access Denied: Accessibility and the Law of Telehealth for People with Disabilities

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ACCESS DENIED: ACCESSIBILITY AND THE LAW OF TELEHEALTH FOR PEOPLE WITH DISABILITIES

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"We need to make every single thing accessible to every single person with a disability."
— **Stevie Wonder**[1]

CONTENTS

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1. *What You Didn't Know About Stevie Wonder's "Braille Joke" at The Grammys*, PERKINS SCH. FOR THE BLIND, https://www.perkins.org/what-you-didnt-know-about-stevie-wonders-braille-joke-at-the-grammys/ [https://perma.cc/KJ58-C523].

I. INTRODUCTION

The Covid-19 pandemic brought telehealth to the forefront of healthcare delivery. However, it also created the reality of having to ensure that telehealth's continued use and implementation does not further exacerbate already existing healthcare disparities for many populations.[2] Individuals with disabilities make up one of those groups,

2. David Velasquez & Ateev Mehrotra, *Ensuring the Growth of Telehealth During COVID-19 Does Not Exacerbate Disparities in Care*, HEALTH

as there is a fear that telehealth will create further disparities on top of those already existing in accessing healthcare persisting over time.[3] While there was a general surge in telehealth use during the pandemic, current existing research on its use specifically by people with disabilities paints a different picture compared to the general population.[4] This leads to an initial question: what is the reason for these differences? Further, the next question becomes, what, if any changes, need to be made from a legal and policy standpoint, to ensure that people with disabilities have access to telehealth? As telehealth's use will continue as a regular option in healthcare delivery moving past the pandemic, people with disabilities' inability to access telehealth may worsen already existing healthcare disparities for this population. Therefore, regulation by policymakers must consider the unique needs of this population. To date, reviews have focused primarily on website accessibility and have not taken a more expansive and nuanced approach to looking at telehealth through the disability lens in terms of multiple challenges involved with access.[5] While website accessibility is a significant current legal barrier, other challenges exist for people with disabilities in accessing telehealth that are also critical to consider in light of shaping policy.[6] This review is distinguished by including a provider perspective, from those currently serving people with disabilities using telehealth, that can and should enhance legal solutions to issues of accessibility. Law and policy solutions will benefit from the provider perspective of those regularly providing telehealth services to the disabled.

This article takes a deep dive into telehealth access for people with disabilities and the potential legal barriers that currently exist to creating greater accessibility to this healthcare delivery option. First, this article will examine the concept of disability—how it is defined and how reframing the narrative on disability is critical to advancing this

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AFFS. (May 8, 2020), https://www.healthaffairs.org/content/forefront/ensuring-growth-telehealth-during-covid-19-does-not-exacerbate-disparities-care [https://perma.cc/H34S-VJ5N].

3. Thiru M. Annaswamy et al., *Telemedicine Barriers and Challenges for Persons with Disabilities: COVID-19 and Beyond*, 13 DISABILITY & HEALTH J. 1, 2 (2020).

4. Carli Friedman & Laura Vanpuymbrouck, *Telehealth Use By Persons with Disabilities During the COVID-19 Pandemic*, 13 INT'L J. TELEREHABILITATION 1, 1 (2021).

5. Peyton B. Brooks, Note, *Websites, Wellness and Winn-Dixie: Telehealth Accessibility During COVID-19 and Beyond*, 107 CORNELL L. REV. 2067, 2068 (2022); Andrew Donnellan, Note, *Invisible Waiting Rooms: Accessible Telehealth and a Comparison of the Americans with Disabilities Act and the Accessibility for Ontarians with Disabilities Act*, 40 ARIZ. J. INT'L & COMP. L. 103, 108 (2023).

6. Annaswamy et al., *supra* note 3.

population's needs, particularly, as the group defined as disabled may significantly grow as a result of Long-Covid. Next, this article will examine existing evidence regarding healthcare disparities for people with disabilities, which the inability to access telehealth will only continue to exacerbate if telehealth access barriers continue to exist for the population. Then this article will explain telehealth generally and its role in healthcare delivery. Next, the article looks at actual telehealth use, both for the general population and specifically for people with disabilities, and how this research might inform understanding of accessibility issues. Then this article will explore the benefits of telehealth for people with disabilities as well as the known challenges of telehealth use by this population. It will then follow with attention to the way these challenges are currently amplified by our existing legal structure and enforcement, with particular attention to two major issues: 1) website accessibility and 2) effective communication. Finally, this article will recommend legal changes to maximize the ability of people with disabilities to utilize telehealth and avoid persistence and possible worsening of current healthcare disparities for this population.

II. UNDERSTANDING DISABILITY & WHY IT MATTERS

a. Defining "Disability"

"Disability" is defined as any impairment of the body or mind that limits a person's ability to partake in typical activities and social interactions in their environment. However, there are various factors contributing to negative stereotypes about disability that emerge as early as childhood.[7]

Different models structure and influence society's view of disability. Historically, the two primary views or models of disability have been: 1) the medical model, and 2) the social model:

> The medical model considers disability a feature of the person, directly caused by diseases, disorders, traumas, or other health conditions, which would require medical treatment or intervention with the primary goal to "correct" the problem within the individual (Johnston, 1996; Marks, 2000; Mitra, 2006; Forhan, 2009; Nind et al., 2010; Brandon and Pritchard, 2011; Palmer and Harley, 2012; Bingham et al., 2013).
>
> By contrast, the social model does not consider the disability an attribute of the individual, but rather a socially created problem. In this case, the problem that needs to be corrected lies not within the individual, but within the unaccommodating social environment (Brandon and Pritchard, 2011; Roush and Sharby,

7. Iryna Babik & Elena S. Gardner, *Factors Affecting the Perception of Disability: A Developmental Perspective*, 12 FRONTIERS PSYCH. 1, 1 (2021).

> 2011; Barney, 2012; Palmer and Harley, 2012; Bingham et al., 2013). According to the social model, disability could be imposed by society on individuals with impairments through isolation and exclusion from everyday activities (Brandon and Pritchard, 2011; Bingham et al., 2013). Such isolation and exclusion may stem from society's unfavorable perceptions of people with disabilities and unwillingness to remove environmental barriers impeding full participation (LoBianco and Sheppard-Jones, 2008; Forhan, 2009; Palmer and Harley, 2012).[8]

Further, another model called the biopsychosocial model advocates that neither the medical model nor the social model truly captures the essence of describing the experience of disability:

> In the light of this model, the World Health Organization defined disability as "the outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives" (Peterson, 2005, p. 106). Importantly, the extent to which impairment becomes a disability depends not only on the severity of the impairment, but also on the individual's ability to participate in social life (Hall and Hill, 1996; Peterson, 2005).[9]

Even if one examines the statutory definitions of "disability" in the U.S., there are numerous differences with no singular definition of disability in use by the federal government.

Despite the various definitions of "disability," there is global recognition that the experience of disability is actually a common part of the human experience and essentially universal. As described by the World Health Organization (WHO), "[d]isability is part of being human. Almost everyone will temporarily or permanently experience disability at some point in their life."[10] Most recently in the U.S., the National Council on Disability (NAD), an agency which advises the Executive Branch on policy regarding disability, also acknowledged this universality in its *Health Equity Framework for People with Disabilities*, stating, "disability is a natural part of the human condition, which occurs across all age, gender, racial, ethnic, language and social groups."[11] With such diversity just in the definition, how can or should we view disability?

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8. *Id.* at 2.

9. *Id.* at 2–3.

10. *Disability*, WORLD HEALTH ORG., https://www.who.int/health-topics/disability#tab=tab_1 [https://perma.cc/38LL-E68H].

11. *Health Equity Framework for People with Disabilities*, NAT'L COUNCIL ON DISABILITY (Aug. 2022), https://www.ncd.gov/assets/uploads/reports/

Having an understanding of disability as a regular part of the human experience, that will virtually impact each individual directly or indirectly through a relationship with another, should motivate the idea that disability must be a prime consideration in how we address the issues of access to healthcare. This includes the availability and use of telehealth at the beginning. Further, many more individuals in the U.S. are expected to have a disability due to the long-term impact of having Covid-19 and may result in greater focus on individuals with disabilities as a population.[12]

b. Disability by the Numbers

According to the WHO, "[a]n estimated 1.3 billion people – or 16% of the global population – experience a significant disability today."[13] The prevalence of disability in the U.S. is a critical part of understanding disability and why it is significant to address the needs of this particular population, especially regarding access to healthcare. The Centers for Disease Control and Prevention ("CDC") estimates that up to one in four adults in the U.S. are living with a disability.[14] However, data collection in the U.S may actually be providing an inadequate portrayal of the actual population of people with disabilities.[15] There are several reasons the number of people with disabilities is expected to grow, including the growth of the aging population, those with chronic conditions, and individuals who have Long-Covid.[16]

2022/ncd_health_equity_framework.pdf [https://perma.cc/3AAA-ZH7A].

12. Frances Stead Sellers, *How Long Covid Could Change the Way We Think About Disability*, WASH. POST (July 23, 2022), https://www.washingtonpost.com/health/2022/06/06/long-covid-disability-advocacy/ [https://perma.cc/EC7C-TH4J].

13. *Disability*, *supra* note 10.

14. *Disability Impacts All of Us*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html [https://perma.cc/52PD-74Z2].

15. Monika Mitra et al., *Advancing Health Equity and Reducing Health Disparities for People with Disabilities in the United States*, 41 HEALTH AFFS. 1379, 1380 (2022) ("Administrative records, such as those collected during health care visits, are inadequate in identifying people with disabilities, as they do not capture the full conceptual definition of disability. Therefore, researchers use surveys to estimate the size and characteristics of the disability population. Surveys differ in how they identify disabled respondents, and none does so perfectly—a limitation that hinders understanding of health needs and experiences of people with disabilities, as well as their health outcomes.").

16. *Id.*

Intersectionality also plays an increasingly important role when examining issues impacting people with disabilities.[17] Kimberlé Crenshaw was the first to use the term "intersectionality" to mean "a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other."[18] Crenshaw initially used this theory to explain systemic discrimination against Black women.[19] However, the theory's use is expansive to further explore other systemic discrimination including disability.[20] The intersection of race and disability provides an example:

> Scholars in the field of sociology and philosophy have since expanded the intersectional conversation to include the disability community. However, even though intersectionality is critical in understanding the diverse experiences of individuals with disabilities, little research has focused on how this intersectionality plays out in the economic sphere.[21]

Intersectionality involving disability and race is more prominent than before.[22] For example: "Among racial and ethnic groups, disability prevalence is highest among American Indian/Alaska Native populations and lowest among Asian populations."[23] The CDC has recorded statistics on the intersection between race or ethnicity and disability to find that one in four Black individuals also have a disability.[24]

With the significance of statistics involving individuals with disabilities in the U.S., it should be a priority, rather than an afterthought, for policymaking to consider disability. This information should drive lawmakers to ensure that legal reforms do not neglect this population, especially as far as healthcare with the greater implementation of technology to deliver healthcare. Further, it remains unknown precisely how many individuals with Long-Covid will

17. *Race, Ethnicity, and Disability: The Financial Impact of Systemic Inequality and Intersectionality*, NAT'L DISABILITY INST. (Aug. 2020), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2020/08/race-ethnicity-and-disability-financial-impact.pdf [https://perma.cc/5ULJ-A2FT].

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

22. Mitra et al., *supra* note 15, at 1379.

23. *Id.* at 1380.

24. *Disability and Health Promotion: Ethnicity and Race*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ncbddd/disabilityandhealth/materials/infographic-disabilities-ethnicity-race.html [https://perma.cc/3HX4-7DRA].

inevitably qualify as disabled even causing some to call this a "mass disabling event.[25]" There has generally been guidance that Long-Covid can be considered a disability under federal disability rights laws.[26] For example, guidance by the U.S. Department of Health and Human Services (HHS) has stated:

> Yes, long COVID can be a disability under the ADA, Section 504, and Section 1557 if it substantially limits one or more major life activities. These laws and their related rules define a person with a disability as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of such individual ("actual disability"); a person with a record of such an impairment ("record of"); or a person who is regarded as having such an impairment ("regarded as"). A person with long COVID has a disability if the person's condition or any of its symptoms is a "physical or mental" impairment that "substantially limits" one or more major life activities.[27]

As this new group of individuals with diagnosis of Long-Covid now qualifies as disabled under legal definitions, it will substantially increase the number of individuals with disabilities overall in the U.S. However, again, the exact impact is still unknown. This understanding must also fuel how modern issues are addressed in terms of existing disability rights protections and to the extent that they have not, alterations must either be made to the sources of those existing rights or new legislative solutions must be explored and promoted to ensure that those protections meet these needs. Our existing legal protections for disability rights are only as impactful as they are implemented and enforced. In other words, to have protection for reasonable accommodation to access healthcare services, including those involving technology, cannot be achieved if the technology is not accessible.

