



Appendix 6.9

Physical Structures Barrier Removal Guidance

Existing Facility – Barrier Removal

Unlike new construction projects, existing buildings often have significant accessibility shortcomings. These are defined as “barriers” to persons with disabilities. For renovations and remodeling projects, the intent of the Americans with Disabilities Act (ADA) and many state building code requirements is that all elements within the renovated area are brought up to the current accessibility standards where “readily achievable.”

Barrier removal requires thoughtful analysis, a detailed plan of action, and a construction budget for remodeling. The complexity and difficulty level of correcting older, existing buildings goes up exponentially with building age, too.

When considering how to make an existing facility accessible, your project team will face numerous challenges, including:

1. A building that is occupied during construction is **difficult to remodel** and **disruptive to patient care**.
2. **Non-compliance may be everywhere you look** (exit stairs, elevators, toilet rooms, exam and treatment rooms, doors, signage, drinking fountains, phones, width of corridors, light switch heights, cafeteria food service height, etc.).
3. **The applicable standards may be unclear**. Depending on date of construction and previous remodeling, the applicable standards may be different than expected.

Ultimately, barrier removal work requires expert-level oversight. Involving an access specialist early in the process will help determine best steps forward and ensure that the end result will be compliant with applicable standards.

Example Project

In 2025, a healthcare organization surveys the accessibility of an existing three-story medical office building they lease. The building was constructed in 1985 and contains the following suites:

- Urgent Care Clinic
- Outpatient Radiology
- Laboratory Services
- Pediatrics
- Adult Medicine
- Cardiac Care
- Dermatology
- Outpatient Surgery

During the assessment phase, the access specialist performs a detailed inspection and issues a 350-page report listing 127 elements that are not compliant with the 2010 ADA Standards. It was noted that the 1991 ADA Standards could also be applied, but are less favorable.

Following the assessment, the architect, access specialist, contractor, and representatives for the building's owner meet over a period of four months to determine the best path forward for remodeling and removing barriers. The original budget estimate triples over the course of these discussions. The team decides to upgrade the following elements in *each* of the suites, where applicable:

- Patient Toilet Rooms: Undersized, accessories to be relocated, door clearances inadequate
- Public Toilet Rooms: Undersized, accessories to be relocated, door clearances inadequate
- Exam and Treatment Rooms: Door clearances not provided, turning circle not provided
- Exit Stair Handrails: Incorrectly configured, must be removed and replaced
- Dermatology Phototherapy Booth: Inaccessible to wheelchair users; possibly requires an alternative method for treatment, or a larger booth
- Radiology Dressing Rooms: Undersized
- Signage: Total overhaul required (lack of visual contrast and placement irregularities)
- Elevator: Control panel needs to be overhauled
- Fire Alarm Strobes: Not provided
- Check-in Counters: Too high
- Entry Doors: Require too much force to open
- Doorknobs: Replace with lever handles throughout
- Drinking Fountains: Need high-low
- Accessible Phone: Not provided
- Accessible Parking Stalls: Over slope
- Curb Ramps: Not provided

After identifying barriers, the architect develops a set of drawings to “remove barriers” throughout the building. The architect confirms with the healthcare organization that the result would meet each individual medical unit's needs. The project team develops a barrier removal plan, a phased approach to organize barrier removal in priority order (priority order identified in the [ADA Checklist for Existing Facilities](#)⁷. Consider the sample priority ratings in Appendix 6.4: *Physical Structures Survey Data Template*).

During the building permit phase, several more accessibility issues are identified in the drawings and noted as non-compliant. The architect makes corrections, and the designs are ultimately approved.

During the construction phase, the architect, building inspector, and access specialist are responsible for walking the project periodically to confirm that the construction indeed matches the paper version of the building that was permitted.

- It's during this phase that problems are most likely to fall through the cracks. There's often pressure to overlook "minor" issues for fear of inconveniencing the medical practices again to make corrections. However, not doing so may result in unequal access for your patients with disabilities, patient safety issues, legal challenges, and more down the line.

When construction is 90% complete, the architect, building inspector, and access specialist complete a thorough walkthrough of the building together, inspecting every modification for compliance. The access specialist notices the wrong doorknobs have been installed in two suites. The project manager corrects the mistake.

When construction is complete and the building is ready to reopen, the access specialist again conducts the same detailed inspection, finding all 127 previously non-compliant elements addressed.