

Pacific ADA Center  
Healthcare and the ADA Webinar  
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>> LEWIS KRAUS: Welcome to the healthcare and the ADA Inclusion of persons 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 ten regional centers that are federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act.

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This Webinar Series is intended to share issues and promising practices in healthcare for people with disabilities. 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](http://ADApresentations.org) under the Schedule tab. Then follow to healthcare.

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 go out two weeks before the webinar and open the webinar to registration.

You can follow along on the webinar platform with the slides, but if you're not using the webinar platform, you can download a copy of today's PowerPoint presentation at the Healthcare schedule web page of [ADApresentations.org](http://ADApresentations.org).

At the conclusion of today's presentation, there will be an opportunity for everyone to ask questions. You may submit your questions using the Chat area within the webinar platform, and the speaker 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. To submit your questions, type and submit them in the Chat area text box as shown on the screen, or if you're using keys, press Ctrl-M and enter text in the Chat area.

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Today's ADA National Network learning session is titled "Access to Healthcare and the ADA - A Review of the Case Law." Access to healthcare is critical for people with disabilities but often many barriers exist. This webinar will review how litigation has impacted the ADA's application to healthcare. Topics will include accessible medical facilities and equipment, effective communication, and service animals in healthcare facilities. In addition to reviewing specific court decisions and settlement agreements, this session will also identify trends and potential issues for future ADA healthcare-related litigation.

Today's speaker is Barry Taylor. Barry is the vice president for Civil Rights and Systemic Litigation at Equip for Equality where he has worked since 1996. At Equip for Equality he has overseen many individual and systemic disability discrimination cases and he is currently co-counsel in five ADA class actions, including lead counsel in *Legus v. Norwood*, a class action on behalf of people with developmental disabilities who are seeking community services.

Barry has given numerous presentations on the ADA across the country to people with disabilities, family members, attorneys, employers, businesses, service providers, and advocacy organizations.

So, Barry, I will now turn it over to you.

>> BARRY TAYLOR: Thanks, Lewis. Welcome to the webinar. I want to note this was funded by the Great Lakes ADA Center where we did the presentation back in May and again at the national ADA symposium. I'm glad you're getting to get this information as well.

As Lewis indicated, we're going to focus on topics where we have seen the most ADA litigation in the healthcare context or emerging issues. Here is what we're going to cover. First we're going to make sure everybody understands what law applies, whether the facility is a healthcare provider, legal standing to bring ADA cases against healthcare providers. The DOJ, Department of Justice's work with effect to access to healthcare. We're going to spend access to healthcare in the healthcare setting, where most cases have been, but also access to healthcare for people living with HIV, people with service animals, also accessible medical facilities and equipment and close with administration and use of medication, and then we'll have time for questions.

So one thing I want to make clear is today's presentation does not address ADA issues for healthcare workers with disabilities, which would be under Title I of the ADA. However, in conjunction with the Great Lakes ADA Center we have developed a brief. There's a link at the bottom. So if you're interested in the issue of employment of healthcare workers with disabilities, feel free to check that out.

Before we get into all the substance, we want to review a few procedural issues since many cases get dismissed not because of a finding of nondiscrimination but because of legal technical Tis. So these kind of technical issues are important because if you don't address them correctly you never get to the underlying issue of discrimination. The first issue is which law applies. A number of issues and laws can apply in a particular healthcare discrimination case. You can have Title II or Title III or the Rehab Act and almost every case you need to focus and see which one would apply. Sometimes more than one would apply. And often when you're looking at this, you need to determine whether the healthcare provider is private or public and whether it receives federal funding. Title II applies to state and local government entities, so public healthcare providers, except those that are federal healthcare providers. Title III applies to private healthcare providers, and, in fact, Title III the listing of public accommodations healthcare provider and hospital, both of those are specifically listed. And then don't forget about the Rehabilitation Act which applies to healthcare providers that are recipients of federal funding. So that can be private and public entities because both can receive federal funding

Also, you might remember that oftentimes there are state laws that apply to these issues as well. Sometimes they provide a different remedy than the federal laws. So, for instance, the California state law provides money damages where Title III doesn't provide that. So it's important to look to see if a state law might be useful in bringing an ADA case. You could add the state law claim along with the ADA claim.

Oftentimes people say, well, what is the difference between the ADA and the Rehab Act when it comes to litigation? And the general rule to remember is whatever is prohibited by Title II or Title III of the ADA is prohibited by Section 504. Discrimination provisions are similar. There are some differences, for instance regulations come from different places. Health and human services issues regulations for 504 and DOJ handles regulations for Title II and Title III. Money damages can be different depending on the statute you rely on.

Section 504 does provide money damages in discrimination cases for healthcare providers. As I said before, Title III does not provide money damages under -- for private healthcare providers.

Under Title II you can get money damages, but you have to show that it was intentional discrimination. So they intended to do so or they were deliberately indifferent to the rights of the person with the disability.

Another difference we're going to talk on the next slide is the religious exemption. The ADA has religious exemption but we don't see that in the Rehab Act. Let's talk about that as another issue that can come up in litigation.

Are religious healthcare providers subject to the ADA or the Rehab Act, and the Reed case is a good example how this can play out. The Reed case you have a patient who has tardive dyskinesia, and she filed a Title III suit against a private hospital, and they -- because what happened is they withheld a device that she used to speak called a DynaVox and put her in seclusion room as punishment. We'll talk about this later, but right now we're talking about whether it's covered by any of these laws. The hospital said, wait, this case can't go forward under ADA because we are covered by the ADA's religious exemption. We are a religious hospital, religiously run hospital. And the 7th circuit court of appeals said, well, the religious exemption is something you could have raised in affirmative defense, but you didn't raise that until the very end of the case. You should have raised it when you initially responded to the complaint. So you waived this, and by raising it at the last minute, you're basically trying to ambush the plaintiff. So we're not going to let you raise it since you didn't raise it when you should have before.

But look at another case, the Cole case, which involved another religiously run healthcare provider and they raised it properly at the beginning of the case and the Court agreed that because this hospital was under the jurisdiction of the Roman Catholic Diocese, the ADA didn't apply. The ADA exemption was very broad and the issue here is who operates it. It doesn't look at whether it's religious services or whether the people who attend are -- believe in a certain religion. It's who operates it. It was clear this was operated by the Roman Catholic Diocese and therefore the ADA exemption applied. Remember, even if the religious exemption applies, the healthcare provider can be liable under the Rehab Act if they receive federal funding. In fact, in this Cole case, even though the ADA case went away, the Rehab Act continues because there is not a same kind of religious exemption under Section 504 of the Rehab Act that we see under the ADA.