25. Kate Anderson, *The Effects of Long Covid*, WORLD INST. ON DISABILITY, https://wid.org/the-effects-of-long-covid/ [https://perma.cc/JP5Y-HD3H]; Karen Bonuck, *Long COVID Persists as a Mass Disabling Event*, MEDPAGETODAY (July 23, 2023), https://www.medpagetoday.com/opinion/second-opinions/105599 [https://perma.cc/DNT8-76G7].

26. *Guidance on "Long COVID" as a Disability Under the ADA, Section 504, and Section 1557*, U.S. DEP'T HEALTH & HUM. SERVS. (July 26, 2021), https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/guidance-long-covid-disability/index.html [https://perma.cc/B8ZT-HYB6].

27. *Id.*

III. Existing Healthcare Disparities

a. Current Understanding of Existing Healthcare Disparities

The Covid-19 pandemic drew attention to the instances in which people with disabilities were being discriminated against in healthcare access.[28] Examples of this discrimination include vaccination availability and allocation of medical resources that may lead to healthcare rationing (i.e., availability of ventilators).[29] However, healthcare disparities of people with disabilities have existed long before the Covid-19-pandemic.[30] The existence of healthcare disparities for people with disabilities has been recognized for some time:

> Persons with disabilities are a vulnerable population with unique social, economic, and environmental disadvantages. They have distinct disparities that influence healthcare access, compromise their health, and ultimately lead to them having far worse healthcare outcomes than persons without disabilities.[31]

The CDC published statistics regarding healthcare access for people with disabilities.[32] These involve general access to healthcare in terms of having a primary care physician to the impact of cost of healthcare on the population:

> 1 in 4 adults with disabilities 18 to 44 years do not have a usual health care provider
>
> 1 in 4 adults with disabilities 18 to 44 years have an unmet health care need because of cost in the past year
>
> 1 in 5 adults with disabilities 45 to 64 years did not have a routine check-up in the past year[33]

In addition to this already bleak picture of healthcare access for people with disabilities, there is greater recognition that healthcare disparities increase more when it comes to intersectionality. This includes those who are both disabled and members of particular racial groups:

> Studies have found that adults with disabilities in underserved racial and ethnic groups are more likely to report fair to poor

28. Mitra et al., *supra* note 15, at 1380.

29. Zachary Parolin & Emma K. Lee, *The Role of Poverty and Racial Discrimination in Exacerbating the Health Consequences of COVID-19*, 7 Lancet 1, 3 (2022).

30. Mitra et al., *supra* note 15, at 1382.

31. Annaswamy et al., *supra* note 3, at 2.

32. *Disability Impacts All of Us*, *supra* note 14.

33. *Id.*

> health or that their health has worsened over the past year, compared with people without disabilities in the same racial/ethnic groups and with non-Hispanic whites with disabilities.[34]

In considering the healthcare for people with disabilities, two concepts that work together are relevant: health disparities and health equity. Health disparities as it applies to people with disabilities means having a lesser quality of healthcare due to systemic issues that are discriminatory to the disabled. "[35] To achieve health equity, the U.S. would need to become devoid of the healthcare disparities that people with disabilities as well as other marginalized groups experience.[36]

But to reach health equity, an adequate understanding of healthcare disparities is necessary. It has only been in the past few decades that the healthcare disparities existing for people with disabilities have achieved greater attention by the U.S. federal government:

> Released in 2000, *Healthy People 2010* was the first of the decennial reports produced by the Department of Health and Human Services (HHS) delineating national public health priorities to identify people with disability as experiencing health care disparities, partially attributing these inequities to common misconceptions about this population. During the past two decades increasing evidence has documented persistent disparities for people with disability, now including more than sixty-one million Americans—numbers that will grow in coming years with the aging population.[37]

In October 2022, a review of healthcare disparities for people with disabilities continues to demonstrate that the existence of civil rights protections have not had a substantial impact on reducing the disparities:

> The enduring health and health care disparities disadvantaging Americans with disabilities are discouraging, given the nearly half century of civil rights laws intended to achieve equity for disabled people. Section 504 of the Rehabilitation Act of 1973 requires that programs receiving federal funds, including Medicare and

34. *Health Equity Framework for People with Disabilities*, *supra* note 11.

35. *Id.*

36. Health equity is the principle underlying the commitment to the attainment of the highest level of health for all people, which requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

37. Lisa I. Iezzoni et al., *Physicians' Perceptions Of People with Disability and Their Health Care*, 40 HEALTH AFFS. 297, 297 (2021).

> Medicaid, ensure equitable access for disabled Americans. The Americans with Disabilities Act (ADA) of 1990 and the ADA Amendments Act of 2008, which clarified definitions of disability, extended these civil rights protections to other public and private settings and services. Section 1557 of the 2010 Patient Protection and Affordable Care Act (ACA) amended Section 504 of the Rehabilitation Act and several other statutes to provide additional protections against disability discrimination in health care services. Nevertheless, disabled Americans experience disparities and inadequate services across the health care continuum, from preventive care to home and community-based services.[38]

Healthy People 2030 gives the population of people with disabilities a specific designation for healthcare disparities and even targeted goals for how to better achieve removing these barriers in accessing healthcare.[39] Research for the National Institute of Health ("NIH") only now recognizes people with disabilities as a population with healthcare disparities as of September 2023.[40] The question then becomes what has contributed to creating these healthcare disparities for people with disabilities. Several factors have been identified as influencing not only the existence but the prevalence of these disparities:

> Many patient-level factors likely contribute to these disparities, such as patients' complex underlying health conditions, disadvantages in social determinants of health, and patients' preferences for care. Systems-level factors also contribute, including inadequate training of health care professionals, ineffective communication accommodations, physical access barriers, and inadequate knowledge among physicians about legal requirements to provide equitable care under the Americans with Disabilities Act (ADA) of 1990. Despite it being more than thirty years since the enactment of this landmark civil rights legislation for people with disability, this population continues to experience inequitable health care on many levels.[41]

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38. Lisa I. Iezzoni et al., *Have Almost Fifty Years of Disability Civil Rights Laws Achieved Equitable Care?*, 41 HEALTH AFFS. 1371, 1371 (2022).

39. *Healthy People 2030: People With Disabilities*, HEALTH.GOV, https://health.gov/healthypeople/objectives-and-data/browse-objectives/people-disabilities [https://perma.cc/ZC7P-KTJH].

40. *NIH Designates People with Disabilities as a Population with Health Disparities*, NAT'L INST. HEALTH (Sept. 26, 2023), https://www.nih.gov/news-events/news-releases/nih-designates-people-disabilities-population-health-disparities [https://perma.cc/EK6Z-SVQ7].

41. Iezzoni et al., *supra* note 37, at 297.

Among the factors listed here is "ineffective communication accommodations." This can be particularly important when thinking about healthcare involving the use of telehealth where individuals with disabilities may have specific needs. This may include such things as the use of assistive technologies that work with the particular technology involved or the use of sign language interpreters for those who are deaf or hard of hearing. Research shows that access to accommodations for these communication needs have often been denied or neglected by medical professionals despite the federal legal responsibilities that exist to provide these:

> Effective communication between patients and clinicians is essential to ensuring high-quality care and is required under the ADA and Rehabilitation Act Section 504. For people with disabilities that affect oral or written communication (for example, relating to hearing, vision, and speech), various auxiliary aids, telecommunication methods, and other services facilitate effective communication. However, research suggests that patients often do not receive these accommodations.[42]

Although physicians are aware that they are failing to appropriately accommodate these communication needs, the issues persist. However, perhaps physicians' lack of knowledge regarding their obligations under federal law and their options for accommodations is an even greater problem leading to extensive litigation over effective communication in the healthcare setting.[43]

Another huge contributing factor is that disability data has been inappropriately maintained historically by the government. It was due to the passage of the Affordable Care Act (ACA) that change was

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42. Iezzoni et al., *supra* note 38, at 1372.

43. "Physicians sometimes recognize that they fail to accommodate disabled patients' communication preferences, blaming logistical concerns, costs, or ignorance about communication options. Not surprisingly, a large fraction of ADA lawsuits involve failures to ensure effective communication. In the 2019–20 survey, 35.8 percent of physicians reported knowing little or nothing about their legal responsibilities under the ADA, and 71.2 percent responded incorrectly about who determines reasonable accommodations for patients with disabilities (these decisions require collaboration between patients and clinicians). To make communication accessible, clinicians need more training about their legal obligations and on strategies and accommodations to address communication barriers. The ADA recognizes that 'there is no one-size-fits-all solution [for the] provision of auxiliary aids and services.' Asking patients which communication accommodations work best for them and then following their preferences would maximize communication access and reduce lawsuit risks." *Id.* at 1372–73.

initiated in collecting data. However, even with the questions in use regarding disability in this data collection, gaps still exist in the information currently collected.[44] Because of this, ensuring the gathering of sufficient information will ultimately transform access to healthcare for people with disabilities:

> As demonstrated during the COVID-19 pandemic, the absence of disability data in public health and health care delivery systems impedes efforts to monitor and manage the health care experiences of people with disabilities. Furthermore, this "lack of data perpetuates the exclusion of disabled people from discussions of health equity and policies that are data driven." Electronic health records also do not consistently capture disability status, despite the need for this information to support clinical care and facilitate the timely provision of reasonable accommodations during health care encounters. In its 2022 *Health Equity Framework,* the NCD included improving disability data collection across the life span among its top priorities.[45]

Research also demonstrates that it is not a disability or health specific issue itself that is as detrimental to the healthcare access for a person with a disability as much as the biases of the healthcare provider as one of the "key factors" contributing to healthcare disparities.[46]The fact that healthcare disparities of people with disabilities are not always based on their disabilities per se ultimately leads to a closer look at the potential influence of both explicit and implicit biases in the providers of healthcare of the disabled.

b. Issues of Bias

It is known that both explicit and implicit bias exists for people with disabilities generally. What does this actually look like practically speaking? In example, "Erroneous assumptions about disabled people affect their quality of care. For instance, clinicians may believe that people with hearing loss have low intelligence and disrespect their perspectives."[47] First, it is important to understand how explicit and implicit bias are distinguished as explicit biases are shown in specific intentional behavior based on a particular characteristic (i.e., disability) resulting in discrimination while implicit bias has the same result of discrimination based on characteristic due to an individual (i.e., the physician)'s negative attitude/assumption without it being blatant. While progress exists to some degree regarding explicit bias, implicit

44. Mitra et al., *supra* note 15, at 1382.

45. Iezzoni et al., *supra* note 38, at 1372.

46. Laura VanPuymbrouck et al., *Explicit and Implicit Disability Attitudes of Healthcare Providers*, 65 Rehabilitation Psych. 101, 101 (2020).

47. Iezzoni et al., *supra* note 38, at 1374.

bias is not experiencing that same success for the disabled. Compared to other groups, disability continues to maintain a significant disadvantage when it comes to eradicating implicit bias.[48] An estimate exists that it could take 200 years to neutralize the present extent of implicit bias surrounding disability.[49]

Research demonstrates the existence of both explicit and implicit biases, in particular, with regard to healthcare of people with disabilities. Implicit biases in healthcare only fosters the creation of healthcare disparities. Implicit bias is likely more difficult to detect in healthcare.[50] Medical providers transfer their implicit bias to their relationships with their patients.[51] In general, healthcare professionals who lack knowledge about people with disabilities have impacted clinical treatment, ultimately leading to people with disabilities to have decreased access to healthcare. [52]

In research conducted on the relationship of explicit and implicit biases of healthcare providers, results revealed that implicit bias was higher than explicit bias but that still led to significant issues in access to healthcare. The study results indicate that healthcare providers have implicit biases against people with disabilities.[53] However, the disabled have been excluded from research, so researchers must, further explore what contributes to providers having implicit bias and the impact on healthcare of people with disabilities.[54]

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48. Nikki Rojas, *Why Disability Bias Is a Particularly Stubborn Problem*, HARV. GAZETTE (Jan. 10, 2022), https://news.harvard.edu/gazette/story/2022/01/why-disability-bias-is-a-particularly-stubborn-problem/ [https://perma.cc/WZH9-WK6R].

