

Pacific ADA Center  
Healthcare and the ADA Webinar: Opioid Use Disorder and the Americans with Disabilities Act  
In Health Care Settings  
Thursday, August 22, 2019  
2:30-4:00 p.m. ET

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>> LEWIS KRAUS: Welcome to the healthcare and the ADA: Inclusion of People with Disabilities Webinar Series. I'm Lewis Kraus from the Pacific ADA Center, your moderator for the series. This series of webinars is brought to you by the Pacific ADA Center on behalf of the ADA National Network. The ADA National Network is made up of 10 regional centers that are federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act.

You can reach your regional ADA Center by dialing 1-800-949-4232.

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The Webinar Series is intended to share issues and promising practices in healthcare accessibility for people with disabilities. Series topics cover physical accessibility, effective

communication, and reasonable modification of policy issues under the Americans with Disabilities Act of 1990, the ADA.

Upcoming sessions are available at ADAPresentations.org under the Schedule tab, and then follow to the healthcare section. These monthly webinars occur on the fourth Thursday of the month at 2:30 Eastern, 1:30 Central, 12:30 Mountain and 11:30 a.m. Pacific time. By being here you are on the list to receive notices for future webinars in this series. Those notices go out two weeks before the next webinar and open that webinar to registration.

You can follow along on the webinar platform with the slides. If you are not using the webinar platform, you can download a copy of today's PowerPoint presentation at the Healthcare Schedule page at ADAPresentations.org. At the conclusion of today's presentation there will be an opportunity for everyone to ask questions. You may submit questions using the chat area within the webinar platform. The speakers and I will address them at the end of the session, so feel free to submit them as they come to your mind during the presentation.

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Today's ADA National Network's learning session is titled "Opioid Use Disorder and the Americans with Disabilities Act In Health Care Settings." Addiction to opioids and other substances has risen dramatically in recent years. How governments and private entities view treatment of addiction to opioids and other substances has raised Americans with Disabilities Act [ ADA ] concerns. In this session, two members of the ADA National Network will discuss how the ADA impacts persons with opioid use disorders in a variety of healthcare settings. The presenters will also cover how to eliminate discrimination that results in barriers to treatment and recovery.

Today's speakers are Jan Garrett. Jan is a program manager at the Pacific ADA Center, a member of the ADA National Network, and Dana Barton. Dana is the director of the Rocky Mountain ADA Center. Jan and Dana, I will turn it over to you.

>> Okay, thank you, Lewis. It's a pleasure to be with all of you today. So as we see this is the healthcare and the ADA including people with disabilities webinar on "Opioid Use Disorder and the Americans with Disabilities Act In Health Care Settings." And I want to welcome Dana as well. We will be going back and forth to present the information to you.

So, on slide 9 we wanted to go over why this is really important to cover this topic at this point, because as Lewis mentioned, opioid use and treatment is often in the news. And, in fact, in 2017, the U.S. Department of Health and Human Services declared a public health emergency regarding increased use of opioids. And drug overdose is the leading cause of unintentional injury-associated death in the United States. The leading cause.

And in fatal drug overdoses, in 2017, prescription opioids were involved in almost 25% of those fatal drug overdoses.

Also, medication-assisted treatment, also known as MAT -- and you will hear us refer to MAT during the webinar -- is treatment for opioid use disorder, or OUD, which we also will refer to in the webinar, that combines the use of medications, such as methadone, buprenorphine, naltrexone and also counseling and behavior therapies.

So that is what is encompassed in medication assisted treatments.

So let's talk a little bit about the definition of disability, because it's always important in any discussion of the ADA to start with the definition of disability, and it's particularly important in this area.

So there is generally a three-prong definition of disability under the ADA. So it's an individual with a physical or a mental impairment, one, that substantially limits one or more major life activities. And we're going to be talking about what each of these means in a little bit more detail later in the webinar.

Typically when you're substantially limited in one or more major life activities, the duration of the impairment is usually, though not always, greater than six months. And you do not consider the presence of mitigating measures. And mitigating measures for purposes of addiction or opioid treatment is often medication. So, the duration of the impairment should generally be greater than six months and do not consider presence of mitigating measures.

So, number two prong of the definition of disability is who has a record of or a history of such an impairment.

And then the third prong is an individual with a physical or mental impairment who is regarded as having such an impairment, even though they do not have the impairment itself.

So, let's give some examples of what major life activities would be. So they include but are not limited to:

Walking

Seeing

Hearing

Breathing

Speaking

Learning

Concentrating

And working.

And the ADA says that if you're limited in the major life activity of working, it needs to be in a broad class of jobs, not just in one particular job. So major bodily functions can also be major life activities. And that can include the function of the immune system, the endocrine system, for example, for thyroid and diabetes, the neurological functions that people have, so their nerve functions. The brain. Normal cell growth, which could also be the same as cancer, causes abnormal cell growth.