Our next question is one that you might not have thought would come up in these cases, but we have seen recent litigation in this issue whether a particular facility is a healthcare provider or not. So as I mentioned before, Title III specifically lists healthcare provider as a covered entity. And this usually isn't a disputed issue because it's pretty clear whether something is a healthcare provider or not. We

have seen this come up in a unique context, and that is in the context of an entity that is a plasma collection center. So the first case listed here is the Silguero case versus CSL Plasma. And so for those who aren't familiar with plasma collection centers, these are entities that pay folks who pass a screening test who want to donate plasma. And in this particular case, there were two people with disabilities who were excluded. One had a mobility disability and another one who uses a service animal, and the Court said before we can look at whether or not this exclusion was because of disability or the use of a service animal, the question was is CSL Plasma a place of public accommodation? Is it covered by Title III? If it's not covered by Title III, whether they were excluded because of their disability would be irrelevant, right? Is it covered by Title III? This went to the 5th circuit court of appeals which said, no, this is not a public accommodation because it's not a service establishment, which, remember, is one of the 12 categories under Title III, and that's what the plaintiffs had claimed, it was a service establishment.

And the way the 5th Circuit explained this is they said, you know, service, that term "service" implies a benefit to customers, and there's no benefit here. You know, the service establishment doesn't pay the customer. Here the customer is actually providing the service, and they're getting paid so when they donate plasma, they're getting paid as opposed to you paying the service establishment. So there's no service being provided, so how can it be a service establishment? Maybe it's an establishment, but it's not a service establishment, therefore it's not covered by Title III.

Okay, so does that tell us that all plasma collection centers aren't going to be covered by the ADA? No, it's not going to tell us that because within a couple of years of that case, there was a similar case that was filed. Actually, it was against the same exact defendant, CSL Plasma. Look at the bottom of this slide we're on, the Matheis case was a very similar case, and it went the exact opposite way. So in this case you, again, had somebody who was denied the opportunity to donate plasma and get paid for it, and in this case they said, no, this is a service establishment under Title III. The service provided is that they have trained personnel and equipment to achieve the customer's goal, which is to provide plasma and get paid for it. And this Court said, we need to read the definition of public accommodation very broadly, because, you know, the ADA is supposed to be to effectuate a purpose, to eliminate discrimination and exclusion of people with disability, so we're going to read public accommodation broadly. Unlike the Silguero case, the Matheis court said it's a place of public accommodation, even though not a typical one where you pay the place, here they pay you, but they provide a service in letting you -- giving you the opportunity to donate plasma.

So this is a very unsettled question, obviously. It's not your typical issue under Title III, but something to remember that you can't assume something is a healthcare provider if you can't fit under one of the 12 categories listed in Title III.

All right, our third and final procedural issue before we get to more of the substance of the case is sometimes it feels very technical but it's really important for everybody to understand this, because so many ADA healthcare cases and other Title III cases get dismissed because they can't show they're covered by the law. So what we're talking about here is that the first question in any ADA case is: Is the plaintiff really covered under the ADA? It sounds technical, but because so many cases have gotten dismissed without getting to the underlying discrimination claim, it is important for people to

understand. Because if you can't show that you're covered by the ADA, then whether you discriminated against really doesn't matter.

So this goes to a legal concept called standing. So we're going to take a quick trip to law school and make sure we understand what this is about. So in order to bring any lawsuit under the constitution, you have to show -- you can't just file a lawsuit. You have to show a few things. One, you have to show that you have incurred some sort of personalized and concrete injury of some sort of legal interest that you had. And you have to be able to trace your injury to something that a defendant did, their conduct. And then it has to be likely, rather than speculative, that this injury could be redressed by a court. What can a court do to redress the injury that you have sustained as a result of the defendant's conduct? That's for any case you bring, that's what the constitution says.

But let's talk specifically about Title III, since that's what we're focused on right now. In Title III cases, you have to show that the plaintiff had some sort of harm because of ADA compliance. Well, that's okay. That's not too hard. That's pretty typical. And then you have to show that the accessibility issues must relate to the plaintiff's disability. Again, pretty straightforward. But it's this third factor. You also have to show a likelihood of future harm. Because of the Title III violation. In order to have legal standing to be the Title III case, you not only have to show that you were injured, but that you're likely to sustain future harm.

Now, why is that?

Well, remember what I said before. Title III doesn't give you money damages. So there's no redress of the injury through money damages. So the only thing you can show is that if they don't provide some sort of -- address discrimination, there's going to be harm in the future that you will incur. This is called prospective injury, and that you need the court to do something to prevent the prospective injury, some kind of change in the future, also called injunctive relief.

Some examples: For instance, in a case where an interpreter wasn't provided, you would show that you're injured by that and that you're likely to not get an interpreter in the future if you go back to that place, that particular Title III entity, like a healthcare provider. Or if they didn't let your service animal in and they don't fix that, your service animal isn't going to be able to go in if you can show that you would likely go back to that place again and again and again.

So let's talk about this, how the court figures out whether there is any kind of allegation of future harm.

What most courts have done is adapted a four-part test. And this four-part test is laid out on this slide. The first factor is can you show future harm because you live near this business, your home is near this business, so it's likely you're going to go to that business again.

Have you been to that place a lot in the past? If so, it's likely you'll be harmed by them again if they keep discriminating against people with disabilities.

How definitive, how definite is it that you're going to return to that place? Do you have a plan to go back to it? Maybe a surgery that is scheduled in the future?

And also, how frequently do you travel near the business? Maybe not near your home but you drive by it every day to work. So they look at those four factors in determining whether there is possibility of future harm. And as I said, many people with disabilities can't pursue a healthcare discrimination case because they can't show any of these four factors and then they don't have legal standing.

So let's look at a couple cases to make this a little bit more clear

So I'm going to give an example where the plaintiff did have legal standing and one where they didn't. So the first one is -- it involved a man who was deaf, and he was denied an interpreter by six different doctors in his network for his insurance. And he kept asking for interpreters and kept getting denied six times and finally he was like, okay, I'm going to go to an out-of-network provider and get an interpreter, because he heard this doctor provided interpreters, but it wasn't in his network. He did it because he needed care, but the problem was, when you go out of network, it's more expensive. After he got the care, he's like, this isn't right. He filed an ADA case against all six of the other doctors who refused to serve him. So what did they say in response in they said, you don't have a likelihood of future harm. Why would they say that?