49. *Id.*

50. VanPuymbrouck et al., *supra* note 46, at 102.

51. *Id.* ("As disability bias is extremely prominent (Friedman, 2019), it is likely that providers not only have biased disability attitudes, but also demonstrate biased interactions with PWD that are impacted by these attitudes.").

52. *Id.* "In addition, research suggests that lack of provider knowledge in working with PWD contributes to inequities in health care access as well as preventable inequities in health outcomes." *Id.* "In fact, Healthy People 2020 [] reveals that common provider misperceptions about PWD contribute to under referral and disparities in methods to manage health []. Evidence also suggests providers make clinical decisions that work to avoid treating PWD [] and that providers' lack of knowledge about disability, as well as their medicalized attitudes of PWD, negatively impact access to care for PWD []." *Id.*

53. *Id.*

54. *Id.* at 108 ("A growing body of literature acknowledges providers' implicit bias, attitudes, and beliefs contribute to unequal treatment and referral to services of patients from minority and ethnic groups (Dovidio & Fiske, 2012; Hall et al., 2015). PWD are a disparate health population often overlooked in these studies; however, the findings from our research indicate the majority of providers do hold implicit biases against PWD,

How do we change the impact of bias in the healthcare industry that is entrenched in healthcare access for people with disabilities? Some medical schools are making calls to implement trainings for disability training including exposure to patients with disabilities.[55] Further, it is critical to ensure that people with disabilities themselves are members of the medical profession. However, the ability of individuals with disabilities to be members of the medical industry and provide this representation are not without significant barriers.[56]

The existence of biases impacts healthcare outcomes for people with disabilities. As telehealth is now a more regular option in the delivery of healthcare, the trust in the patient-provider relationship is increasingly critical to healthcare, which often experiences significant strain for many patients with disabilities.

IV. UNDERSTANDING TELEHEALTH & ITS USE

Before addressing the potential barriers to telehealth use by the disabled, a basic understanding about telehealth generally is necessary. This includes what it means in terms of delivering healthcare and what we know about its use in the U.S., particularly among people with disabilities. This may provide specific guidance into how particular segments of the disabled population use telehealth while others do not.

a. Defining Telehealth

First, there is not a single definition of telehealth in use in the U.S.[57] At its most basic level, the Center for Connected Health Policy ("CCHP") describes telehealth's role in healthcare delivery as follows:

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and, in many cases, are not cognizant of their own biases. As such, we believe these findings indicate a need for increased study of this phenomenon and the mechanisms that influence it, as well as how providers' attitudes continue to impact the health care experiences and health outcomes of PWD. Based on the results of our analysis as well as previous literature, it may be theorized that biases toward PWD contribute to unequal clinical treatment, similar to those inequities experienced by other social minority groups. More research is needed to fully understand the impact of bias on PWD in health care contexts, as well as to determine and implement effective means of reducing bias among providers. Specific interventions aimed at prejudice reduction among providers must be tailored not only to individual health care contexts but also to address the four distinct combinations of explicit and implicit bias to better address the mechanisms that can influence clinical decision making and negatively impact healthcare experiences and health outcomes of PWD.").

55. *Id.* at 108–109.

56. *Id.*

57. *What Is Telehealth?*, CTR. FOR CONNECTED HEALTH POL'Y, https://www.cchpca.org/what-is-telehealth/ [https://perma.cc/SB2R-

> telehealth refers to a collections of methods to enhance health care delivery and education — it's not a specific service. Ideally, there should not be any regulatory distinction between a service delivered via telehealth and a service delivered in person. Both should be held to the same quality and practice standards. The "tele-" descriptor should ultimately fade from use as these technologies seamlessly integrate into health care delivery systems.[58]

This article uses the following definition for "telehealth:" "a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies."[59] There are various forms of telehealth, including "live video, store-and-forward, remote patient monitoring, and mobile health."[60] Frequently, in the telehealth policy landscape, the terms "telehealth" and "telemedicine" are interchangeable. However, the two terms are technically distinct.[61] Despite these distinctions, telehealth has increasingly become the dominant term in the policy space and thus, this article adopts its use as well.[62]

There has been growing recognition of the impact of telehealth globally in the delivery of healthcare by the WHO, which emphasizes ensuring that there is attention to its implementation:

> Telehealth is a service that has been widely applied in many countries for decades now. During the Covid-19 pandemic, the

34ZP] (monitoring and tracking legislation and policy developments federally as well as the state level specific to telehealth).

58. *Id.*

59. *A Framework for Defining Telehealth*, CTR. FOR CONNECTED HEALTH POL'Y, https://cdn.cchpca.org/files/2018-10/Telehealth%20Definintion%20Framework%20for%20TRCs_0.pdf [https://perma.cc/7W2L-SAHG].

60. *What Is Telehealth?*, *supra* note 57.

61. *Frequently Asked Questions*, HEALTHIT.GOV, https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine [https://perma.cc/QJW4-TCWA] ("Telehealth is different from telemedicine because it refers to a broader scope of remote healthcare services than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.").

62. *What is Telehealth?*, *supra* note 57 ("While 'telemedicine' was commonly used in the past, it is being phased out in favor of 'telehealth,' which is a more universal term for the current broad array of applications in the field. Its use crosses most health service disciplines, including dentistry, counseling, physical and occupational therapy, home health, chronic disease monitoring and management, and disaster management; it's also expanded beyond traditional diagnostic and monitoring activities to include consumer and professional education.").

> use of telehealth services has increased substantially in many countries, becoming a basic need for the general population, enabling people in real time to contact health care providers from home. As such, telehealth contributes to achieving universal health coverage (UHC) in countries by improving access to quality and cost-effective health services for patients regardless of their setting. It is particularly valuable for those who live in remote areas and for marginalized populations.[63]

Given this understanding of the global impact of telehealth, an examination of the use of telehealth specifically in the U.S.is found below.

b. Use of Telehealth in the U.S. Generally

It is undisputed that the use of telehealth significantly increased during the pandemic and research demonstrates this is particularly true during its peak:

> The use of telehealth services surged during the COVID-19 pandemic. A 2020 study found that telehealth use during the initial COVID-19 peak (March to April 2020) increased from less than 1 percent of visits1 to as much as 80 percent in places where the pandemic prevalence was high, 2 and a recent ASPE report found that Medicare telehealth utilization increased 63-fold between 2019 and 2020.[64]

However, there has been a decline in telehealth use since this peak in the pandemic.[65] Despite this, the use of telehealth has continued to remain relatively high:

> As Americans navigate the new normal, telehealth use remains relatively high. Recent data from FAIR Health shows a 0.3 percent decline in telehealth as a proportion of all medical claim

63. WORLD HEALTH ORGANIZATION & INTERNATIONAL TELECOMMUNICATION UNION, WHO-ITU GLOBAL STANDARD FOR ACCESSIBILITY OF TELEHEALTH SERVICES vii (2022).

64. Madjid Karimi et al., *National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services*, U.S. DEP'T HEALTH & HUM. SERVS. (Feb. 1, 2022), https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf [https://perma.cc/TZK4-U3UM].

65. Andis Robeznieks, *Inside the Big Variations in Telehealth Use Among Physicians*, AMA (July 11, 2022), https://www.ama-assn.org/practice-management/digital/inside-big-variations-telehealth-use-among-physicians [https://perma.cc/226U-XCEH] ("The survey of 2,232 physicians (PDF) conducted online in late 2021 found that telehealth use has dropped off somewhat since adoption skyrocketed at the start of the COVID-19 pandemic, but interest in maintaining virtual visits remains high.").

> lines from February to March. But still, in March, telehealth encompassed 4.6 percent of all medical claim lines.[66]

Further, the American Medical Association ("AMA")'s survey demonstrated that there has been various use of telehealth among physicians. Further, the extent to which physicians have telehealth available also varies.[67] "Not all physician practices are making equivalent use of telehealth, the AMA survey found. About half (46.8%) said up to 20% of their patient visits were conducted via telehealth. One-fifth of respondents (21.3%) reported seeing more than 80% of patients through telehealth."[68] This research also revealed only 1.3% of physicians had no telehealth visits.[69] Despite these differing statistics, the AMA has generally acknowledged that satisfaction exists in telehealth use by both providers and patients.[70] Because of this, the AMA supports continuing efforts to remove barriers to telehealth accessibility.

Newer research, however, suggests that people's preference for continuing telehealth use is not as high beyond the pandemic with 52% of those polled in a recent study indicating they will not continue to use telehealth post-pandemic.[71] 48% of those polled indicated that telehealth was good to keep for the use of healthcare delivery beyond the pandemic.[72]

c. Use of Telehealth by People with Disabilities

i. Purpose and Scope of the Study

While research on telehealth use involving people with disabilities is slim, there is evidence of what telehealth use looked like for those with disabilities during the pandemic.[73]

In the first major study to examine telehealth use by the disabled, the authors acknowledge the existing healthcare disparities as well as the possibility that issues involving telehealth access may have increased these during the pandemic.[74] Among the concerns as far as

66. Anuja Vaidya, *Over Half of Americans Unlikely to Use Telehealth Post-Pandemic*, MHEALTH INTEL. (July 6, 2022), https://mhealthintelligence.com/news/over-half-of-americans-unlikely-to-use-telehealth-post-pandemic [https://perma.cc/V6WD-8Y8X].

67. Robeznieks, *supra* note 65.

68. *Id.*

69. *Id.*

70. *Id.*

71. Vaidya, *supra* note 66.

72. *Id.*

73. Friedman & Vanpuymbrouck, *supra* note 4, at 1.

74. *Id.* ("During the pandemic, PWDS were disproportionally affected by COVID-19 (Centers for Disease Control and Prevention, 2021a, 2021b;

barriers to telehealth use, the study lists enforcement of laws.[75] However, the main goal of the study was to provide initial insight to telehealth use by people with disabilities during the pandemic in order to provide greater understanding as to where accessibility gaps may exist.[76] The parameters of the study involved examining the use of telehealth from the period of April through July 2021, covering the second year of the COVID-19 pandemic.[77] Data collection from about 39,000 people with disabilities was a representative sample of the existing demographics in the U.S. overall.[78]

The research indicates that the use of telehealth by disability type is potentially a strong indicator of accessibility issues:

> Given the significant proportion of a PWDS accessing telehealth during the pandemic in our study, it is important to ensure telehealth is accessible for this community as the pandemic continues and beyond. Understanding the use of telehealth by persons from different disability groups may expose those members from within the larger group of at the most risk of inequitable access issues and, ultimately, disparate health outcomes.[79]

Below are some takeaways from this research.

ii. Outcomes from the Study

While this was only a representative study from during the pandemic, there is still relevant and valuable insight this study provides as far as guidance in terms of potential challenges for the accessibility of telehealth to people with disabilities. First, it is critical to recognize the overall use of telehealth by the disabled during this period: "Our findings showed 39.8% of PWDS used telehealth within the last month of the survey during the second year of the pandemic."[80] However, the

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Chakraborty, 2021; Dobransky & Hargittai, 2020; FAIR Health et al., 2020; Turk et al., 2020). However, it is unknown how longstanding barriers to health care access contributed to these inequities, or if new barriers arose, such as related to telehealth, that also impacted person's health care access.").

75. *Id.* at 1.

76. *Id.* at 2 ("Understanding if, and how, persons from across different disability communities used telehealth during the pandemic is vital to assuring that this evolving and increasingly common form of health care is equitably developed and delivered to avoid reproducing disparities in health outcomes for PWDS.").

77. *Id.* at 1.

78. *Id.* at 2–4.

79. *Id.* at 8.

80. *Id.*

use of telehealth by the disabled differed with respect to type of disability with the greatest use by those with mobility disabilities by 43.3% while those with hearing disabilities were utilizing telehealth the least with 34.5%.[81]

Aside from disability type, examination of other demographics demonstrated notable differences including gender, race, education, marital status, and geographic location.[82] Regarding gender, women with disabilities were 1.16 times more likely to use telehealth during this period controlling for all other variables.[83] As far as race, "other race" or "multiracial" individuals with disabilities were 1.22 times more likely to use telehealth than those with disabilities who were white.[84] Educational level also seemed to influence telehealth use for individuals with disabilities as those with graduate level degrees being more likely to utilize telehealth than other educational levels.[85] Marital status was another indicator as far as telehealth use for people with disabilities who were married as more likely to utilize telehealth.[86] Geographic location was further associated with different telehealth use by the disabled as those in the Northeast utilized telehealth more during this period of those surveyed.[87]

Another indicator as far as telehealth use of people with disabilities was whether or not individuals had health insurance.[88] Those with employer-based insurance demonstrated use of telehealth services with a 1.41 times greater use, private insurance (1.21), Medicare (1.36), Medicaid (1.79), and Veterans Affairs insurance coverage (1.62).[89] The greater use of telehealth by people with disabilities in the federal public benefit programs (particularly, in Medicare and Medicaid) is largely the result of the flexibilities that were created in policies during the COVID-19 pandemic in response to the limited in-person opportunities for healthcare (if, at all) and the need to try to maintain continuity of healthcare in this period.[90]

81. *Id.* at 4.