The respiratory system.

And the digestive system.

The bladder.

The reproductive system.

And the circulatory system.

So addiction itself is an impairment that affects the brain and neurological functions. So let's talk a little bit about what substantial limitation means. How do you know when a major life activity is substantially limited?

So what you do here is that you compare the major life activity with most people in the general population. And so that's how you would know if the major life activity is substantially limited. Also, the definition of disability should not require extensive analysis, particularly after the ADA amendments act took effect in 2009, and Congress said specifically in the ADA Amendments Act that they want broad coverage of the ADA, that they do not want to limit the coverage unless it absolutely needs to be limited.

So in addition to those three prongs of the definition of disability, there is also associational discrimination, and an individual who is associated with a person with a disability, for example, a family member, a spouse, a domestic partner, is also protected from discrimination. That means they might receive discrimination from healthcare entities, but it might mean they receive discrimination in the workplace. Now, these people who are associated with someone with a disability are not entitled to reasonable accommodations in the workplace, but they are entitled to not receive outright discrimination by an employer, for example, in not hiring them because they are aware that they are associated with someone with a disability.

So impairments can be in occurrence all the time or they can also be episodic or in remission. So impairments that are episodic or that might go into remission are considered disabilities if they substantially limit a major life activity when they are active. Examples of this might include bipolar disorder, posttraumatic stress disorder, epilepsy, addiction and cancer.

So when those disorders go into remission, they are still considered disabilities because when they are active, they substantially limit a major life activity.

So a record of an impairment, the definition of the disability as we said earlier includes those who have a record or a history of an impairment that substantially limits a major life activity. So this could be someone who completed a drug rehabilitation program and is no longer illegally using drugs. We're going to talk about what illegally using drugs mean in a moment.

So, regarded as having an impairment, which we mentioned earlier in the definition of disability, means that you are perceived as having an addiction, in this case, but you actually do not have the addiction.

So recovery, which is something that people often are striving toward that have opioid use disorder is protected for a person who is no longer engaging in the current illegal use of drugs. So if you are in recovery and are no longer engaging in the current illegal use of drugs and you can meet the requirements of the definition of disability, you are covered by the ADA.

So what does the illegal use of drugs mean? And it's not -- let me clarify. It's not the use of illegal drugs. Because it's both illegal and legal drugs. So it could be the use of illegal drugs such as heroin or cocaine, but it also could be the use of controlled substances for which the person has no prescription or is using more than prescribed, or may have a fraudulent prescription. So it includes illegal drugs and legal drugs for which you have no prescription, you're using more than prescribed, or you have a fraudulent prescription.

And what does the current use of illegal use of drugs? That means that the illegal use occurred recently enough to justify a reasonable belief that a person's drug use is real and ongoing problem. So, in other words, you can't simply have been in treatment for a couple of weeks in order to be outside of the word "current." You are still currently considered to have a real and ongoing problem of illegal use of drugs. But once you are maybe a few months out, there's no real specific amount of time, but under the ADA, if a covered entity makes a decision based on a person's current illegal use of drugs, that person is not covered by the ADA. So they are not entitled to the ADA's protections if they are considered to be currently illegally using drugs.

So, under the ADA, if you're in recovery, that means you are in recovery from a substance use disorder, including opioid use disorder. You have ceased engaging in the illegal use of drugs. And you are either participating in a supervised rehabilitation program or you have been successfully rehabilitated.

Generally people in recovery are covered by the ADA. And the ADA generally covers those in recovery from substance use disorder, which we mentioned earlier, or opioid use disorder, who currently do not engage in the illegal use of drugs. And people in recovery can include individuals using medication-assisted treatment, or MAT.

It is also important to understand that there is a distinction between alcohol addiction and the illegal use of drugs. So, alcohol addiction generally is a disability regardless of whether it is in the present -- so it can be current, or it can be in the past. However, the alcohol addiction must substantially limit a major life activity to be considered a disability under the ADA. And that might mean that it substantially limits your ability to care for yourself. It might limit your ability to work in an entire class of jobs. So if the alcohol addiction does that, then you are covered as a person with a disability, even though you are currently using alcohol. And as a note here, employers are not required to allow employees to use alcohol before or during work hours. And that is obviously the same with drugs.

So I think we're going to turn it over to Dana at this point.

>> LEWIS KRAUS: Dana, this is Lewis. You want to hit your "talk" button. We are not hearing you.

>> DANA BARTON: Can you hear me now?

>> LEWIS KRAUS: Yes, there you go.

>> DANA BARTON: So sorry, everyone. All right, well, thanks, Lewis, and thanks, Jan. I am going to start here and talk about how the ADA covers opioid use disorder and how it plays out in the workplace and with employment.