Well, they would say, you know, you already found a doctor who provides an interpreter, why would you return to the original doctors who wouldn't serve you? There's no likelihood of future harm, why would you go back to a place that was discriminating against you? And he actually hadn't renewed his request after the first tries. He stayed with his doctor and filed a lawsuit. And the Court said, wait a second, he does have standing. He alleged he would return to the in-network physician, one of the six, if they provided the accommodation he had been seeking, because he had to pay higher expenses by going to the out-of-network doctor. So even though the others didn't provide the interpreter, he wanted to go back to them if they would provide an interpreter because it was cheaper, it was in-network. And the Court said he didn't have to engage in any kind of -- he dependent have to keep going back and saying, are you going to provide an interpreter, because he knew he would get the same answer. Because he could show he would go back if they provided the interpreter, because it would be cheaper, he did have legal standing.

But let's look at a case that went the other way. This an example of -- this Juich case is an example of legal founding not found. This woman was deaf and she brought her daughter to the ER, the emergency room, and they had video remote interpreting service, which we'll talk about later, but that service malfunctioned and the staff wasn't trained, so no effective communication.

And so she filed a suit against the hospital, and the Court said, sorry, without even getting to whether she was discriminated against. You don't have legal standing because you can't show future harm. Well, why couldn't she? Well, she failed to allege any kind of fact that she was going to have any kind of future harm. And when you looked at the doctors we talked about, like the proximity factor, there were six hospitals that were closer. So it was unlikely she would return. She had said she thought she would return someday but the Court also said, well, that definitive factor is not there because you didn't say you were definitely going to go back, and then it also showed that since she filed the lawsuit and since she had that initial incident, she had never gone back. She had only been to it once. There was no history of her going to that other hospital. It was not proximity. It wasn't close. And

there was no definitiveness that she would return. Since she couldn't meet any of those factors, she couldn't bring her lawsuit. She didn't have legal standing.

So, again, remember those four factors if you're trying to prove that you are going to have any kind of future harm in bringing a Title III ADA case against a private healthcare provider.

Let's now just briefly talk about some of the work that the Department of Justice has done, because they've done quite a bit. In fact, they have what they call a Barrier-Free Healthcare Initiative that was started in 2012, to really focus more exclusively on these issues. There's a link on this slide to all the different agreements that they have had against healthcare providers. In fact, they have over 50 settlements under Title II and Title III on their website that they have gotten over the years.

And there's some common elements you're going to see in the settlement agreements. We obviously don't have time to go through all of them, but if you look at the agreements, they're cellular on what the DOJ gets healthcare providers to do. This is helpful for people to know what to ask for, if you're a personal with a disability, but also helpful for healthcare to know what to put in place to try to avoid any kind of ADA liability.

So one thing the DOJ requires healthcare providers to do is revise their policies to ensure that appropriate auxiliary aids and services, including sign language interpreters and materials in alternate formats are part of their policies and procedures in serving their patients.

Another thing that they commonly require is perform a communication assessment, requiring consulting with a patient and documenting that decision in the patient's chart. Also providing signage about available auxiliary aids and services and for sure always something about training your staff, about interacting with people with disabilities and providing them with accommodations they need.

You've got a couple of -- or three different links here on this page to recent settlements over the last three or four months. Two of them, the first two, the Pro-Medica and Lincare case involving communication access through ASL interpreters, and the Hazelden Betty Ford Foundation settlement is about architectural access to a healthcare provider.

So, again, looking at these will be very helpful in understanding what the Department of Justice expects for healthcare providers to give.

We're now going to move to the area where we have seen the most litigation, and that is the effective communication in the healthcare setting. And, like I said, it's the most common issue that comes up, and when talking about these cases, we almost see the vast majority of these are involving people who are deaf who are seeking some sort of interpretive services, and there's been some problems with that.

Before we jump into the cases, I should note that the Department of Justice does have some helpful guidance there that is listed involving -- providing an interpreter versus the other option of exchanging written notes. And what DOJ tells us is that for people who know English, as well as American Sign Language, written notes may be okay when talking about conversations that is minimal, like routine lab tests or regular allergy shots, but interpreters are really what should be used when communication

is more complex, when talking about your medical history or diagnoses, those kind of things. And, in fact, courts have pretty uniformly found that when a deaf individual uses ASL to communicate and we're talking about a medical -- complicated medical procedure, like a surgery, the exchange of written notes is almost always going to be found to be inadequate to meet the obligation of effective communication.

So let's talk about some cases. So the first case is a case where they found that an in-person American Sign Language interpreter was required by the ADA. The Liese case is a case that involved two different people, a husband and wife, who brought a discrimination claim. They were both deaf. It was the wife who needed the medical procedure to remove her gallbladder, and despite requesting an interpreter, the only communication provided by the healthcare providers here was by mouthing words and writing notes and doing pantomiming, and initially they brought their lawsuit and the trial court found in favor of the hospital. They said you know, they did enough. Mouthing words and writing, that's enough. But then when they appealed to the 11th circuit court of appeals, they found otherwise and they said, no, there was plenty of evidence that what was provided here was ineffective. It was not effective communication. They didn't understand what was going on and they should have provided an interpreter. And they found for the plaintiffs here.

And we've got another similar case, another settlement by DOJ, the Overlake Hospital case, really sad facts involving somebody who -- it was a deaf woman who was giving birth and her mother, her also knew sign language was forced to come and interpret. And that meant her husband couldn't participate in the birth because only one person was allowed to be in the birthing room with this woman. They made a request for interpreters ten days in advance and it wasn't provided. That was a horrendous situation that could have been avoided.

But cases don't always go in favor of the plaintiffs. Let me give you an example of one that didn't. And we can try to explore why. So the Martin case involved a deaf patient who had a brief emergency visit, emergency room visit. He had a bump on the head, and he asked for an interpreter but wasn't provided with one. And the 11th circuit court of appeals found that, you know, in this case, it really wasn't necessary to have an interpreter. Well, why? Because the plaintiff here, they found, had received typed instructions and the plaintiff here, although he knew ASL, he also was able to read and write English. And, in fact, he had indicated that he understood what was going on through the written notes. So the Court here found that effective communication was achieved. And they talked about, you know, when talking about effective communication, we're talking about accommodations that are effective. It doesn't have to be the best preferred accommodation always, at least that's what the Court said here. We'll talk about that in a second.

And so because he had understood and knew English, he was deemed not to need an interpreter. We want to make sure you understand the distinction, though, between the American Sign Language and English aren't the same and there are many deaf people who can be fluent in American Sign Language but still unable to read English and making passing notes ineffective. That's why the individualized assessment is so important.