82. *Id.* at 4–6.

83. *Id.* at 7.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.* at 7.

88. *Id.* at 10.

89. *Id.* at 6.

90. Mark Melchionna, *House Passes Bill Extending Telehealth Flexibilities to End of 2024*, MHEALTH INTEL. (July 28, 2022), https://mhealthintelligence.com/news/house-passes-bill-extending-telehealth-flexibilities-to-end-of-2024 [https://perma.cc/S9KW-XMY6].

Current research seems to have only evaluated what we know as far as telehealth use for the population during the pandemic thus, continued research is necessary to learn more to further guide understanding to inform policymaking. Regardless, there is quite a bit of exploration that must occur as far as both the barriers to telehealth use by people with disabilities as well as possible benefits.

d. Benefits and Barriers of Telehealth to People with Disabilities

No two disabilities are alike, even within the same category of disability. Because of this, it is only possible to provide broad suggestions about the benefits and barriers of telehealth use for people with disabilities as a population. Each individual with a disability is going to have specific needs.[91] Therefore, each person with a disability will have a different experience with telehealth.[92]

i. Potential Barriers

A. The Digital Divide

In order to benefit from telehealth, an individual needs access to technology in multiple ways.[93] Specifically, an actual device (i.e., a cell phone, laptop, computer, or iPad) as well as internet access.[94] The lack of access to technology such as a cell phone, laptop, or iPad, the lack of a good internet connection, and the actual ability to use these various forms of technology are what is known as "the digital divide."[95] "First used in the mid-1990s, the "digital divide" refers to the inequities between those with computer and internet access and those without, including educational, economic, and social inequities."[96] Although a number of actions taken by the federal government to improve the digital divide, these are likely not enough to improve the needs of people with disabilities.[97] Research demonstrates the impact of the digital divide on the disabled both in terms of access to the technology as far as devices as well as Broadband internet access.[98]

91. Rupa S. Valdez et al., *Ensuring Full Participation of People with Disabilities in an Era of Telehealth*, 28 JAMA 389, 390 (2021).

92. *Id.*

93. *Preparing for a Virtual Visit*, TELEHEALTH.HHS.GOV, https://telehealth.hhs.gov/patients/preparing-for-a-video-visit [https://perma.cc/73FK-RRA3].

94. *Id.*

95. Velasquez & Mehrotra, *supra* note 2.

96. NATALIE LAWSON ET AL., DISABILITY AND TELEHEALTH SINCE THE COVID-19 PANDEMIC, BARRIERS OPPORTUNITIES, AND POLICY IMPLICATIONS 2 (2022).

97. *Id.*

98. Valdez et al., *supra* note 91, at 390.

Having access to technology and the financial means to have the technology are considerable barriers to telehealth use for people with disabilities highlighting the impact of the digital divide on them. "According to a survey by the Pew Research Center, people with disabilities are 20 percentage points less likely to own a computer, smartphone, or tablet compared to people without disabilities .[99] Plus, 26% of people with disabilities lived at or below the poverty line in 2019, compared to just 11% of people without disabilities."[100] Further research indicates the severity and impact of affordability of technology for the disabled given the low level of income many in the population experience: "People with disabilities also had median full-year work earnings $8,000 lower than those not disabled Thus, highspeed internet connections and advanced devices may be disproportionately unaffordable for people with disabilities."[101] Intersectionality can also come into play, as several racial or ethnic groups with disabilities experience greater poverty.[102] Further, the job losses of people with disabilities were significant during the pandemic possibly increasing the inability of this population to afford the technologies and internet needs.[103]

B. Inaccessible Design of Technology

Having the necessary technology and connectivity may not be enough for someone with a disability to have a successful telehealth experience if the design of the technology is inaccessible.[104] The following describes the inaccessibility of technology:

> The design of multiple forms of telehealth technology is largely inaccessible. For example, video-based telehealth services remain

99. LAWSON ET AL., *supra* note 96, at 4.

100. *Id.* at 2.

101. *Id.*

102. *Id.* at 3; NANETTE GOODMAN ET AL., FINANCIAL INEQUALITY: DISABILITY, RACE AND POVERTY IN AMERICA 11 (1992) ("There are also racial disparities within the disabled population. For example, approximately 40 percent of African Americans with disabilities live below the poverty line, compared to 26 percent of non-Hispanic whites with disabilities."

103. LAWSON ET AL., *supra* note 96, at 3; *Governors' Role in Promoting Disability Employment in COVID-19 Recovery Strategies*, NAT'L GOVERNORS ASS'N (Mar. 23, 2021), https://www.nga.org/wp-content/uploads/2021/03/SEED_Memo.pdf [https://perma.cc/GT5Z-4HKN] ("From March to April 2020, the number of employed working-age people with disabilities fell by 20 percent (950,000 people), while the number of employed working-age people without disabilities decreased by 14 percent [. . .] [b]ased on trends in previous recessions, it is likely people with disabilities who experience job loss will be slower to recover their previous employment status.").

104. Valdez et al., *supra* note 91, at 390.

> inaccessible to many with communication-related disabilities (ie, individuals who are deaf, hard of hearing, deafblind, blind, low vision, and speech disabled), as well as individuals who have intellectual disabilities. Likewise, patient portals remain inaccessible to a wide-range of people including some of those mentioned above and those who rely on assistive technology to interact with technology-based systems.[105]

If there are not future modifications to improve technology to make it with the needs of people with disabilities in mind from the start, many in this population may be unable to access telehealth due to inaccessible design.

C. Decreased Quality of Care

If telehealth is not truly accessible to people with disabilities, the inaccessibility could lead to a disruption of care and ultimately reduce the quality of the individual's healthcare.[106] Having a lack of access such as appropriate internet and up-to-date technology may lead to cancellation of medical appointments.[107] It could also increase the chances of having incidents of disconnection and the potential of medical professionals to misinterpret situations.[108] This may contribute to furthering the already existing healthcare disparities for people with disabilities previously discussed.

D. Lack of Training of Medical Professionals/Accessibility of the Health Care System

Another challenge presented by telehealth comes with ensuring that people with disabilities are able to use the technology involved.[109] These realities, both in terms of training and other assistance, are best captured in this description:

> At the level of the health system, additional considerations relate to training both for providers and patients in the use of telehealth technologies. In particular, patients may need assistance learning how to use new forms of technology, including the ways in which they can configure the technology to be accessible for them. Some individuals with disabilities may benefit from a "test run" to minimize stress associated with a new form of interaction. Training and resources need to be developed and made available to providers who are less familiar with ensuring the highest degree of accessibility. Health care systems must make available

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.* at 390.

> necessary personnel (eg, qualified sign language interpreters, speech to speech translators, and readers) and help providers integrate these accommodations into standard clinical workflow. Closed-captioning, alt text, audio description, and large text options must also be provided. Attending to these implementation factors will further ensure that people with disabilities are able to fully engage with a broad range of telehealth services.[110]

If the implementation of telehealth services occurs without these considerations for training and accessibility, people with disabilities may not benefit from this delivery method of healthcare.

ii. Possible Benefits of Telehealth Use

While there are several potential barriers to telehealth use and access for people with disabilities, there are likewise many possible benefits.[111] Perhaps one of the greatest benefits is the potential of creating greater access to healthcare for people with disabilities (which is known to already be complex).[112] Also, this could lead to improving the overall quality of care.[113] This is achievable because being able to seek and receive healthcare from one's home removes several potential needs for individuals with disabilities even prior to arrival at the doctor's office. Even once an individual with a disability reaches the doctor's office, this can also pose accessibility issues.[114] Telehealth can also serve to reduce transportation costs and increase access to specialists.[115]

V. Legal Barriers to Access to Telehealth for People with Disabilities

There are several federal protections for people with disabilities to healthcare, including the ADA, the Rehabilitation Act of 1973, and the ACA. As much of the legal protections come under the ADA, these

110. *Id.* at 390–91.

111. *Id.* at 390.

112. *Id.*

113. *Id.*

114. *Id.* ("Additionally, people with disabilities frequently encounter another layer of barriers upon entering the clinical space. Despite provisions within Title II and Title III of the Americans with Disabilities Act (ADA), guaranteeing the accessibility of both public and private health care facilities, those attempting to engage in traditional clinical visits often encounter barriers such as inaccessible medical equipment, waiting rooms, and bathrooms as well as lack of appropriate accommodations, including wheelchair assistance and sensory-friendly spaces.").

115. *Id.*

protections are the focus of this article. A June 2022 Forbes Magazine article highlighted the irony of people with disabilities' ability to potentially benefit from telehealth yet the current major challenges in accessibility to that technology: "Unfortunately, the very group of people with the most to gain from telehealth, namely the one in five American citizens living with a disability, risk being shut out of the healthcare revolution due to the proliferation of inaccessible apps and websites providing these services."[116] In July 2022, the federal government provided the first official guidance regarding telehealth accessibility for people with disabilities.[117] A number of federal laws apply to using telehealth as a means of delivering healthcare for the disabled. In issuing this guidance, the department states the following:

> All entities subject to Section 504, the ADA, Title VI, and Section 1557 should review their telehealth systems, policies, and processes, to ensure accessibility of their telehealth programs for all persons with disabilities and limited English proficient persons.[118]

Despite existing federal protection, the adequacy of these protections are likely insufficient as such challenges already exist in healthcare access in the accessibility of the in-person healthcare experience.[119] Often medical professionals are unaware of the legal protections for people with disabilities in the telehealth context.[120] One of these hurdles

116. Gus Alexiou, *Inaccessible Telehealth Apps Don't Just Exclude — They're A Matter Of Life and Death*, Forbes (June 29, 2022, 6:00 AM), https://www.forbes.com/sites/gusalexiou/2022/06/29/inaccessible-telehealth-apps-dont-just-exclude--theyre-a-matter-of-life-and-death/?sh=755f9c5d493c [https://perma.cc/UEK7-Q67B].

117. *Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons*, U.S. Dept. Health & Hum. Servs. Off. Civ. Rts., https://archive.ada.gov/telehealth_guidance.pdf [https://perma.cc/3QB9-DNSF]; Amanda Krupa et al., *Issue Brief: The Critical Role of Web Accessibility in Health Information Access, Understanding, and Use*, Ahima Found. (Nov. 3, 2022), https://ahimafoundation.org/research/the-critical-role-of-web-accessibility-in-health-information-access-understanding-and-use [https://perma.cc/9FEC-R54B].

118. *Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons*, *supra* note 117.

119. Annaswamy et al., *supra* note 3, at 2.

120. Valdez et al., *supra* note 91, at 391 ("As individuals with disabilities cannot be excluded, denied, or given differential care, all covered entities (ie, health programs and activities that receive federal funding) must ensure accessibility of all programs delivered through electronic and information technology under Section 1557 of the Affordable Care Act. Additionally, under Titles II and III of the ADA, providers are required

is website accessibility for many individuals with disabilities under the Americans with Disabilities Act.[121]

a. Website Accessibility

Using websites and apps is a critical component of telehealth. but because there remain significant barriers to accessibility of both of these pathways to having access to healthcare digitally for people with disabilities, this remains undoubtedly one of the major obstacles to ensuring people with disabilities can benefit from the use of telehealth.[122] This was observed as follows:

> telehealth refers to a collections of methods to enhance health care delivery and education — it's not a specific service. Ideally, there should not be any regulatory distinction between a service delivered via telehealth and a service delivered in person. Both should be held to the same quality and practice standards. The "tele-" descriptor should ultimately fade from use as these technologies seamlessly integrate into health care delivery systems.[123]

This issue of inaccessibility of both websites and apps became especially prevalent during the Covid-19 pandemic when individuals first needed to access websites to register for vaccination.[124] Due to documented instances of inaccessible websites for the disabled, the DOJ approved settlements over website accessibility.[125] In its 2022 guidance, the DOJ recognized specific barriers for people with disabilities to website accessibility including:

> Poor color contrast
> Use of color alone to give information
> Lack of text alternatives ("alt text") on images
> No captions on videos
> Inaccessible online forms
> Mouse-only navigation (lack of keyboard options).[126]

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to communicate effectively with patients and their companions. Although these policies exist, there is a high level of ignorance surrounding the enforcement of this legislation.").