So, a first thing to know is that the ADA has a nondiscrimination requirement. And that means that employers must integrate people with disabilities to the maximum extent appropriate. They need to allow for reasonable modifications as practices, policies and procedures, and they also need to provide effective communication.

The ADA protects employment discrimination against qualified individuals with disabilities, and qualified means that the individual meets the skill, the experience, the education and other job-related requirements of a position that is held or desired, and they can do that with or without reasonable accommodations. They can perform those essential functions of the job.

The ADA divides employment into three phases, and those are pre-job offer, post-job offer and employment. So during the pre-job offer phase, an employer should not ask any questions about a disability, even if that disability is obvious. They also should not require any pre-employment medical examinations or require about an applicant's medical history. But they are able to ask, however, if an applicant can perform the essential duties of the position with or without accommodations. But once the job offer is made and you're in the post-job offer phase, employers may require that medical examination. So that's going to be dependent on as long as all of the employees who are hired for that specific job type, if they're all required to take that medical examination, then you can require that. Basically you cannot single out one person for a medical examination, and it's also important to note that any medical questions or exams, they need to be related to the job and consistent with the business

necessity. So, for example, you likely wouldn't ask employees who were going to be in clerical positions at a desk to take a medical exam to show that they can run ten miles at a time. That's likely not a business necessity or would be consistent with the business necessity as a clerical position.

So, tests for illegal drugs, which Jan just talked about, those tests are not considered medical examinations under the ADA. And they can be requested at any time, even during the pre-offer phase. But keep in mind that you can't single out an individual for any kind of discriminatory reason. So, requiring people of a specific race or gender to test for illegal drugs or, you know, if you know someone is a friend of someone and you suspect that might be using illegal drugs, you can't single that person out. So the question becomes, what happens if an applicant or an employee tests positive for drugs that are commonly used in medication-assisted treatment? In that case, they tested positive. The employer cannot refuse to hire an applicant or move to terminate an employee at that time. They need to initiate a conversation and conduct this individualized inquiry to determine if the person can perform the essential function of the job with or without reasonable modification. Because that medication-assisted treatment might be a reasonable accommodation, but you have to test that individually. So recently we have seen a rise in discrimination cases being litigated by the equal opportunity employment commission and I'm going to go over those now. This is a case that is still pending, but in this case it's alleged that an employer is barring applicants from certain positions if they are taking certain prescription, suboxone or methadone. And it's alleged they are not evaluating whether the medication affects the ability to safely and effectively perform the job. So right now the EEOC is litigating that case.

We have another case from last year with the EEOC, and in this case, a gentleman was hired and was subjected to a drug test on his first day of work. He completed his first week of work, he had no issues. And then on his second week of work, he was fired because the drug test came back positive for methadone and he was in a medication-assisted treatment program. He took the methadone at night as treatment for his addiction, and once the drug test came back positive, the lab that conducted the drug test actually cleared him to work after he provided them a copy of his methadone prescription and some other documentation. In fact, his doctor even provided a letter detailing his treatment, but the human resources department still refused to allow him back to work. And so, again, this is another trial that is currently pending.

Employers do have some protections and some defenses. And these include undue hardship of reasonable accommodations. So if an employee with opioid use disorder meets one of the first two definitions of disability that Jan described in the beginning, the employers may have to provide a reasonable accommodation unless they can show this undue hardship. Undue hardship is an action requiring significant difficulty or expense. There's also a direct threat defense, and if they use -- if an employer uses this direct threat defense, they need to show a significant risk of substantial harm. And, again, this is going to be based upon an individualized assessment.

All right, so now that we've talked a little bit about employment, we're going to shift gears and talk about the ADA within healthcare and discrimination under Titles II and III. So just like title

I, employment, there is a nondiscrimination requirement under both Titles II and Title III of the ADA. Title II deals with state and local government entities, and Title III deals with places of public accommodation, like doctor offices or healthcare facilities.

I'm going to start with this example from actually earlier this year in January. This medical provider Selma Medical Associates, a Title III medical provider had a complaint filed against them after they refused to accept a new patient appointment because the new patient takes suboxone to treat their opioid use disorder. And throughout the investigation it was alleged that they regularly turned away prospective patients who are taking controlled substances lawfully. And that's important "lawfully," to treat their medical conditions.

As part of the settlement, Selma Medical agreed to not deny services based on disability, including opioid use disorder, or apply standards or criteria that screen out individuals with disabilities. The agreement also requires Selma Medical to adopt the nondiscrimination policy that we talked about. They are required to train their staff on their nondiscrimination obligations and report in compliance of that training. They also had to pay \$30,000 in damages to the complainant and a \$10,000 civil penalty to the U.S. In this example, this was a 2018 case, a Title III skilled nursing facility refused to accept a patient for treatment at their facility because that patient was treated with suboxone for their opioid use disorder. During the settlement they were required to adopt a similar nondiscrimination policy and they had to provide ADA an opioid use disorder training to staff and pay a \$5,000 penalty.