One thing I wanted to emphasize, we'll give a link later, but DOJ does have a document on effective communication, and what they do in that document, among many things, they talk about the difference between Title II and Title III. In Title II you're required to give primary consideration to the

person with disabilities' preferred mode of communication. Whereas in Title III you're only encouraged to consult with the person with a disability. There's a higher standard for Title II providers. They are required to provide primary consideration to the person with disability's preferred mode of communication, whereas under Title III they're only encouraged to consult with the person with a disability.

This next slide we have is a recent settlement agreement that was reached with the Department of Justice and the Washington State Healthcare Authority. And it's involving providing interpreters.

In Washington, this entity, the Healthcare Authority, they're in charge of administering Washington's Medicaid program. And they claim they had a whole program set up for American Sign Language interpreters for all the Medicaid recipients' medical appointments, but actuality the interpreters often weren't available. In fact, the Department of Justice found that only 30% of the time was an interpreter even provided. So what happened was people who needed interpreters were forced to either cancel or reschedule appointments or proceed without an interpreter. Really terrible options for them. 70% of the time. Washington realized the problem and agreed to settle with the Department of Justice. It's an interesting and I think very strong settlement. First of all, Washington is required under the settlement to contract with an interpreter services provider that has at least 100 qualified interpreters. And those interpreters have to cover the whole geography of the state of Washington. So it's not like 100 interpreters in Seattle. They have to be spread out and able to cover the whole state.

And then when they're monitoring their compliance, DOJ wants to see that Washington 90% of the time is meeting the American Sign Language requests in each geographic region. Not just 90% in one city, but 90% in all the geographic regions laid out in the settlement. And they said if you do use video remote interpreting, you have to meet the high quality video images that are set out in the Department of Justice's regulation.

So this is, I think, a really helpful settlement if involved in a state-wide review of providing interpreters for state-funded medical services.

Now, I've been talking about a lot of effective communication involving deaf patients, and while the vast majority of these cases do involve people who are deaf, it's important to remember this requirement goes to providing effective communication for all disabilities. So you might remember that Reed case we talked about before, when we were talking about the religious exemption. The Catholic owned and operated hospital. So remember that was the case involving the woman who had tardive dyskinesia, which limits her ability to speak, and she used a communication device, and she had gone to the hospital for mental health issues and she was denied access to her communication device. And she was actually put into a seclusion room. It really led to some terrible circumstances for her. She soiled herself and she actually tried to commit suicide while she was segregated away. Really, really sad situation. And so she ultimately filed a lawsuit against the Columbia St. Mary's Hospital, as we said before, and they said she did have a viable ADA complaint because they failed to provide effective communication. We wanted to give this example of a case involving somebody other than somebody who is deaf who had an effective communication case under the ADA.

As I mentioned before, we wanted to talk a little about video remote interpreting, because that's a new way of communicating technology that has evolved.

So video remote interpreting, you know, I think everybody is familiar, but just in case, it connects an off-site interpreter through the use of video conferencing system. This is a developing issue because this is a technology that wasn't really around when the ADA was passed in 1990. So it's not specified in the laws or early regulations when the Department of Justice put out regulations on effective communication. But the most recent DOJ regulation does address video remote interpreting. They have laid out the performance standards they expect in order to have effective communication, and you'll see the citations on this slide for Title II and Title III. And the two main things they say you need high-speed wide bandwidth video connection to prevent low quality video images. And not only the technology, but you also to provide effective staff training to ensure that there is quick set-up, they're not figuring it out on the spot, and they can operate the machine. Because, you know, technology without training really is useless. And we have many cases we have seen where the healthcare provider has the technology but the staff doesn't know how to use it because they weren't trained. So that is a really important one too. You have the technology and you have good staff training and we have a link to an agreement where they talk specifically about the DOJ standards at the bottom of this slide involving the state health systems case.

What are potential problems? The Department of Justice and the National Association of the Deaf have both put out documents to talk about this. The Department of Justice is really concerned that sometimes somebody can't access a screen, a video remote interpreting, because they have vision loss or maybe because of the nature of their injury, it's hard for them to -- and positioning, it's hard for them to see the screen. I mentioned before DOJ has this really great document on effective communication, and part of that document does describe their requirements for video remote interpreting and the potential problems that can arise if not used correctly.

So that is something to definitely check out. But also check out what the National Association of the Deaf has put out. They're concerned that healthcare providers are over-relying or exclusively relying on video remote interpreting for communication with people who are deaf. They're concerned about the technology problems and lack of training. So check out that link at the bottom -- at the middle of the screen on what they consider really important issues when it comes to video remote interpreting and why they think in-person interpreters is the way that healthcare providers should go in almost all circumstances.

You've got an example of a day here, the Shaika case out of Pennsylvania where, again, a tragic situation. I point these cases out because, you know, these cases really can just -- I don't know -- the lack of communication isn't just an annoyance, it's tragic circumstances. Here with a situation where a woman, her daughter had been at the hospital and passed away, and she was -- the mother was deaf, and so she went to the hospital to find out what had happened. She had just heard that her daughter had been there. She didn't know that she had died. They didn't have an interpreter on staff and they didn't have video remote interpreting that worked effectively. It was not working well. And so they just wrote her a note that said, "your daughter is dead."

Talk about how horrible it would be to read a note without any context, without any kind of more sensitive way of providing that information. It was a very just straight note, and that's all she got. In fact, she had a follow-up appointment and VRI wasn't working and no interpreter was provided. This happened multiple times. She filed suit under the ADA. They said, you know, this hospital acted with deliberate indifference to the plaintiff's rights so she can proceed with her case. Very tragic circumstances can arise without effective communication.

Another case where VRI versus in-person interpreter played out that is helpful and goes through careful analysis is the Silva case out of Florida. And this was a case, again, involving two deaf people who alleged that the hospital -- persistent use of video remote interpreting violated the ADA because of the very technical -- constant technical difficulties and practical limitations that occurred.

In fact, it was often inoperable or the picture would be blocked or frozen. Not a lot of good staff training. They didn't know how to use it.