121. Annaswamy et al., *supra* note 3, at 2.

122. Alexiou, *supra* note 116.

123. *What Is Telehealth?*, *supra* note 57.

124. Alexiou, *supra* note 116.

125. *Id.*

126. *Guidance on Web Accessibility and the ADA*, U.S. Dept. of Just. Civ. Rts. Div. (Mar. 18, 2022), https://www.ada.gov/resources/web-guidance / [https://perma.cc/73K5-WH6K].

Many legal challenges still occur over website accessibility under the ADA with the most recent class action cases having been brought against major universities including Harvard University.[127] Target has also recently been brought into litigation over website accessibility.[128]

The ADA,[129] a pivotal federal anti-discriminatory law protecting the legal rights of people with disabilities, is a law that came into effect in the 1990s prior to the existence of the Internet and its full utilization. Because of this, the internet, website, and app accessibility is not in the text of the legal protections under the ADA.[130] Even when amendments to the ADA came years later in 2008 through the Americans with Disabilities Amendment Act of 2008 ("ADA Amendments Act"),[131] technological developments did not impact the amendments. Because the ADA Amendments Act also did not include more specific legal protections as far as technology, numerous court battles continue, even increasing in recent years, under both Title II and Title III of the ADA.[132]

i. Title II of the ADA—State and Local Governments

Title II of the ADA is one of the major sections that applies to healthcare entities regarding health care agencies run by state and local

127. Jessy Edwards, *Harvard University Class Action Claims Website Inaccessible to Visually Impaired, Blind*, TOP CLASS ACTIONS (Oct. 12, 2022), https://topclassactions.com/disability-class-action-lawsuit/harvard-university-class-action-claims-website-inaccessible-to-visually-impaired-blind/ [https://perma.cc/6SFP-J6PJ]; Abraham Jewett, *Colleges Face ADA Accessibility Lawsuits Over Websites*, TOP CLASS ACTIONS (Nov. 3, 2022), https://topclassactions.com/disability-class-action-lawsuit/colleges-face-ada-accessibility-lawsuits-over-websites/ [https://perma.cc/W98F-3BVP].

128. Jon Styf, *Target Class Action Claims Website Not Equally Accessible to Blind, Low-Vision Customers*, TOP CLASS ACTIONS (Oct. 11, 2023), https://topclassactions.com/disability-class-action-lawsuit/target-class-action-claims-website-not-equally-accessible-to-blind-low-vision-customers/ [https://perma.cc/R77X-W5XV].

129. *What Is the Americans with Disabilities Act (ADA)?*, ADA NAT'L NETWORK (Jan. 2024), https://adata.org/learn-about-ada [https://perma.cc/2BJD-TEEF].

130. Jeffery Collins, *Website Accessibility: The ADA And Access in Cyberspace*, JDSUPRA (June 1, 2023), https://www.jdsupra.com/legalnews/website-accessibility-the-ada-and-1168849 [https://perma.cc/GF5Y-PKRC] ("The ADA does not directly address whether places of public accommodation include websites, mobile applications, or other emerging web-based technologies.").

131. *Questions and Answers on the Final Rule Implementing the ADA Amendments Act of 2008*, U. S. EQUAL EMP. OPPORTUNITY COMM'N, https://www.eeoc.gov/laws/guidance/questions-and-answers-final-rule-implementing-ada-amendments-act-2008 [https://perma.cc/4EAG-6ZZ5].

132. Collins, *supra* note 130.

governments.[133] This section provides that qualified individuals with disabilities shall not be excluded from "participation in or be denied the benefits of the services, programs, or activities of a public entity."[134] There has generally not been major dispute that Title II of the ADA is applicable to coverage of website accessibility for state and local government healthcare entities as evidenced by various positions expressed by the federal government as seen by the Department of Justice ("DOJ").[135] The DOJ's 2003 Technical Assistance Guidance reiterates the legal protections for people with disabilities regarding website accessibility under Title II.[136]

The DOJ continued to reaffirm its position on website accessibility under Title II when it provided advanced notice regarding proposed rulemaking regarding Title II in 2010. [137] In March 2022, the DOJ issued guidance but stopped short of issuing regulations on the ADA for both Title II and Title III for website accessibility.[138] In describing the potential issues of inaccessibility of websites under Title II, the DOJ commented as follows, "A website with inaccessible features can limit the ability of people with disabilities to access a public entity's programs, services and activities available through that website—for example, online registration for classes at a community college."[139]

133. 42 U.S.C. § 12132; *Health Care and the Americans With Disabilities Act*, ADA NAT'L NETWORK, https://adata.org/factsheet/health-care-and-ada [https://perma.cc/CG35-4GAP].

134. 42 U.S.C. § 12132.

135. Nondiscrimination on the Basis of Disability; Accessibility of Web Information and Services of State and Local Government Entities and Public Accommodations, 75 Fed. Reg. 142 (proposed July 26, 2010) ("There is no doubt that the websites of state and local government entities are covered by [T]itle II of the ADA.").

136. *Accessibility of State and Local Government Websites to People with Disabilities*, U.S. DEPT. OF JUST. (June 2003), https://www.ada.gov/websites2.htm [https://perma.cc/66GB-J73X] ("One way to help meet these requirements is to ensure that government websites have accessible features for people with disabilities, using the simple steps described in this document. An agency with an inaccessible website may also meet its legal obligations by providing an alternative accessible way for citizens to use the programs or services, such as a staffed telephone information line. These alternatives, however, are unlikely to provide an equal degree of access in terms of hours of operation and the range of options and programs available.").

137. Nondiscrimination on the Basis of Disability; Accessibility of Web Information and Services of State and Local Government Entities and Public Accommodations, 75 Fed. Reg. 142 (proposed July 26, 2010) ("As use of the Internet to provide and obtain healthcare information increases, the inability of individuals with disabilities to also access this information can potentially have a significant adverse effect on their health.").

138. *Guidance on Web Accessibility and the ADA*, *supra* note 126.

139. *Id.*

Because of this, the DOJ reiterated its position in this guidance that Title II's coverage, that applies to state and local healthcare providers, "For these reasons, the Department has consistently taken the position that the ADA's requirements apply to all the services, programs, or activities of state and local governments, including those offered on the web."[140] These pronouncements demonstrate a consistent position from the federal agency ultimately charged with creating the regulations as far as website accessibility under Title II of the ADA. In July 2023, in conjunction with the 33rd anniversary of the ADA, the DOJ announced it would move forward with providing regulations for Title II for website accessibility and begin its agency rulemaking process, however, no proposed language for the regulations has yet been released.[141]

Case law has also supported the acceptance that "website accessibility" falls under the protection of Title II of the ADA as evidenced in a 2021 case.[142] In *Meyer*, challenges occurred to three State of Indiana agency websites to providing public benefits information for Medicaid, SNAP, and TANF arguing that loss of benefits had occurred and the "Benefits Portal" website was inaccessible in using screen readers. The argument by the state that both Title II of the ADA and Section 504 of the Rehabilitation Act of 1973 (which covers entities that receive federal funding), did not apply to their websites.[143] The court stated:

> Title II does not define the terms 'services, programs, or activities,' but applicable regulations provide that Title II 'applies to anything a public entity does,' *Oconomowoc Res. Programs, Inc. v. City of Milwaukee*, 300 F.3d 775, 782 (7th Cir. 2002) (citing 28 C.F.R. pt. 35, app. A), and 'most courts that have considered the phrase have concluded that the terms are to be defined broadly,' *Culvahouse*, 679 F. Supp. 2d at 939. *See also Ashby v. Warrick Cnty. Sch. Corp.*, 908 F.3d 225, 231, 234 (7th Cir. 2018) (noting the breadth of the ADA and the phrase 'services, programs, or activities').[144]

The court ruled against the state finding there was no "articulable reason" why websites "would fall outside the broad category of government activities encompassed by 'services, programs, or

140. *Id.*

141. Shaun Heasley, *Feds Propose Rules For Web Accessibility*, DISABILITY SCOOP (July 26, 2023), https://www.disabilityscoop.com/2023/07/26/feds-propose-rules-for-web-accessibility/30476/ [https://perma.cc/WRG6-T8UL].

142. Meyer v. Walthall, 528 F. Supp. 3d 928, 953 (S.D. Ind. 2021).

143. *Id.* at 948.

144. *Id.* at 958.

activities.'"[145] The court further went on to address the significance of the impact of the Covid-19 pandemic and the reality that we now live in a time where digital access is critically important: "[T]he realities of 21st century interactions—including those brought about by the COVID-19 pandemic—further confirm that a government's provision of information and services via websites is encompassed by Title II."[146] While there is still uncertainty as to when a plaintiff has standing in an ADA Title II case in some federal Circuits, the position of the DOJ has been accepted in terms of internet/website accessibility.[147]

While the DOJ's latest guidance does not have the same force of authority as regulations, the consistency in both case law and the position of the DOJ has left website accessibility under Title II generally much more settled than under Title III of the ADA. More formal adoption of regulations or law could otherwise firmly cement the requirements of website accessibility under Title II of the ADA. As mentioned above, the DOJ has signaled through a notice of proposed rulemaking that it will begin the process of implementing formal regulations for website accessibility under Title II. However, the DOJ is not yet taking similar action for Title III where the majority of litigation and a current Circuit split exists.

145. *Id.* at 958–59.

146. *Id.* at 959.

147. As noted by other courts in this district, there is a lack of guidance on Title II claims in the website context. *See, e.g.*, Price v. City of Ocala, Florida, 375 F. Supp. 3d 1264, 1274 (M.D. Fla. 2019) (The DOJ, which is charged with creating regulations to implement the ADA, has suggested such claims are available: "Although the language of the ADA does not explicitly mention the Internet, the Department has taken the position that [T]itle II covers Internet Web site access. Public entities that choose to provide services through web-based applications (e.g., renewing library books or driver's licenses) or that communicate with their constituents or provide information through the Internet must ensure that individuals with disabilities have equal access to such services or information, unless doing so would result in an undue financial and administrative burden or a fundamental alteration in the nature of the programs, services, or activities being offered. . . . [A]n agency with an inaccessible Web site may also meet its legal obligations by providing an alternative accessible way for citizens to use the programs or services, such as a staffed telephone information line. 28 C.F.R. § 35, App. A.") Furthermore, public entities are prohibited from "providing any aid, benefit, or service" that "[a]fford[s] a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others." 28 C.F.R. § 35.130(b)(1)(ii). They must also "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." *Id.* at § 35.130(b)(7)(i). *See also* Price v. Town of Longboat Key, 2019 U.S. Dist. LEXIS 84086, at *4–6 (M.D. Fla. May 20, 2019).

ii. Title III: Private Businesses/Public Accommodations

Unlike Title II, the vast majority of litigation involving website accessibility under the ADA has focused on Title III.[148] Even though more litigation has focused on Title III, there has been a dip in these lawsuits by approximately 22% between June 2021 and June 2022.[149] However, this has varied geographically as a decrease in these lawsuits was evident in California while those in New York were not as severe making it replace California as the leading state in Title III lawsuits regarding website accessibility.[150] Although the ADA at the federal level (as well as frequently Section 504 of the Rehabilitation Act if federal funding is involved with the entity)[151] has been the primary source of legal challenges, it is important to note that state anti-discrimination laws are often also used for these challenges.[152] First, an understanding of what and how Title III of the ADA may apply to website accessibility is essential.

Title III of the ADA provides that: "No individual should be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of *any place of public accommodation* by any person who owns, leases (or leases to) or operates a place of public

148. Minh Vu et al., *The Law on Website and Mobile Accessibility Growing at a Glacial Pace*, AM. BAR ASS'N (Jan. 1, 2022), https://www.americanbar.org/groups/law_practice/resources/law-practice-magazine/2022/law-website-mobile-accessibility/ [https://perma.cc/922Q-RYGZ].