So in both these cases, a modification of policies -- of their policy would have avoided this litigation and really is a requirement. Given what we have seen in these cases for these healthcare providers out there, it's advisable to take a look at and have ways to modify your policies and procedures to make sure you are including a nondiscrimination policy stating that your covered entity will not discriminate against people with disabilities including those with Opioid Use Disorder and who are currently on medication assisted treatment.

The second case we talked about was inpatient treatment facility. Even if a facility has a policy they don't administer medications, they would have an obligation to provide legally prescribed medications when patients admitted have a prescription and there is a medication dispensary program in the facility.

Of course, Title I there are legal defenses available for Title II and Title III entities. A healthcare can use the defense of a fundamental alteration, undue burden, and a direct threat, but, again, all of these defenses are evaluated individually.

So now moving on to the modification of another type of policy. We're going to discuss service animals. This is one of the top questions as a national network we get, and it can get confusing in the healthcare world. So we're going to break that down for you.

So any entity covered by the Americans with Disabilities Act, including healthcare facilities, must modify a no pets policy to allow for service animals. The ADA may require a business to reasonably modify a policy, practice or procedure to avoid discrimination. And so modifying

the no pet policy would avoid discrimination. So, for example, allowing a service animal into a place where a pet would normally not be allowed, that's going to be considered a reasonable modification.

The definition of a service animal -- we get a lot of questions about this -- but it is a dog, any dog, unless it's a miniature horse, who has been individually trained to perform a task that is directly related to the handler's disability. There is no registration, there is no certification, no paperwork, no special ID card, no special patch or vest, no documentation from a doctor or any other form of proof that a dog or a miniature horse is a service animal.

And so that's where it gets confusing. We get a lot of questions about, is this a service animal or an emotional support animal? Under the Americans with Disabilities Act, an emotional support animal is not -- or emotional support is not considered work or a task. So the ability to soothe is not a task, not work. That's the inherent purpose generally of having a pet, is to calm you or make you feel good. And that's not something that is individually trained. So there is two questions you can ask to determine if an animal is a service animal or not. The first is: Is this service animal required because of a disability? It's not a short answer question. It's just a simple yes or no. You could also shorten this question to "Is this a service animal?"

The second question is: What work or tasks has the dog been trained to perform? The person's answer should be a verb or an action performed by the animal. You wouldn't ask to see them perform that task. For example, if a service animal is being used for a person with seizure disorder and the dog might go underneath the person's head to provide stability during a seizure, it would not be reasonable to ask a person to demonstrate that, you know, at the drop of a hat. So, again, it's not show-and-tell.

Also, you should note that disclosing the type of disability is not required, that the handler does not need to say what their disability is. And just saying what that disability is, if that's the answer they give you, that's also not an appropriate response. Another responsibility of the handler is their service animal must be house broken and always under control through voice, signal or another effective control. The animal is permitted to be off leash for the time it is performing the task. And an example of this could be a person seeking -- or an animal seeking help for their handler or making sure a room is safe or is open for maybe someone with posttraumatic stress.

A service animal can be excluded from your Title II or Title III entity if they cause a disruption and the handler doesn't take effective action to control it. This would include uncontrolled barking. If the animal barks or lunges at someone, or any other risk to health and safety. The ADA does not address service animals in training, however, certain states give individuals the right to take their service dog in training into public spaces. I was in Colorado, and, for example, here in Colorado, service animals in training have the same rights as service animals. So you will want to check with your state laws for more information on service animals in training.

When it comes to service animals in recovery programs, if an individual is in a treatment program and has a service animal, the program would need to allow the animal and its handler

into the program. A person using a service animal, again, has the right to public access regardless of the presence of someone who might have a fear or allergy of that animal.

So a program would need to make appropriate accommodations, if program staff or participants have an allergy or a fear that rises to the level of a disability. Other things to keep in mind is the handler needs to remain with the dog and is responsible for the dog's care.

There are some defenses for service animals. A service animal can be excluded if they cause a disruption, we mentioned that earlier, and that the handler does not take effective action to control it. They could also be excluded if it causes a fundamental alteration to the service, such as maybe a dog in the pool, a cat cafe, if you've ever been to a bookstore that has a cat cafe, that's the purpose of the store. If they're seeing prey or might be seen as prey at a zoo. Also, perhaps, in an operating room or a burn unit within the healthcare setting, that infection control is important. But the decision to exclude the service animal should be based on actual witnessed behavior, not just assumptions or stereotypes of certain animals. Also, it's important to remember that it's the handler or the person with the disability that has the rights, not the animal. So excluding an animal does not exclude the person from service without the animal. So if you are excluding a service animal for one of the reasons we talked about, you still want to invite that handler or that person with the disability back in without their service animal.