And they brought their lawsuit and the initial court said you know, they provided enough effective communication. You can't show that you were misdiagnosed or you had improper medical treatment because of the problems with VRI, and you didn't identify what they failed to understand. I don't think you have legal standing to bring this to get injunctive relief. The Silvas weren't happy and filed an appeal. The Department of Justice got involved and wrote a brief that supported the plaintiff's position. We have a link on the slide. This made it to the 11th circuit court of appeals and found for the plaintiffs. They said, there wasn't effective communication with this video remote interpreting. What they said that was most important was that when talking about the ADA, you don't have to show that you had adverse medical outcome for an ADA claim. It's not a medical malpractice case. You don't have to show medically horrible happened because of ineffective communication. The focus is on the communication itself, not the consequences of the failed communication. So the real question here should have been, did the patient experience a hinderance, a real hinderance do a disability, being able to exchange material, medical information, with her healthcare professionals. And the Court said, yeah, the plaintiff showed that they were hindered due to the problems with VRI and the lack of in-person interpreters. In fact, she had kidney pain that was very serious, and while the staff was trying to figure out how to work VRI, she was literally writhing in pain. She had experienced a hindrance because of the ineffective communication that was provided.

And to require them to identify what information they were unable to understand or convey, that's not fair. You can't require somebody to prove a negative. They couldn't know what they didn't hear. Because of the ineffective communication. That doesn't make sense. And the Court also favorably sided that the Department of Justice regulation on VRI, which is very important, that the Court's approve what the Department of Justice found about VRI and they found that the plaintiffs did have standing because they regularly returned to the hospital or they regularly used the hospital, lived nearby, so they have proximity, and they were likely to return. there was a definitiveness. They met the factors we talked about before. So they could bring an ADA case. They were able to proceed with their case.

The last VRI case we want to show you is another Department of Justice settlement. The reason we wanted to show this one, this settlement actually lays out all the DOJ regulatory requirements, and they go even further. Not only do they say it has to meet those requirements, but they also put in a

time limit. They said if they cannot make the VRI working within 45 minutes they have to get an on-site interpreter. If they do use VRI, they have to confirm it's meeting individual's needs. If not, they need to find an onsite interpreter. If you want an agreement that lays out specifically what a hospital needs to do to comply with DOJ's regulatory requirements, I would strongly recommend checking out the Morales agreement.

One thing we often forget is ADA doesn't cover just patients coming to healthcare providers, but they can also cover companions who have disabilities who are accompanying family members or other people that they know who are coming to the hospital or healthcare provider. And the ADA is well said that the obligation extends to companions with disabilities and not just the patients. And the definition of companion is very broad. It's on the slide. It can be found in the Department of Justice regulations. And it's in both Title II and Title III.

So let's first look at a case where companions -- cases where companions were found to be upheld. And remember, this is an independent cause of action for the companion. The patient themselves doesn't have a disability for the companion to have an ADA claim. They have their own claim because they're a person with a disability and not provided effective communications. And the Perez case is you had parents of a child with cancer, parents were deaf and they needed sign language interpreters to communicate with the healthcare providers and they didn't provide that. So they found that they did have a clear claim against the healthcare provider for ineffective communication.

And the Fairfax nursing center case is another example where you had two companions, a woman who lived -- 83-year-old woman who lived in a nursing home and the woman's daughter and the granddaughter were both deaf and they asked for interpreters, and the nursing home said, we only have to provide interpreters for our patients, not for companions. And DOJ said, no, you also have to provide effective communication for companions too, and ultimately they reached a settlement where the nursing home agreed to provide interpreters for companions and not just for the patients they had.

There's a difference between being a companion, a person with a disability and also there's legal rights that people have even if they don't have a disability but they are discriminated against because they associate with somebody with a disability so companions or people with disabilities accompanying a patient but also people who associate with a person with a disability might have a claim too. Let me explain how this works out. The Loeffler case is a great example. Here you had hearing children that were ages 13 and 17 and their dad was a patient at Staten Island University Hospital and their mom was also accompanying the dad, and she was deaf too. And so they didn't provide interpreters, so the kids were required to provide the interpreting services. And when they filed a lawsuit, they filed a lawsuit on behalf of the dad who was deaf, the patient, the wife who was a companion, who also was deaf who didn't get an interpreter, but also filed on behalf of the kids who didn't have a disability. They were hearing for association discrimination. Because they had to do something that they shouldn't have had to do. They had to miss school for two weeks to provide interpreter services for their parents because the hospital refused to do so. So they had an independent claim.

The McCullum case went the other way because here the kids didn't have an independent injury. They didn't miss school or even though they had to help out interpret for the parents. The parents had a claim but the kids didn't because they couldn't show an injury. In the Loeffler case they had an injury, they missed school and exposed to very detailed information about their dad's diagnosis as kids they shouldn't have been exposed to. So that was a really clear case of association discrimination.

And, in fact, DOJ has put out regulations on family member interpreting. They say if it's an adult you can't have a family member interpret unless there's an emergency and immediate threat to the safety or welfare of the person. An interpreter isn't available so a family member has to step in, or if the family member agrees that the family member can interpret and is appropriate. DOJ is much more restrictive when talking about minor children interpreting, and the only time it's okay for a minor child to interpret is when there's an emergency or imminent threat and the family member can't consent to a child to interpret in that circumstance.

As we stated earlier, most of the cases involve -- these effective communication involve deaf people, but there are some other examples we wanted to show you that might be relevant as well. One is the whole concept of talking prescription containers. And these are when people get home with their medication, if you're blind and you want to try to keep your health information private and want to independently administer your own medication, these talking prescription containers can really make a difference. We've got information about an agreement reached with CVS pharmacy, but also these have been reached with Walgreen's and Rite Aid, a new developing technology and something you need to consider when thinking about effective communication. It's not just effective communication in the facility but when people come home and need to access medication.

Check out the links there if you want to dive deeper on that.

Then we had a recent case involves access to healthcare with respect to alternative formats. This was not an ADA case because it involved the federal government where the federal Medicaid and Medicare agency was not providing alternate formats for people who are blind. So they weren't providing information in large print, in Braille, or electronically. And also the forms on Medicare.gov were not accessible to people who use screen readers. And so a settlement was reached where they're going to make sure that these -- all this information that is provided by Medicare is accessible in alternate formats.

Also just a reminder that effective communication also includes digital information. And we've got a couple links here to settlements involving inaccessible websites, again, for blind people, and there's links for two different medical entities that websites were not accessible.

And we just wanted to kind of -- on the horizon, watch two brand-new cases filed with respect to inaccessible digital health information. Equip for Equality, the organization I'm with, filed a lawsuit last week against the federal government and Blue Cross Blue Shield. So under Title III as well as the Rehab Act, for insuring that the website and other digital information was accessible to blind people who are federal employees. Those websites were inaccessible. And then also in Indiana, similar litigation was filed against a state medical provider that provides Medicaid applications and food

stamps called SNAP, those websites weren't accessible and the portal was inaccessible over the Internet for people who use screen readers. Those were just filed in the last month or so and we'll be watching those in the coming year.