149. Kristina Launey et al., *2022 ADA Title II Mid-Year Federal Lawsuit Filings Drop 22% Compared to 2021*, JDSUPRA (July 13, 2022), https://www.jdsupra.com/legalnews/2022-ada-title-iii-mid-year-federal-9525314/ [https://perma.cc/SWZ5-JN8Z] ("The year 2021 was a blockbuster for ADA Title III lawsuits filed in federal court, with over 11,452 filings. At the end of June 2021, the lawsuit count was 6,304. This year, the number of lawsuits filed by the end of June 2022 has dropped to 4,914 – a stunning 22 percent reduction.").

150. *Id.*

151. 129 U.S.C. § 794.

152. Vu et al., *supra* note 148 ("Over the past decade, courts have been increasingly inundated with lawsuits filed by individuals with disabilities claiming that businesses' websites are not accessible to them. These lawsuits, filed mostly by people who have sight or hearing disabilities, allege discrimination in violation of various local, state and federal laws. For example, Title III of the Americans with Disabilities Act (ADA) applies on the federal side. Similar laws such as California's Unruh Civil Rights Act or New York State and City Human Rights Laws apply on the state side. Because none of these laws or their regulations specifically address websites or contain any standards for website accessibility, courts across the country have had to apply more general nondiscrimination principles to website accessibility lawsuits. This application of general nondiscrimination principles has resulted in a web (no pun intended) of complex and sometimes conflicting decisions.").

accommodation."[153] The question then becomes how a "place of public accommodation" is defined. The ADA defines these terms by acknowledging twelve categories that qualify as a place of public accommodation.[154] Additionally, there is a requirement that to qualify as public accommodations, there must be entities that "affect commerce."[155] Arguably, not every website may "affect commerce" given that some websites can simply be informational but having a telehealth encounter will obviously result in commerce as a doctor or other medical professional will need to be paid for providing healthcare. The twelve categories identified by the ADA under Title III as places of public accommodation are as follows:

> an inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such establishment as the residence of such proprietor;
>
> a restaurant, bar, or other establishment serving food or drink;
>
> a motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment;
>
> an auditorium, convention center, lecture hall, or other place of public gathering;
>
> a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;
>
> a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;
>
> a terminal, depot, or other station used for specified public transportation;
>
> a museum, library, gallery, or other place of public display or collection;
>
> a park, zoo, amusement park, or other place of recreation;
>
> a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;

153. 42 U.S.C. § 12182(a) (emphasis added).

154. 42 U.S.C. § 12181(7); 8 C.F.R. § 36.104 (2016).

155. *Id.*

> a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and
>
> a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.[156]

Despite these specific recognized categories, there is no reference regarding websites, the Internet, or digital technology specifically here under the ADA. However, when thinking about legal protection involving telehealth, one category is "professional office of a health care provider, hospital, or other service establishment" where telehealth could be provided. This has resulted in litigation with the legal issue of whether a website is a "public accommodation" under the law.

DOJ's position has also been consistent for website accessibility under Title III of the ADA.[157] However, litigation in this area has been far more divisive than under Title II. In the absence of direct reference to the Internet under the ADA and the absence of regulations implemented by the DOJ, the area of litigation under Title III has resulted in courts adopting different approaches. The earliest cases in the Title III area focused on whether a physical location is required (i.e., if I go the Amazon website, I must be able to visit an Amazon store physically in person).[158]

The first case in which a court found that Title III applied to making websites accessible was *National Association of the Deaf v.*

156. 42 U.S.C. § 12181(7).

157. Letter from Deval L. Patrick, Assistant Att'y Gen., to Senator Tom Harkin (Sept. 9, 1996) (on file with the Department of Justice) ("Covered entities . . . are required to provide effective communication, *regardless* of whether they . . . communicate through . . . *computerized media such as the Internet*.") (emphasis added); Brief of the United States as Amicus Curiae in Support of Appellant at 12, Hooks v. OK Bridge, Inc., 232 F.3d 208 (5th Cir. 1999) (No. 99-50891) (Defining public accommodation as "plainly broad enough to encompass establishments that provide services in their clients' homes, over the telephone, or through the internet."); Letter from Stephen E. Boyd, Assistant Att'y Gen., to Senator Ted Budd (Sept. 25, 2018) (The DOJ "first articulated its interpretation that the ADA applies to public accommodations' websites over 20 years ago. This interpretation is consistent with the ADA's title III requirement . . . ").

158. Daniel Sorger, *Writing the Access Code: Enforcing Commercial Web Accessibility Without Regulations Under Title III of the Americans with Disabilities Act*, 59 B.C. L. REV. 1121, 1128 (2018) ("The judiciary has often limited the reach of Title III in the context of claims asserting rights to accommodation that are not governed by specific standards contained in the ADA or its implementing regulations. Specifically, in early Title III decisions, U.S. Courts of Appeals divided on the extent to which the Title reached past brick-and-mortar insurance offices to cover the contents of insurance and benefits policies and the non-public-facing businesses that offered them.").

Netflix, Inc.[159] This case involved a challenge to Netflix in requiring closed captioning for individuals who were deaf.[160] Here there is no Netflix store a consumer can go to for the streaming service and reliance is on this online home and whether or not Netflix is considered a "place of public accommodation".[161] The court determined that even without a physical site, Netflix was a "place of public accommodation" under Title III of the ADA.[162] However, what has ultimately emerged in the litigation in this area is courts adopting three different approaches involving website accessibility under Title III. Generally, 1) that ADA covers websites without there having to be an actual physical location associated with the website (i.e., no Amazon store location in person necessary—website is covered under the ADA and must be accessible), 2) alternatively, courts have taken the position that in order for websites to be covered, there must be a connected physical location (i.e., there has to be an Amazon store you can go to in person), and 3) that websites are covered under Title III as a "service" and must be accessible if they are a service of a place or public accommodation.[163] Cases provide guidance on what has constituted a nexus when that is involved in the analysis.[164]

This current legal landscape essentially results in people with disabilities not all enjoying protection of legal right to website accessibility under the ADA. If only a portion of the population enjoys the right to access based on geographic location, there is no true equality here for people with disabilities pursuant to the ADA under Title III in securing telehealth services involving private health providers that require website accessibility.

159. Nat'l Ass'n of the Deaf v. Netflix, Inc., 869 F. Supp. 2d 196 (D. Mass. 2012).

160. *Id.* at 198.

161. *Id.* at 200.

162. *Id.* at 202.

163. *See* Wright v. Thread Experiment, LLC, No. 1:19-cv-01423-SEB-TAB, 2021 U.S. Dist. LEXIS 13214 (S.D. Ind. Jan. 22, 2021) (finding no physical location requirement); Mahoney v. Bittrex, Inc., No. 19-3836, 2020 U.S. Dist. LEXIS 5746 (E.D. Pa. Jan. 14, 2020) (finding no nexus between physical location and online); Markett v. Five Guys Enters. LLC, No. 17-cv-788 (KBF), 2017 U.S. Dist. LEXIS 115212 (S.D.N.Y. July 21, 2017) (highlighting the service "of" standard).

164. *See* Murphy v. Bob Cochran Motors, Inc., No. 1:19-cv-00239, 2020 U.S. Dist. LEXIS 139887, at *21 (W.D. Pa. Aug. 4, 2020) (In order to establish a nexus, the allegation must indicate that the "full and equal enjoyment" of the goods and services offered at the physical location is impacted by the website's inaccessibility.); Haynes v. Dunkin' Donuts, Ltd. Liab. Co., 741 F. App'x 752 (11th Cir. 2018) (highlighting nexus arguments of a website used to search for physical store locations and purchase gift cards).

b. Effective Communication

Aside from accessibility as far as the Internet, websites, and apps which all impact healthcare access given the intersection with technology and ability to use telehealth as an option, another important aspect of healthcare generally for people with disabilities has been effective communication.[165] This requirement of effective communication applies to state/local governments, businesses, and non-profit organizations.[166] The ADA is also integral to people with disabilities under both Titles II and III in ensuring the ability to communicate by providing protections for effective communications.[167] This has been no different in examining the telehealth space as the U.S. Department of Justice's Civil Rights Division's guidance on telehealth and the ADA includes providing advice to healthcare providers using telehealth in providing effective communication.[168]

While there is a requirement to make communication effective for patients with disabilities, this is not without limitations. Specifically, the method of doing so cannot result in an "undue burden" as the DOJ explains:

> A healthcare provider is not required to provide communication aids and services if providing them would place an "undue burden" on the provider. An undue burden can be a major difficulty or expense. Whether an undue burden exists varies from healthcare provider to healthcare provider, and sometimes from one year to the next.[169]

Furthermore, despite the requirement of providing auxiliary aids under the ADA for effective communication, the healthcare provider does not have to take an act that ultimately results a fundamental change to the healthcare provider's operation: "Communication aids or services are also not required in the rare situations where they would fundamentally

165. *See Communicating Effectively with People with Disabilities*, U.S. DEP'T OF JUST., https://www.ada.gov/topics/effective-communication/ [https://perma.cc/RB5S-KL85].

166. *Id.*

167. *Id.*

168. *Telehealth*, U.S. DEP'T OF JUST., https://www.ada.gov/topics/telehealth/# [https://perma.cc/9V7S-RQLF] ("To make sure that patients with disabilities can communicate effectively while participating in telehealth, providers may need to provide communication aids and services. The communication aids or services that are effective for an individual patient may depend on the context. The provider should work with the patient to figure out what would be effective for them. The provider may not charge the patient for any aids or services the patient needs.").

169. *Id.*

change the nature of the provider's services."[170] Some examples of providing effective communication for telehealth under the ADA include the following examples depending on the context:

> give the patient the chance to request a communication aid or service when scheduling an appointment
>
> provide a qualified sign language interpreter during the appointment []
>
> ensure that the telehealth platform can support effective real-time captioning its telehealth platform is compatible with screen readers . . . .
>
> its videos have audio descriptions, or audio tracks that describe and give context for what is happening on screen . . . .
>
> offer additional time before the appointment so the patient can become familiar with how the telehealth platform works
>
> make sure the telehealth platform allows a support person to log in, regardless of whether the support person is in the same room as the plaintiff or is logging in from somewhere else
>
> take more time during the appointment as needed to make sure the patient understands what is being discussed.[171]

The U.S. Department of Justice's Attorney's Office for the Eastern District of Virginia sent out a letter in April 2023 addressed to healthcare providers in an effort to "remind" them of their obligations under the ADA as far as the effective communication requirements under Title II and Title III.[172] The letter clearly indicates that the ADA applies to telehealth the same as it does to in-person encounters.[173] Additionally, the letter went on to explain how it has initiated and entered settlement agreements for instances of violations under the ADA for healthcare providers not providing effective communication.[174]

170. *Id.*

171. *Id.*

172. Letter from Steven Gordon, Assistant U.S. Att'y, to Healthcare Providers (Apr. 13, 2023) (on file with the U.S. Department of Justice).

173. *Id.*

174. *Id.*

VI. Through the Lens of the Provider: How Healthcare Providers are Using Telehealth with People with Disabilities

In order to more fully propose any sort of legal solutions to the issues discussed as far legal barriers to accessibility of telehealth for people with disabilities, getting the insight and experience of medical professionals themselves who are serving people with disabilities using telehealth is critical. While this is not an exhaustive evaluation of all areas, the areas and professionals chosen highlight important considerations about using telehealth with people with disabilities, particularly to certain populations, including those with intellectual and developmental disabilities (IDD), in thinking about regulations moving forward.

a. Emergency Care

StationMD is a telehealth provider that specifically targets providing healthcare to people with intellectual and developmental disabilities.[175] In recognizing the unique healthcare needs of this population and attempting to prevent unnecessary emergency department ("ED") trips, StationMD began coordinating ED services to benefit people with IDD living in local group homes in New York using video conferencing (both audio and visual) in real-time even prior to the Covid-19 pandemic.[176] This platform for telehealth for the IDD population is described as follows:

> StationMD's doctors are all board-certified and rigorously trained to understand the complex health conditions that people with I/DD frequently experience. Leveraging common technology and offering wrap-around services, this partnership flexes the healthcare delivery system to bring specialized doctors to patients with I/DD anytime they need medical attention. This helps avoid chaotic and often traumatic visits to the ER, and lengthy and unnecessary hospital admissions that have detrimental impacts on individuals with I/DD, their caregivers, support professionals, and the entire health system.[177]

The work of StationMD, which began in New York, has been spreading to other states through pilot programs tied to Medicaid funds.[178] Dr.

175. Interview with Deven Unadkat, Chief Medical Officer, StationMD (Dec. 5, 2022).

176. *Id.*

177. Ariana Anderson, *Response to Recent News Highlighting Systemic Healthcare Inequities*, StationMD News (Oct. 24, 2022), https://stationmd.com/response-to-recent-news-highlighting-systemic-healthcare-inequities/ [https://perma.cc/MDJ4-9942].