And I think from here I'm going to hand it back over to Jan to talk about effective communication.

>> JAN GARRETT: Okay, thank you, Dana.

So, effective communication says, under the ADA, that covered entities -- so that could be a Title II state or local government or it could be a Title III private entity, including all healthcare entities, must ensure that people with disabilities that affect communication -- and that's really important -- people with disabilities that affect communication, have communication access that is equally effective as that provided to people without disabilities. We're going to talk a little bit about what does that mean in terms of equal access or what does effective communication mean. But the disabilities covered under effective communication are only three. They are hearing disabilities, vision disabilities, and speech disabilities. Those are communication disabilities, and those are covered under the effective communication section of the ADA. And effective communication is provided through auxiliary aids and services. So here is a list of an example, at least, of auxiliary aids and services. You could have a qualified sign language interpreter, and there is a specific definition of "qualified" in the ADA for both an interpreter and a reader that is later on down this list. But it basically means that that interpreter can communicate receptively and expressively with both people who can hear and the person who cannot hear in the room. So that is the example of a qualified sign language interpreter.

Also realtime captioning. You all may or may not know, but there is realtime captioning going on in this webinar for the people who need it. And that is where someone sits and types the words that people are saying literally in realtime. More like a court reporter captures what people are saying. And then it comes up on the screen. Realtime captioning, as opposed to sign language interpreters, can be more useful for people who maybe were not deaf as

children and did not grow up knowing sign language but they need English and they need to be able to see that on the screen. So as long as they can see, then realtime captioning is often very effective for people who did not grow up knowing American Sign Language or even people who did who know English well.

And obviously interpreters are for people who know sign language. That's the only time that an interpreter is going to be effective for someone.

Also, assistive listening devices can be used, especially in assembly areas. That would be a device that often will connect your hearing aid or that you wear in a device around your neck, and there is a transmitter and a receiver for that, and if the person speaking into the PA system or microphone, then that person using the assistive listening device can hear that person using the public address system. So that is something that is required in assembly areas within the ADA.

Also, telephone relay services are available for people with a variety of disabilities. And that could be a hearing disability. It could also be a speech disability. And so I don't know if you have ever dialed 711, but that is generally the nationwide number for the relay service. And that involves a person who is sitting in front of a computer and has a phone system as well, and the person who is deaf will often contact the relay service through the computer. So the interpreter can see the deaf person and the deaf person can see the interpreter as well. And they are able to sign back and forth through the computer. Then the deaf person will ask that relay interpreter to make a call for them to someone who does not have the ability to, you know, read and transmit sign language or does not even have maybe a TTY or a teletype machine. So that interpreter, that relay operator will provide the relayed communication back and forth between the deaf person and the hearing person.

Also exchanging notes can be an example of auxiliary aids and services in a brief conversation. You don't want to do that for something like a training or any kind of longer conversation, but if you say, you know, how much is this book, it's 8.95. Exchanging written notes can be very effective as a means of communication in that kind of short scenario with people.

Also, in terms of people who have vision impairments, qualified readers can be used as an auxiliary service. And that, again, is somebody who is qualified to read the material that the person who is blind or low vision needs to read. So if it's very technical material, that reader would need to be qualified to read that. Same, in fact, with the American Sign Language interpreter. There are specific interpreters that are for healthcare, specific interpreters that are for legal settings. So you would want that person to be qualified for the setting in which they are interpreting or in the case of a qualified reader, the setting in which they are reading documents.

You can also have a reader just at a restaurant. You can ask the waiter to read the menu to you if you are not somebody who can read the menu because of your vision disability.

There are also alternative format materials for people with vision disabilities. You can have large print documents. You can have Braille documents, audio cassettes, which are not often used anymore, but they might be by some people, especially books on tape, they might still have an audio cassette recorder. You can also write to CDs. Also people with vision disabilities, especially people who are blind, can often use these days screen reading software which helps them read any kind of document that is on the screen, whether it's on a computer or even on their phone or tablet.

So these are all examples, although it's certainly not an exhaustive list of examples of auxiliary aids and services that can be used to make communication effective for people with vision, speech and hearing disabilities.

So to determine the appropriate auxiliary aid or service, the covered entity, whatever entity that is covered by the ADA, has to make an assessment of the nature, the length, the complexity, and the context of the communication. So how complex is it? How lengthy is it? And what is the context of it?

So you have to make that assessment. And you also have to assess the person's typical method of communication to determine what auxiliary aid or service to use.

So if someone does not understand American Sign Language, then having a sign language interpreter is not going to be a means of effective communication for that person.

If a person with low vision, you know, cannot see, then having large print -- and if they are blind, they are not going to be able to see the large print. So they are going to need either Braille or some kind of electronic document that they can use to be able to access that information.