So that was a lot about effective communication, but I wanted to spend that time because that's where we've seen the vast majority of litigation, but we're going to cover a few other subjects and then open it for questions.

The next issue we wanted to focus on is access to healthcare for people living with HIV and AIDS and most remember that the very first ADA case was on behalf of somebody who was denied healthcare -- in this case dental services -- just because of HIV status. And the Supreme Court said that you know, this particular dentist said that a person with HIV posed a direct threat without actually doing an individualized inquiry as to whether there was any threat or not. And the Court said, you know, whenever you decide you're not going to serve somebody in a healthcare scenario you have to do an individualized inquiry of that particular plaintiff and really find out whether or not they are a significant risk of substantial harm. You can't sort of make decisions based on a particular diagnosis like HIV.

And you thought that would take care of things, but 20 years later we have another case where a cosmetic surgeon excluded all of its patients with HIV or on HIV-related medication. And the Court here found that was discrimination under the ADA because this doctor had an automatic policy for screening out people with disabilities and did not do the individualized assessment or determine whether there were reasonable modifications he should have made to ensure that the person could safely be treated.

And, in fact, DOJ in recent years entered into numerous settlement agreements involving people with HIV who have been discriminated against. This is something that surprisingly continues to be an issue of many healthcare providers denying services or treating people with HIV differently. And here on this page you'll see a link to numerous settlement agreements that Department of Justice has reached against healthcare providers that have had some sort of differential treatment or denial to patients with HIV.

So hopefully these agreements will not only address these particular entities but also inform other healthcare providers that they can't do this under the ADA.

Our next issue we want to cover is access to healthcare for people who use service animals. And service animals is obviously a big issue in respect to the ADA but we're going to focus on how it plays out in the healthcare setting. In fact, you might remember the Department of Justice put out guidance on service animals specifically back in 2010. But if you look at that guidance and you have a link at the bottom of the slide, they actually have a specific section just on healthcare facilities. And that's really what we're going to focus on given the topic for today. And the general rule in this DOJ guidance is that in a hospital, it would be inappropriate to exclude a service animal from pretty much all areas of a hospital or a healthcare provider where other patients and visitors are permitted to take or permitted to access without taking precautions. They said in some circumstances it might be appropriate to exclude a service animal where it would compromise a sterile environment, like an operating room or a burn unit. But that's the exception. And the general rule is generally service

animals should be able to go where anybody else can go. And what is most important is that healthcare providers should not impose blanket bans against service animals, ha they need to engage in the interactive process and do individual assessment. As we know not all service animals are created equal. Some are much more well-trained and behaved and focused than others. And so you can't just have a rule, a blanket ban. It has to be based on individualized assessment. And you also have to identify, are there any kind of reasonable accommodations to address having a service animal in the healthcare environment.

So let's talk about how this plays out. We'll look at two cases, one where the service animal was allowed to go and one where it wasn't.

Tamara is a case where it was said the service animal should be allowed in the setting. It involved a woman who was a psychiatric patient and she was denied her service animal while hospitalized. The hospital seemed to believe that the psych unit was an inappropriate place for any kind of service animal, so they had a ban to anybody with a service animal in the psych unit. Not in the whole hospital, but in the psych unit. They specifically said that the harness on the service animal could be used as a weapon and the presence of the animal might upset patients. Again, because it was a blanket ban they didn't do the individualized assessment, and the Court found, you know, the risks that you've come up with they're not based on anything, they're speculation. You didn't try it and make this decision, and you should have done an individualized assessment about this particular service animal and how it could have been potentially accommodated in the context. And they didn't do that and they didn't look at any kind of reasonable accommodations, and so the Court found it was a violation of the ADA here.

Contrast that with the Roe case involving a service animal on the other end of the spectrum. He was not trained well. He had what they call a putrid odor, and here the healthcare provider, to its credit, tried to work with this particular woman with her service animal. But this service animal is really a problem. It was always growling, wasn't handled well. He wandered around the hospital. They thought he was dirty, had maybe infections, so very extreme case obviously not your typical service animal. And the hospital tried to accommodate the patient with the dog even though he had this putrid odor that required a lot of patients to transfer because they couldn't stand the smell. What if we put you in a room and kept the door closed and had a filter on, would that work? The plaintiff refused the offer. Sorry, I don't want the door closed. Even though they tried, it was the plaintiff who refused to engage in the interactive process and come up with any kind of alternate solutions or accommodations. And so the Court found here in this extreme case that it was okay to exclude a service animal.

A couple other service animal cases that aren't as typical, one was involving a service animal and whether they could -- a healthcare provider was required to put the service animal in the ambulance. They had a blanket policy saying no animals in the ambulance and the Court here said that was improper exclusion and they should have modified their policy to allow service animals in the ambulance. And you've got a list -- a link to the settlement here where they're required to hire an ADA coordinator. They're required to permit service animals to accompany owners in the ambulance unless the animal is out of control or not house broken. There's no surcharge that should be assessed for service animals, that you can only ask the permissible questions about service animals

laid out in the DOJ guidance and also making sure that you train your personnel about the opportunity for service animals to accompany their owners.

And then you also have the Sheely case, where another service animal case where we are confirming that service animal access is not just about patients but also companions, once again. That whole companion issue is not just important for effective communication, it's also important when we're talking about service animals and companions who use service animals. Here you have a mom who is blind, who is bringing her son to get an MRI, and the radiology entity wouldn't allow the mom to come in with her service animal. And what they said was, you know, they're not the patient, so they're not covered by Title III. And the Court said, yeah, they are, because Title III covers companions, including service animals, companions who use service animals.

What was interesting about this case, the facility saw they were going to not win the case, so they changed their policy during the pendency of the case and said, we changed the policy, so the case is moot. And the Court said, you know, it's not moot, because it's a new policy and it's not clear that the wrongful behavior won't recur. You can't avoid liability just by simply changing your policy. So that didn't get them out of ADA liability just because they changed their policy while the litigation was pending, and the Hurley case at the bottom is another example of that issue.

We're moving into the final two issues. Second to last issue we want to talk about is accessible medical facilities and equipment. So people might remember, just to give a little bit of background here, is that the Department of Justice did issue guidance regarding healthcare providers when we're talking about physical access and facilities as well as the equipment, and you've got a link here that talks about what they say are the different standards that are required. You might also remember back in 2010 that the Department of Justice issued a Notice of Proposed Rulemaking. They were going to issue regulations -- not just guidance but regulations -- for accessible medical facilities and equipment. As well as other types of furniture and equipment. That was pending. And then at the end of 2017, in December, those proposed rules on equipment and furniture were withdrawn by the Department of Justice. They said, you know, we are reevaluating whether the regulations are necessary. They pulled this regulation as well as others, like on websites and accessible 9-1-1. So there were a bunch of proposed rules that were being considered and people were making comments on that DOJ in 2017 just pulled. And so those are kind of not really on the table anymore, and there's no indication that those are going to move forward under the current administration.