178. Interview with Deven Unadkat, *supra* note 175.

Unadkat, StationMD's Chief Medical Officer, originally came to this idea from his own professional experience working in the ED with people with IDD and the challenges they faced, particularly, frequent trips and disruption of their lives as individuals with IDD often struggle to be comfortable in such unfamiliar and overwhelming settings.[179] His experience spans over 20 years in the acute care setting specifically in the ED that he brings to his work at StationMD.[180] Dr. Unadkat recognized that use of the ED is disproportionate for people with IDD as there are frequently issues of access to healthcare even in terms of having a regular primary care physician ("PCP").[181] Further, trips to the ED create significant disruption for people with IDD.[182] While everyone experiences disruption with events such as a trip to the ED, for an individual with IDD, this can be significant in terms of things like a long wait causing the individual to miss regular medication doses and other disruptions of the individual's routine which is much more significant for someone with an IDD to encounter and have to recover from.[183]

After consulting other colleagues who had similar experiences with the IDD population, Dr. Unadkat started building a program to provide virtual care to these individuals before they got to their ED first launching a test with a nursing home in providing care to the geriatric population.[184] This resulted in outreach with groups involving those with disabilities also wanting to try to test this telehealth involving ED services with those with cerebral palsy at group homes.[185] It soon became clear to Dr. Unadkat that there were significant benefits to this including saving patients from exposure to communicable diseases (even aside from Covid such as pneumonia), financial benefits to the homes, not needing transportation services, and overall well-being benefits to both patient and caregiver.[186] StationMD started with only three ED trained physicians and quickly grew to thirty as well as expansion from previously only being available in New York to eight states.[187] As of

179. *Id.*; *see also Dr. Deven Unadkat – StationMD*, Anderson Ctr. for Autism (Feb. 27, 2021), https://www.andersoncenterforautism.org/autism-community/online-resources/dr-deven-unadkat/ [https://perma.cc/R3PS-7Q6J].

180. 1 in 36, *Dr. Deven Unadkat – Station MD*, Anderson Ctr. for Autism, at 1:11 (Feb. 25, 2021) (downloaded via Apple Podcasts).

181. *Id.* at 1:45.

182. *Id.* at 2:07.

183. *Id.*

184. *Id.* at 4:00.

185. *Id.* at 5:20.

186. *Id.* at 5:35.

187. *Id.* at 6:39.

2020, StationMD saw 20,000 patients with IDD with approximately 89% of them being able to stay safe in the home and avoid a trip to the ED.[188] In a December 2022 interview with Dr. Unadkat, this had increased to as many as sixteen states.[189] StationMD now serves as many as 15,000 patients in one state alone as the example of Ohio provides through its pilot program for this with Medicaid.[190] Twenty-one states are now utilizing StationMD.[191] Another aspect that can further be complicating in these situations is that of family members (who are not living, for example with the individual) who get the call that a loved one with IDD needs to go to the ED.[192] The ability to have a virtual visit with the patient and StationMD also enables family members to join the virtual visit.[193] This allows for the opportunity for quick and open communication between the doctor and family whereas this may be delayed in the in-person setting if a family member has to travel or is unable to get to the ED.[194] In the event that someone with IDD does need to go to the ED in person as a result of the initial virtual visit because the healthcare needs of the individual requires it, the StationMD doctor can then call the ED that is going to receive the patient with the IDD to help the ED prepare (to the extent possible) for the patient in terms of understanding of the disability and potentially finding the best space in the ED for the patient with IDD (i.e., one with dimmer lights if the individual has a sensitivity to light as can, for example, often be the case involving someone with autism).[195]

Dr. Unadkat initially thought it might be challenging to recruit doctors for this telehealth specific healthcare provider business, particularly, due to the fact that there is an absence of direct physical

188. *Id.* at 6:55.

189. *Compare* Ariana Anderson, *Press Release: StationMD Announces Formation of Advisory Board*, STATIONMD (Sept. 12, 2022), https://stationmd.com/press-release-stationmd-announces-formation-of-advisory-board/ [https://perma.cc/E2JB-M6MM], *with* Ariana Anderson, *Press Release: Mainstay's Telemedicine Partnership with StationMD Prevents ER Visits, Saving $100k*, STATIONMD (July 11, 2023) https://stationmd.com/press-release-mainstay-partnership-prevents-er-visits/ [https://perma.cc/65B3-PJWH].

190. Interview with Deven Unadkat, *supra* note 175.

191. Eric Wicklund, *I/DD Care Provider Uses Telehealth to Save $100k in ER Costs Over 2 Years*, HEALTHLEADERS (July 25, 2023), https://www.healthleadersmedia.com/telehealth/idd-care-provider-uses-telehealth-save-100k-er-costs-over-2-years [https://perma.cc/M7PC-F5JH].

192. Interview with Deven Unadkat, *supra* note 175.

193. *Id.*

194. *Id.*

195. *Id.*

touch in the absence of the in-person encounter.[196] However, doctors were far more accepting than anticipated since so much of healthcare is possible with the use of technology while it is recognized and practiced by StationMD that not everything can or is appropriate for use of telehealth in a healthcare situation.[197] Many doctors have accepted that high-quality healthcare can be delivered using the Internet and from the comfort of home.[198]

In addition, people with IDD have specific and complex healthcare needs (and even individualized as no two disabilities are alike even in the same category) as a population, which would require any physician working for StationMD to either come to the practice already having experience treating patients with IDD or that the physicians have an interest or passion to work with patients IDD and StationMD will train them.[199] Training physicians to work with the IDD population is a part of StationMD's platform.[200] Specifically, Dr. Unadkat indicates that StationMD uses training modules with their physicians of 7 lectures that not only cover understanding the healthcare needs of the IDD population but also of the common terminology used in the IDD world such as important acronyms like "DSP" for "direct support professional".[201] In addition to the particular training on IDD, the virtual visit has an average of 1-3 physicians on as well as a physician on the call as a backup to provide assistance on a medical issue if needed as the healthcare surrounding the IDD population can be incredibly complex.[202] Additionally, there is a physician who also serves as an "on-call" physician who can be brought virtually onto a call if needed for a second opinion.[203] Dr. Unadkat explained that the idea is to ensure that they "get things right" which involves collegiality as none of them are considered "experts" in this area but can and do help each other if specific issues arise.[204]

Another interesting aspect of the model utilized by StationMD is the significance of the caretaker's role in the experience. The design of StationMD embraces the understanding that individuals with IDD are mostly going to need assistance, especially with the technology, in the telehealth experience. Further, the business obtains informed consent through the individual with IDD's legal representative, such as a

196. *Id.*

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

guardian, for the caretaker to be involved in this process, including the exchange of health information.

Another hallmark of this model is the focus on compliance with state regulations for the documentation of medical care with these individuals being cared for through group homes. Dr. Unadkat explained in our interview that typical primary care physicians do not take patients with disabilities for a variety of reasons, including not wanting to have to deal with the significant and timely paperwork that comes with treating these patients with often highly specialized needs.

In speaking with Dr. Unadkat about barriers to access, he indicated that internet access is a huge one, in fact, the number one barrier stating, "I can tell you the biggest problem with accessibility is connectivity."[205] A close second is having access to the actual technologies themselves-the Smartphone, tablet, or computer. [206] This brings up the issue again of the digital divide and the fact that many people with disabilities may not have adequate Broadband access due to living in a rural area or it may not be affordable.[207] Additionally, the reimbursement is a significant barrier.[208] As Medicaid has traditionally used a fee-for-service payment model, this is really not ideal for providing telehealth for this population with its complex needs and why the Medicaid pilot projects have been created based on alternative payment models.[209]

Having developed the StationMD platform prior to the pandemic, Dr. Unadkat explained how many more people with IDD were helped during the pandemic when there was a surge of telehealth use.[210] Despite the barriers, StationMD's model is proving to be effective both in terms of reducing ED visits for people with IDD and the financial savings.[211]

b. Mental Health Services

While initially unclear how telehealth would be best utilized in terms of various medical specialties, the overnight explosion of telehealth use during Covid-19 caused us to become more aware of which areas might most benefit patients. This also was shown through research as certain areas of medical practice emerged as seeing a greater

205. *Id.*

206. *Id.*

207. Laura C. Hoffman, *Reconnecting the Patient: Why Telehealth Policy Solutions Must Consider the Deepening Digital Divide*, 36 J. L. HEALTH 1, 3 (2022).

208. Interview with Deven Unadkat, *supra* note 175.

209. *Id.*

210. *Id.*

211. Wicklund, *supra* note 191.

use of telehealth. One of those areas was for mental health services.[212] The CDC has acknowledged that people with disabilities are more likely to have instances of mental health challenges which has only been exacerbated by the Covid-19 pandemic:

> A recent study found that adults with disabilities report experiencing more mental distress than those without disabilities.[2] In 2018, an estimated 17.4 million (32.9%) adults with disabilities experienced frequent mental distress, defined as 14 or more reported mentally unhealthy days in the past 30 days. Frequent mental distress is associated with poor health behaviors, increased use of health services, mental disorders, chronic disease, and limitations in daily life.
>
> During the COVID-19 pandemic, isolation, disconnect, disrupted routines, and diminished health services have greatly impacted the lives and mental well-being of people with disabilities.[213]

Knowing that people with disabilities are also more likely to experience a mental health issue, it should be no surprise that the use of telehealth for this population in order to receive mental health services deserves some examination from the perspective of the provider.

While at first blush, using telehealth to provide mental health services may seem like an ideal situation, especially in terms of the patient's level of comfort (i.e., being able to receive counseling services from the comfort of home), the picture is actually much more complicated as explained by Dr. Brian Bethel, a counselor in southern Ohio who specializes in trauma and works with many children with disabilities who have mental health needs.[214]

Dr. Bethel first expressed concern that one of the challenges with providing mental health services for individuals with disabilities, especially for children, is that there is the socialization that is lost in telehealth compared to the in-person experience.[215] This inevitably results in "loss" in the experience.[216] When the pandemic caused a switch to frequently delivering healthcare through the use of telehealth,

212. Justin Lo et al., *Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic*, KAISER FAM. FOUND. (Mar. 15, 2022), https://www.kff.org/mental-health/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/ [https://perma.cc/L8YJ-7L8N].

213. *Mental Health for All*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 20, 2023), https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html [https://perma.cc/5768-7EMX].

214. Interview with Brian L. Bethel, Founder and Dir., Interplay Counseling & Consultation Servs. (Feb. 7, 2023).

215. *Id.*

216. *Id.*

everyone was forced to interact in the online space. Mental health services also were provided using telehealth. For many experiencing mental health challenges, this only fueled the symptoms of depression, and led to exacerbating those symptoms.[217] Because of this, Dr. Bethel described telehealth use in providing mental health services as a "double-edged sword."[218] While many patients with mental health needs have found comfort in this virtual delivery of counseling services, Dr. Bethel cautioned that from a provider perspective, there are things you cannot observe in the same way as you can with an in-person encounter.[219] He also did not feel it would be best in the mental health context for a patient to have a patient-physician relationship that was based solely on an online encounter. His position is that an established patient-physician relationship that occurred in-person should exist before implementing telehealth to deliver the mental health services.[220]

Having a disability also makes individuals often less open according to Dr. Bethel's experience. This is largely a result of the stigma generally that accompanies disability that has been longstanding. The environment where a patient is receiving services in may also be lacking in boundaries when the patient-provider relationship is now occurring virtually. For example, this may result in a caretaker being "present" in the room either because of need of the individual with a disability or simply because it is the home of the person with the disability or the caretaker. Dr. Bethel explains this has the potential to create very complicated situations. One possible situation is the case that the caretaker is the one abusing the individual with a disability (and thus, the individual feels unable to express to the provider these details because of the presence of the caretaker). Dr. Bethel articulated how the in-person mental health appointment provides greater controls for the mental healthcare provider to try to alleviate that situation (i.e., having a caretaker wait in a waiting room while the provider speaks with the patient). While having a caretaker present for a person with a disability may be a necessity, it could be detrimental in terms of the disabled individual's ability to truly open up regarding a situation involving the caretaker.[221]

Another reality to this described by Dr. Bethel is that there are mental health situations that are so complex that they are not best suited for the telehealth encounter (i.e., PTSD). Further, some treatments for trauma may not work well as explained by the inability of a patient visually impaired to follow light that is an often utilized treatment for trauma. While Dr. Bethel explained that this could be

217. *Id.*

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.*

modified by using a different practice like tapping, it does not necessarily provide the same experience or have the same impact as if the visually impaired child was in the office and could still see the light.[222]

Contemplating the use of telehealth for mental health services for people with disabilities, Dr. Bethel articulated that it would be important to have an assessment performed to determine whether this method of delivery of healthcare would be an appropriate option. This could be for a variety of reasons such as the lack of accessibility to needed devices. While Dr. Bethel shared that there is not a current standard assessment, he strongly suggested one be created and he typically does this with his patients, but it would be especially important for patients with disabilities.[223]

As telehealth has reached specialties like providing mental health services, there may be a need for particularized considerations for the patient with a disability that may be different from the experience of the non-disabled patient.