So, a few questions and answers here, basically, about effective communication. So when is communication effective?

When the person actually understands the information.

How do you know that you have achieved effective communication? So, how do you know when the person understands?

You can ask the person to repeat back to you what they have understood if that's appropriate. You don't, obviously, want to do that after every sentence or paragraph. But periodically asking the person to repeat back to you what they have understood can be appropriate, particularly in a complex communication situation.

And there is an excellent resource on effective communication for the US Department of Justice. It's called the Effective Communication Fact Sheet that the Department of Justice developed, and that can be found at [ADA.gov/effective-comm.htm](http://ADA.gov/effective-comm.htm).

So, again, [ADA.gov/effective-comm.htm](http://ADA.gov/effective-comm.htm).

It's an excellent resource on effective communication from the U.S. justice department.

So there are, like other parts of the ADA, and like we mentioned earlier in this presentation, there are also effective communication defenses that are available. So fundamental alteration. You've heard that term before earlier in this presentation. If some means of auxiliary aid or service or means of communications fundamentally alters the program, like turning on all the lights in a planetarium so somebody deaf can see the interpreter, well, that would fundamentally alter the planetarium program, because then you couldn't see the stars in the ceiling. So what you could do instead that you could not be a fundamental alteration would be to spotlight the interpreter and have the interpreter stand next to or near the person who is deaf that needs to see them so that the lights can still be off in the planetarium, you can still see the stars, but the person who is deaf could also see the interpreter in that case.

Another defense that could be available for effective communication could be undue burden. So significant administrative requirements or expense is what could be considered an undue burden. So, providing an interpreter or realtime captioning 24/7 in a recovery program could be considered an undue burden because that would be very expensive, or providing an interpreter on five minutes' notice could be an administrative burden on that, or asking that program to buy an expensive computer screen or a screen reading program for one recovery client who is going to be in the recovery program for a relatively short time.

So what you need to do, if you run into fundamental alteration or undue burden scenarios, you as a recovery program or a healthcare entity need to figure out, well, what can I do to communicate effectively with this person? Because they clearly need communication. So what can I do that would not pose a fundamental alteration or would not pose an undue burden? And that, as an ADA covered entity, that's really what you need to do, is determine what you can do outside of these defenses.

So, let's talk a little bit about resources that are available under both the ADA National Network and other resources. So, you can actually file an ADA complaint if you are somebody with a disability who believes that they have experienced discrimination. If you believe you have experienced discrimination on the job, you can file with the Equal Employment Opportunity Commission. And there is a link there. If you go to [eeoc.gov](http://eeoc.gov), then you can find the link. You can find one for federal employees, but there are also links to just general employees that have experienced discrimination.

You can also call their toll-free number at the EEOC. They have one number for the general public at 1-800-669-4,000. They also have a number that is a TTY number for deaf and hard of hearing callers that is 1-800-669-6820. You would have to have a TTY yourself to be able to use that number because that is going to be answered by a TTY on the other end.

And they also have an ASL video phone for deaf or hard of hearing callers that can communicate via sign language. And that at the EEOC would be 844-234-5122.

These are all ways to get ahold of the EEOC to file an employment complaint. Also, the U.S. Department of Justice, which we have mentioned numerous times in the presentation, has a way of filing complaints with them as well. Again, you can go to [ADA.gov](http://ADA.gov), and if you do forward slash [filing\\_complaint.htm](http://filing_complaint.htm), [ADA.gov /filing\\_complaint.htm](http://ADA.gov/filing_complaint.htm), you can file a complaint there. You can also reach them at 1-800-514-0301, the voice number, or 1-800-514-0383, that's their TTY number. That's where you can file an ADA complaint.

Also, the ADA National Network has many healthcare resources that could be of interest and use to you. So obviously we have this Webinar Series, and as Lewis described earlier, you can find the ADA and healthcare Webinar Series at [ADApresentations.org](http://ADApresentations.org). There are also healthcare and the ADA fact sheets that are available on the national network websites at [adata.org](http://adata.org). Also we have at the Pacific ADA Center a specific page of our website that has links to state and federal resources and also some fact sheets. So to see that you would go to [adapacific.org /healthcare](http://adapacific.org/healthcare). And that is the ADA Pacific page on healthcare. And ADA questions can be answered, again, as Lewis mentioned earlier, throughout the country by calling your ADA National Network regional center at 800-949-4232 or by going to their website to find out what their email address is. You can also receive training and all kinds of technical assistance from your regional ADA Centers.