However, it's important to recognize that even though DOJ has pulled its proposed rules, the Access Board has moved forward with issuing standards on accessible medical diagnostic equipment. Now, it's important to remember that Access Board standards don't have the force of law until DOJ adopts it in its own regulations. However, because we don't have those clear rules right now, I would contend that these standards that were issued by the Access Board provide important guidance for healthcare providers who are trying to determine what are their responsibilities under the ADA, how can they make their equipment accessible. So, again, because these don't have the force of law, they're not as strong as maybe regulations or something in the actual law, but they do provide a really thoughtful analysis of what healthcare providers can do to comply with the ADA and make their medical diagnostic equipment accessible. I think it's good for healthcare providers to check these out, and if you're trying to comply, I think following the Access Board standards is a really great step to take.

There are some settlements in some cases on these issues we wanted to share with you. There are many of these on DOJ's website. I just pulled one as an example, the Beth Israel case. Here you had an allegations that the healthcare provider had inaccessible patient rooms and bathrooms, that the exam tables and medical equipment, there weren't enough of those accessible, and even the routes for maneuvering space was insufficient for people who used wheelchairs. Beth Israel reached an agreement with DOJ where they agreed to hire an ADA compliance officer and agreed that 10% of rooms will be accessible and agreed to ensure that 10% of the treatment room and equipment is accessible and each would have one accessible entrance. If you're looking to comply and determining what Department of Justice's expectations are on complying with issues, these settlement agreements are great thing to check out.

There's also been some private settlements and structured negotiations where people have negotiated accessibility without going to litigation. So you've got a couple of links here on this page, the UCSF Medical Center settlement agreement, and the Massachusetts General Hospital settlement agreement, which were voluntary agreements that were reached without litigation. And then a private settlement agreement Metzler v. Kaiser. This is one of the first comprehensive ADA settlement agreements with a major healthcare provider. You have a link at the bottom of the slide that I think is very thoughtful and very comprehensive. One of the things I like about this settlement agreement is that it includes the requirement that the healthcare provider will survey all of its medical equipment for accessibility, and not only look at what they currently have, but they also have to develop a procurement plan for acquisition of accessible equipment in the future.

So it has both the remedial, fixing what is already there, and a prospective, a good accessible procurement plan going forward.

So I think that's a really nice combination of fixing what you have and making sure when you buy things in the future, that those are accessible.

The final agreement under this section is an agreement that was reached involving accessible eyeglass and eye care facility. This was America's best contacts and eyeglasses reached a number of years ago here in Illinois. This was a class action brought by a number of wheelchair users who really couldn't get access to their eye exam because there were inaccessible exam rooms and equipment at 337 stores across the country. And they reached a settlement and agreed to retain an ADA consultant to perform accessibility surveys and monitor mediation efforts and agreed to train their personnel on interacting people with disabilities. They agreed to update their policies and procedures for treating people with disabilities, and they required each store to have a variety of accessible equipment, including a chair glide, accessible eyeglass and contacts fitting locations and accessible exam room in every single facility they owned, all 337. So very comprehensive.

All right. Our final issue and then we'll open it up for questions, is the issue of administration or use of medication. And this is another sort of emerging issue that we're seeing more and more across the country.

So in recent years, the Department of Justice has really looked at this focus, especially when talking about kids with insulin-dependent diabetes, to ensure that they have equal access to places of public

accommodation. This is less about access to a healthcare provider and more about entities that are covered by the ADA and how they interact with kids with disabilities, including kids with diabetes, and what responsibilities they have with respect to the administration of medication. And so we think that administration of medication is healthcare issues and that's why we included these series of cases in our discussion today.

What we found is kids that do have insulin-dependent diabetes are often excluded by institutions because they're not willing to change their policies to provide basic diabetes management care. And you know, sometimes kids here need assistance with blood glucose monitoring or the administration of insulin for people who have low blood sugar or issuance of emergency medication like glucagon, when you raise blood sugar. These are issues when they are going to camp or maybe a recreational entity covered by Title II. Let's talk about a couple cases that have come up. One of the ones that got the most press recently is an agreement that the Department of Justice reached with Kindercare. This was a case involving -- people are probably familiar with Kindercare. They have 1800 facilities across the country for childcare and camp. And as a blanket policy, Kindercare refused to administer insulin via a syringe or epi pen. And ultimately DOJ reached a settlement agreement with Kindercare, and what Kindercare agreed to do is first of all they agreed to evaluate the reasonable modification request on an individualized basis. Using objective evidence and current medical standards as opposed to having this blanket refusal policy that they're not going to do this for anybody who seeks their services. They also agreed that where a parent, guardian and physician healthcare professional says it's okay for a kid to be assisted by a layperson who had training, that that was generally going to be reasonable.

So you want to make sure that the kid's parent or guardian and healthcare provider says it's okay for a person to do that who has training before you do this. That's a reasonable thing to do.

And they also agreed in this agreement to contact all the families they had denied access over the past year because this policy really affected a lot of people.

Kindercare also agreed to revise and publicize a new policy that includes a sample diabetes plan. They agreed to provide a range of training to managers, to their teachers, and then there was monetary damages that were given to each agreed family, three different families that filed this complaint with DOJ.

But it's not just about diabetes. DOJ also looked at other kinds of medication, and one of the other ones we have seen is kids with disabilities who have epilepsy who need medication when they are interfacing with a Title II or Title III entity. So DOJ reached a settlement with Camp Bravo, when that camp refused a camper with epilepsy who required emergency medication when he had seizures and the camp agreed to administer Diastat, an epilepsy medication and agreed to adopt an emergency seizure action plan and physician's order for admission of Diastat, so individualized instructions for kids who needed that, as well as providing training for kids responsible for the camper with epilepsy. What DOJ said in this settlement is that it's their position it will generally be a reasonable modification under Title III for certain public accommodations such as camps and childcare centers to train laypersons to administer Diastat. The presumption is it will be reasonable from DOJ's perspective, and the burden of the Title III entity here to say why it wouldn't be reasonable in this specific situation. But the general presumption is it will be reasonable.