VII. RECOMMENDATIONS

a. An Example in the International Space: WHO's Blueprint

In thinking about how the U.S. might proceed in addressing accessibility for telehealth for people with disabilities, one organization that has been considering this globally is WHO. In January 2022, WHO produced a guidance document specifically detailing recommendations for regulation of telehealth accessibility focused on people with disabilities. "Accessibility" is defined as "the degree to which a product, device, service or environment (virtual or real) is available to as many people as possible."[224] The introduction to this technical guidance contains the following statement:

> While telehealth provides the means for an equitable health service provision, in reality many persons with disabilities experience difficulties and challenges accessing and using telehealth services. There is more and more evidence that especially in low- and middle-income countries persons with disabilities cannot benefit from telehealth services due to highly inaccessible formats of delivery. For example, very often telehealth platforms are not compatible with devices such as screen readers that facilitate people with vision impairment to access information, or the lack of captioning or volume control in video conferencing impedes persons who are deaf or hard of

222. *Id.*

223. *Id.*

224. WORLD HEALTH ORGANIZATION & INTERNATIONAL TELECOMMUNICATION UNION, *supra* note 63, at v.

> hearing to interact with health professionals virtually. It is, therefore, critical to upscale efforts to address the "digital divide" faced by persons with disabilities, in order to ensure equitable access to telehealth services and address any structural inequalities.[225]

The technical guidance provides recommendations on the basis of the best available evidence at this time as well as collaboration with both individuals in society as well as the industry.[226] Of particular interest is that there are separate recommendations which are categorized by type of disability.[227] These categories of disability include: vision impairments and blindness, deaf or hard of hearing, speech difficulties, mobility impairments, mental health conditions, IDD, and learning disabilities.[228] This is of particular interest given that earlier the discussion of use of telehealth by disability type indicated that use was not same across different disabilities in the U.S. suggesting that reforms must take into consideration these specific differences to ensure all disabilities are addressed. For example, focusing on website accessibility is especially important to those who are visually impaired using screen readers and those who are deaf or hard of hearing that may use captioning, however, the accessibility issue may be different for others such as those who have cognitive impairments where the actual use of the technology or the availability of a caretaker or assistance are critical.

An explanation is provided in this document of how these standards are applicable: "The requirements in this document are intended for adoption by Member States as regulations or legislation and should also be voluntarily implemented by healthcare professionals and manufacturers."[229]

The digital divide is recognized as a critical part of creating the barrier to telehealth access for people with disabilities.[230] WHO emphasizes that standards are regulations which are necessary to ensure people with disabilities have equitable access to healthcare services using telehealth.[231] The WHO explains how accessibility regulations can miss the mark of true accessibility:

225. *Id.* at 1.

226. *Id.* at vii.

227. *Id.*

228. *Id.* at vii–ix.

229. *Id.* at ix.

230. *Id.* at 1 ("It is, therefore, critical to upscale efforts to address the 'digital divide' faced by persons with disabilities, in order to ensure equitable access to telehealth services and address any structural inequalities.").

231. *Id.* at 1–2.

> Most of the common challenges faced by persons with disabilities can be addressed through standardization and regulation. The development of standards for telehealth is an important and valuable process to help ensure accessible, effective and safe delivery of healthcare. There are examples of existing guidelines in different countries. For example, the American Telemedicine Association (ATA) has created practice guidelines that are being adopted by numerous professionals. The Government of New South Wales has adopted a telehealth framework and implementation strategy for the 2016–2021 period. The Web Content Accessibility Guidelines (WCAG) are universal guidelines used in many countries and practices. However, none of these guidelines and standards cover all areas of accessibility which end-users with disability might experience.[232]

The last line of this reference from WHO is telling and has already been demonstrated by the recognition that there are variations in telehealth use by people depending on their disabilities discussed earlier.

i. Telehealth Technical Standards That Address the Needs of Various Disabilities

What is clear from the examination of the barriers to telehealth access for people with disabilities, the specific legal barriers, and the practical examples discussed involving practitioners, is that the experience of healthcare access for people with disabilities is going to differ between individuals. This is captured in the WHO blueprint and the formulation of standards to become regulations:

> Firstly, the starting point in the development of the document were the challenges that persons with disabilities experience when using telehealth services. As persons with disabilities are a diverse group of individuals, the challenges, hence also the corresponding requirements vary substantially and cannot be grouped into one category. Secondly, the document contains specific requirements for features that need to be incorporated in the design of the telehealth platforms. These features will then enable healthcare providers to adapt their services to the different needs and priorities of persons with disabilities. For example, an available feature that provides the option of changing size and font of text will allow healthcare providers to select the most appropriate font and size of text depending on the patient. As such, a list of requirements structured around types of disabilities will facilitate practitioners to have information on the specific needs of different populations, e.g. persons with hearing loss or persons with psychosocial disabilities. Finally, this document aims to standardize a whole sector. As many countries provide specialized telehealth services such as tele-audiology focusing on a specific

232. *Id.*

> subpopulation, it is important that this document outlines specific requirements for different subpopulations.[233]

The WHO's plan is much more individualized by at least several major disability types to challenges for access to telehealth even acknowledging that there can be overlap in similar challenges between groups.[234] However, this more disability-type specific approach is much more nuanced and particularized. A telehealth regulatory plan that attempts to use a cookie-cutter approach, as WHO acknowledges, does not adequately account for the variety of disability types and needs.

ii. Generalized Requirements for Healthcare Providers and Manufacturers

There is acknowledgement that there are some features of accessibility that can and should be required for both healthcare providers and manufacturers designing products for accessing telehealth for people with disabilities.[235] While there should be efforts made to accommodate different disability types, there are still some basic standards across accessibility overall that can and should be incorporated into a regulatory scheme.

iii. Advancing Planning for Patients with Disabilities and Anticipated Telehealth Use

Another important aspect of the WHO blueprint is the significance of planning and having a system to do so for a patient with a disability when the use of telehealth is anticipated:

> The healthcare service providers and manufacturers of telehealth platforms should develop a system to facilitate administrative advance planning for persons with disabilities. This system should provide easy to use communication techniques and ensure that these are in place so that healthcare professionals can anticipate users' specific needs when setting up telehealth appointments.[236]

As both the technology industry and the medical profession move forward, these are ideal opportunities to improve systemically but a matter as to how far to regulate. As indicated, WHO made adoption voluntary for these groups but to the extent possible and reasonable, mandating some aspects of this through regulation could further

233. *Id.* at 4.

234. *Id.* at 5.

235. *Id.* at 9 ("This clause describes requirements on concrete accessibility features that healthcare providers and manufacturers of telehealth platforms need to ensure when delivering telehealth services. The requirements are based on the challenges identified and included in Section 3. Some of the requirements might overlap across different groups of persons with disabilities.").

236. *Id.* at 18.

advance accessibility. Further, for example, the implementation of training of medical professionals has been lacking regarding disability generally. Medical professionals must now be prepared to use technology in medical practice, including telehealth. This will have to include training specific to different disability needs and would be an ideal place to bring disability into the medical education model.

There have also been thoughts that incentivizing medical professionals through loan forgiveness programs or awarding technology companies through grants where accessibility for people with disabilities is a priority could help spurn accessibility to spread in both industries. The success of StationMD where doctors must be trained and continually being educated on disability to work with patients with IDD demonstrates that the healthcare of the population benefits from increasing understanding and expertise.

b. A Technology First Federal Movement?

Another avenue that has the potential to impact telehealth access has gained some traction at the state level in the U.S. through an initiative called *Technology First.*[237] States that have adopted Technology First initiatives enable people with disabilities, specifically IDD, to benefit from integrating the use of technology in care:

> Several states have developed technology initiatives, sometimes referred to as "Technology First." These programs apply a policy that expands access to technology for people with intellectual and developmental disabilities to increase independence. 'Technology First' states offer an option to utilize remote support and assistive technology within care plans to provide support that is more person-centered. And by making technology a reimbursable service, providers can fund its purchase and use.[238]

One of the early states to adopt this approach is the State of Ohio.[239] This initiative, adopted through an Executive Order of the Ohio Governor in 2018 is designed as follows:

> Under Ohio's Technology First initiative, DODD will work with county boards of developmental disabilities to ensure technology

237. Carli Friedman, *Technology First Yet to Impact HCBS Allocation*, COUNCIL ON QUALITY & LEADERSHIP (Aug. 3, 2023), https://www.c-q-l.org/resources/articles/technology-first-yet-to-impact-hcbs-allocation [https://perma.cc/EE2J-QWCN].

238. MediSked Staff, *Putting Technology First: End the Disparity for Individuals*, ANCOR (June 26, 2020), https://www.ancor.org/connections/putting-technology-first-end-disparity-individuals [https://perma.cc/C9WA-QERU].

239. *Technology First*, OHIO DEP'T DEVELOPMENTAL DISABILITIES, https://dodd.ohio.gov/about-us/resources/tech-first/Technology-First [https://perma.cc/NL4B-4XPB].

> is considered as part of all service and support plans for people with disabilities. Remote Support must be considered as the first option when authorizing services for a person with disabilities before authorizing on-site Homemaker/Personal Care staff. Technology First, created through a 2018 executive order, is not a technology-only policy but aims to help people learn more about how to use technology to improve their quality of life and how they can experience more independence and personal freedom.[240]

While this has been seen on the state level and has been specific to a particular set of individuals with disabilities-those with IDD-the question is could this approach be expanded further to the federal government and beyond one category of disability. This approach to technology use also goes to further attention to social determinants of health (SDOH)[241], the idea that various other factors will influence an individual's overall health. Being able to use and implement technology this way both within healthcare access and beyond could improve the overall health of people with disabilities.

c. Increasing Digital Accessibility at the State Level

In commemoration of the 33rd anniversary of the ADA on July 26, 2023, the State of Massachusetts has launched the creation of a Chief IT Accessibility Officer in the state government specifically to focus on digital accessibility.[242] An Executive Order creates this position and outlines among the purposes to provide digital accessibility for people with disabilities.[243] This news came in relation to the announcement by the DOJ of the plan to begin the rulemaking process for developing website and app accessibility standards applicable under Title II of the ADA for state and local governments.[244] Such local efforts could further accessibility where people are and perhaps create a network that could work with a federally created accessibility office to both advise and monitor issues of accessibility.

240. *Id.*

241. *Social Determinants of Health*, U.S. DEP'T HEALTH & HUM. SERVS., https://health.gov/healthypeople/priority-areas/social-determinants-health [https://perma.cc/5E6Y-28K4].

242. *Massachusetts Gov. Creates Position to Advance IT Accessibility*, GOV'T TECH. (July 26, 2023), https://www.govtech.com/workforce/massachusetts-gov-creates-position-to-advance-it-accessibility [https://perma.cc/S82H-TTJ4].

243. MA Exec. Order No. 614 (July 26, 2023).

244. *Massachusetts Gov. Creates Position to Advance IT Accessibility*, *supra* note 242.

VIII. Conclusion

This article is designed to both educate and challenge policymakers to more fully understand disability and its experience in the context of access to healthcare, particularly with the expansion of delivery by the use of technology through telehealth. Now is the critical moment when decisions are being made about law and regulation, including the creation of accessibility standards under Title II of the ADA, to make sure there is thoughtfulness in this and other efforts. Unless and until a consideration of disability occurs at all stages of telehealth from creation to implementation and finally, regulation, people with disabilities will be left out of the very delivery option for healthcare using technology through telehealth that has the amazing potential to benefit this population extraordinarily. These changes must occur with the training of our medical professionals, designing technology with requirements for accessibility, and legal protections in the name of enforceable regulations. Accessibility is only as good as it works for all, and not just some. The real "disability" lies in the nation's current lack of access to something as fundamental as healthcare.