There is also a Department of Justice initiative under the Barrier-free Healthcare. It's called the Barrier-free Health Care Initiative, and it's a partnership of the Department of Justice Civil Rights Division and the U.S. attorney's offices across the nation, and it's a resource for court cases, but it can also be a resource to many healthcare entities to see what has been going on in this Barrier-Free Healthcare Initiative. It targets enforcements in a critical area for individuals with disabilities. Because healthcare is obviously a huge area for everyone, but certainly for people with disabilities and people with disabilities are often more likely to use drugs, use opioids in particular, and so they need to be able to have access to healthcare, whether that's recovery programs or other healthcare areas. This Barrier-free Healthcare Initiative was launched on the 22nd anniversary of the ADA in July 2012, and you can find the agreements that are part of this Barrier-free Healthcare Initiative at [www.ADA.gov](http://www.ADA.gov) -- again, the Department of Justice website -- [ADA.gov /usao-agreements.htm](http://ADA.gov/usao-agreements.htm).

And that stands for the U.S. attorney's office. So [ADA.gov /usao-agreements.htm](http://ADA.gov/usao-agreements.htm).

And obviously, as Lewis said earlier, you can contact us. We have already given you our toll-free number, 800-969-4232, and the emails for Dana and myself are on this slide as well if you need to email us about this particular presentation. And we thank you all for joining us today, but we also want to hear your questions now, so I'm going to turn it back over to Lewis. >> LEWIS KRAUS: All right, thank you, Jan and Dana. All right, everyone, this is your chance to submit your questions in the Chat window. And we'll get to those in a moment. I do want to mention one person did add to where you can file complaints, and I'm going to put that up in the Chat window. You can also file your complaints with the U.S. Department of Health and Human Services Office of Civil Rights. So you can do that as well. That's another resource for you.

While people are writing in their questions, I'm going to get to your first question here. Someone says "Thank you for covering this material."

A question about substance use disorder professionals and prejudice stigma. Now, substance use disorder professionals have experienced the reality of stigma for years and maybe desensitized. How do you imagine new rules providing substance use providers to confront such prejudice where they see it?

>> DANA BARTON: That's a big question, isn't it? I'm assuming the question is asking, when a professional, a substance use disorder professional, when meeting with individuals, how do you feel people are not coming at you just for the prescriptions, is that how you're interpreting it, Lewis?

>> LEWIS KRAUS: I think that's one way to -- let's take an tight ohm-by-item. Let's take it that way first.

>> DANA BARTON: I'll speak to that. And I think examining implicit biases is really important, you know, across all industries, but also within the healthcare industry. We do all have these biases, and they affect the way we interact with all sorts of different people whether or not they have a disability or they're also using opioids or they're on medication assisted treatment.

So I would say really practicing mindfulness. You know, that's where I would go to answer that question. I think that there are workshops and programs to help people kind of sess out where they have implicit bias and kind of put what they learned into action for their professional life. That's how I would address that question. How are you interpreting that question, Lewis?

>> LEWIS KRAUS: Well, let's also say -- let's take advantage of another opportunity here. If a substance use disorder provider is looking -- or they're hearing from people who they are working with that they are experiencing some sort of discrimination, then I think you have now the opportunity from this presentation to know the resources that you can help the person get to and be able to guide them through dealing with discrimination. I think that's another way to deal with this. Jan, do you have other ideas?

>> JAN GARRETT: I was just wondering if the person was facing bias, so they're maybe a provider of treatment and they may be facing bias from their friends or family or people outside of their workplace against them because they provide treatment, and perhaps people think, why would you do that? Why would you actually help people that have addiction or, you know, have Opioid Use Disorder, or some other substance abuse disorder. I don't know if that is what the question was about or not.

>> DANA BARTON: I think that's a good point. That could play out in employment for providers who may be currently working in a situation where they are providing that counseling and now they're wanting to break in maybe to a hospital or to a different job and they're being discriminated against under Title I because of maybe thoughts and feelings, biases against what they have done in their past career. So that would be a Title I situation.

>> JAN GARRETT: Potentially, yes.

>> LEWIS KRAUS: Great. And the person who asked that, John Swanson, if you want to clarify he said all good considerations for the question and Lewis's responses is some potential for everything. Good to hear that.

Another question that I think you can address is the issue of people being on MAT and then participating in other kinds of services and those services already having rules to say you cannot be using drugs to be in our program. Do you want to address that topic?

>> DANA BARTON: Are you talking about Title II service, the TANF program, depending on the state you're in?

I think that's where entities need to make sure that they're reasonably modifying their policies. If the policy says that you cannot be using drugs to be part of the program, you need to have that individualized approach to have the conversation with the individual, you know, maybe providing a doctor's note and talking about what that medication-assisted therapy is looking like. I know in one of the examples we shared today, we talked about the person who was taking methadone at night and, you know, is it affecting them during their workday? Does it affect their participation in the program, etc.? So it's all, you know, just like everything with the ADA, it's all individualized. It's all on a case-by-case basis, but you really need to make sure that you're looking at modifying your practices and procedures and that when you're looking at your defense, if you choose not to allow someone to return to a program, that you're really looking at undue hardship or fundamental alteration of the program.

>> JAN GARRETT: Also, this comes up in a variety of contexts, some of which we actually talked about and the cases that we had, but it can also come up for people who are trying to get custody of their children or regain custody of their children, and they've gone through a recovery program, they're on methadone or suboxone and the judge will say, well, as long as you're on that, I'm not going to allow you to have your children. And that would be considered discrimination under the ADA, if that's the only reason.

>> LEWIS KRAUS: Okay. Other questions from anyone, please write them into your -- into the Chat room and we will get to them in a moment.

I think that just to go on this topic for a little bit longer, this is a similar issue to one that happened many years ago more toward the beginning of the ADA where heroin addiction was being treated with other drugs like methadone or whatnot, and people were being held out of services, Title II services, because they were still being perceived as being on a drug. So I think this does speak to, Jan, part of the talk you were bringing up about the -- this nuance of the illegal use of drugs as opposed to the legal use of drugs.

>> JAN GARRETT: Right. If you're legally using prescribed drugs, whether those are for medically assisted treatment, or even for your disability, then that is not considered -- you are still covered within the ADA if you have a disability. And it's only when you're, you know, illegally using drugs that you would be considered outside of the ADA, and that's current illegal drug use, whatever current is deemed to be at the moment.

>> LEWIS KRAUS: Dana, did you want to add? I saw your name pop up. Did you want to say something else?

>> DANA BARTON: No, I think that covered it.

>> LEWIS KRAUS: Okay. All right, everyone, I am not seeing any more questions, so apparently they have covered it well enough for you all. So, we are --

>> JAN GARRETT: Really, there are no service animal questions? [chuckles]

I'll pat myself on the back for that one.

>> LEWIS KRAUS: All right. If you think of some questions afterwards, feel free to contact Jan or Dana there at their contacts on the screen, or you can contact your regional ADA Center at 1-800-949-4232 to answer those questions.

You will receive an email with a link to an online session evaluation. Please complete that evaluation for today's program, because we really value your input. We want to thank Jan and Dana today for sharing their time and knowledge with us and a reminder for all of you that this was recorded. This session was recorded and will be available at ADAPresentations.org in the Archive section of the Health area.

On our next webinar, on October -- on September 26th, I should say, we will cover Access to Healthcare and the ADA: A Review of the Case Law. We hope you can join with that.

Okay, wait, we're getting more questions.

Before I completely dismiss you, if you're hanging on, let's see.

With OUDs, it can be a challenging issue with quality implication. If an OUD patient is on MAT and denied pain management medication because of alcohol use treatment, is this an ADA issue? This is the type of advocacy consideration I'm thinking about for substance use disorders/providers.

Can you clarify for us, John, OUD?

>> That's Opioid Use Disorder, I know what that is.

>> LEWIS KRAUS: So there you go, guys.

>> JAN GARRETT: Dana, did you want to weigh in on this one?

>> DANA BARTON: You know, I'm not confident of my answer. You know, I think...

ADA doesn't have provisions for how something is being treated, how a disability or Opioid Use Disorder, how it's being treated. It doesn't say, you know, you have to receive pain management medications or, you know, suboxone. It doesn't say that. So I think, you know, I could certainly look into this question more for you and discuss it with folks who are more ingrained. I have some folks I can call, John, if you want to reach out to me, unless Jan or Lewis, you all have an answer. I just don't want to give a wrong answer.

>> JAN GARRETT: I guess what I would --

>> DANA BARTON: I don't have that off the top of my head.

>> JAN GARRETT: What I would sense is if somebody needs a medication for a co-existing condition that is considered a disability -- so it depends on -- so what I heard you say is that this pain is as a result of maybe alcohol withdrawal. You know, I wasn't really sure what the pain was from, but if the pain is from something that is considered a disability -- and that could be true for -- if somebody has epilepsy or diabetes, their medication that they need for their disability that falls under the ADA definition should be allowed to be given to them. You know, they should be allowed to have that, and if it's a residential program, they definitely should be administering that, if there's a prescription for it, for the person with the disability. So it depends on if this pain is related to a disability specifically, and if this medication is prescribed.

>> LEWIS KRAUS: Okay. Great. I think that satisfies -- he wrote "thank you for that." So that's good.

All right, everyone, thank you very much for attending. So on September 26, we're going to cover ADA and the Healthcare Access: A Review of the Case Law. We hope you can join us then. Watch your email two weeks ahead of time for the announcement of the registration for that session.

So thank you so much for attending today's session. We're going to end a little early because we have no more questions. So, all right... thank you Jan and Dana. And to everyone, have a good rest of your afternoon!

Thank you!