However, not all the cases have gone in favor of people with disabilities. In fact, at the bottom of this slide, DOJ brought a case in Illinois against a special rec association where the judge actually found that it was not a reasonable modification to require the special rec staff to administer this medication for epilepsy. Frankly, I think the fact that this medication is administered rectally was one of the things that made the judge uneasy about requiring staff to do that. Sometimes it's going to be the kind of medication or how it's administered that may impact whether it's deemed reasonable under the ADA.

And the last case I wanted to mention to you is a little different. It's not about the administration of medication but about the use of a particular medication and this is obviously a very hot topic in our country right now involving opioid use. So this is an agreement that DOJ reached with Selma Medical Associates. Here is complainant, the person who filed the complaint with DOJ used suboxone, and he tried to schedule an appointment at a practice and they turned him away because he use suboxone, and they said, we have a general policy that we do not treat people who use this type of medication, and essentially DOJ said, wait a second, you're basically discriminating against people because they have a particular disability, because only people with this type of disability Opioid Use Disorder, use this particular medication, so you're basically excluding a whole category of people with a particular type of disability, and that discriminates from the ADA.

So they reached a settlement and there were monetary damages that were found. Selma Medical Associates agreed to revise their policy. They agreed to publicize their change on the website. They agreed to put up signage in the reception area and to train managers and employees who interact with patients so this wouldn't happen again.

So that is leaving 15 minutes for questions. Why don't we open it up and see if there are questions. If not, there are other things I can talk about. I think now would be a good time to check and see if people have questions about what we talked about so far.

>> LEWIS KRAUS: Okay, great, thank you, Barry. Please remember to submit your questions in the Chat window and we'll get to those as they come in.

One question here, Barry is, on these last ones you discussed about the administration or use of medication, those are Title III entities, it sounds like. Have you seen cases of maybe Title II entities that may run summer camps or whatnot and need to also administer medications, sort of like the Kindercare one, for example?

>> BARRY TAYLOR: Right. Yeah, I think, if I'm not mistaken, I think at the bottom of slide 57, the Northern Illinois Special Rec Association is a Title II entity, I think affiliated with a particular local government. I think that was actually a Title II case as opposed to Title III case. I think whether it's private or public camp, we're going to see the same kind of issues coming up.. And I think the same arguments apply and same defenses apply.

>> LEWIS KRAUS: Great. Thank you. For anyone who is writing in about whether the slides are available, they are available. As mentioned at the beginning, they are there on the website at ADApresentations.org in the Schedule page today. As of tomorrow they will move to the archive where all of the archive information is. So you can be aware that that is there.

All right, so, well, Barry, at the moment we don't have more questions, so if you wanted to go into the other information you have, then I'll just let you know when we've got some questions.

>> BARRY TAYLOR: Sure, I'd be happy to. So one thing I didn't cover just because I was afraid we would run out of time is the issue of insurance and the ADA. And one of the things that oftentimes we have seen over the years is people who feel like their insurance policy is somehow discriminatory against a particular disability. So we'll see things -- like in the '90s we saw a lot of caps for people who had HIV and AIDS, or caps for people who had mental illness. Because I think insurance providers were concerned, especially with HIV and AIDS that they were going to get this huge rush of people because that was affecting so many individuals, and so they decided to cap that disability differently, and the benefits capped for people with those types of disabilities that were different than people who had things other than HIV and AIDS or other than mental illness.

And what was interesting about that, and one reason I want to bring this up is it's been applied outside the insurance context because what a lot of insurance companies said here was that insurance policies themselves aren't places of public accommodation. And they said, you know, place of public accommodation, that seems to raise the issue of a physical place, and that that is really what Title III is supposed to be about, is preventing discrimination for access to physical place. And insurance policies aren't physical places. I mean, you do have insurance office listed in Title III as an example, but how many people buy their insurance policies at an insurance office? And even if they did, they were saying that the ADA is about, you know, physical accessibility to those insurance offices as opposed to accessibility to that particular policy.

And so you had a lot of these kinds of cases that were dismissed because of this place of public accommodation argument, and so it's been very, very difficult for people to bring claims against insurance companies for discrimination under the ADA.

The other problem is that even if the courts didn't find that the place argument was the barrier, there is provisions in the data and subsequent case that is have said you know, the ADA is -- would be applying to insurance policies if somebody was excluded from the policy itself.

Because of a particular disability. But if they're just given different benefits, the ADA doesn't get into that kind of minutiae and assess sort of how you serve somebody within a policy. It's only if there is total exclusion from a policy would the ADA be applicable.

However, there is at least one case I have seen that goes a different way.

What it talks about is a mom behalf of her son with autism where they excluded behavioral therapy for people with autism spectrum disorder and they claimed that violated Title III. And Blue Cross Blue Shield say people with autism spectrum disorder weren't excluded from the policy. They had access to the policy, they just couldn't get this particular service that they were looking for, this certain kind of behavior therapy, and the court here said that because of the exclusion of a specific behavior treatment, called ABA therapy, applied behavioral analysis, I think it's called, because it only affected people with autism spectrum disorder it was discriminatory under the ADA and that Blue Cross Blue Shield did provide behavioral therapy for other conditions, and so because of this differential

treatment and singling out people with ASD, autism spectrum disorder, Blue Cross was deemed in violation of the ADA.

So there have been some limited exceptions, but trying to bring claims against insurance companies when you're treated a little differently in a policy as opposed to being excluded have generally been hard to prove. If people are interested in that case, it's Reed v. Blue Cross Blue Shield, and the site is 984F sub second 909 out of Minnesota.

I think questions may have come in. I'll turn it to you Lewis, to see if we can answer before the time is up.

>> LEWIS KRAUS: Great. Thank you. Do you know of any cases involving refusal or inability to provide assistive listening devices to hard of hearing patients?

>> BARRY TAYLOR: That's a great question. I have not seen it in the healthcare context. The only time I have seen those kind of cases come up is in the context of theaters, like live theaters, when people have gone and asked for those kind of accommodations, but I haven't seen it in the healthcare context. But I don't see why you couldn't make that argument. I think the argument that the healthcare provider might talk about is whether or not that would be considered a personal you know, device, like a hearing aid, but I think assistive listening devices are a little different. So I think because some entities provide those services that you could argue that is an auxiliary aid that should be provided.

>> LEWIS KRAUS: All right, so if you have another topic Barry, we can go into that. Otherwise we'll wrap.

>> BARRY TAYLOR: I guess I could tell you about a case or two involving accessible facilities and equipment that I didn't include but is pretty interesting. We have seen litigation that has been brought against nursing homes that are physically inaccessible, a case out of California, the Montano case in 2015. This was a man quadriplegia, living in a nursing home, a lot of folks in nursing homes, right? But their bathroom and showers were not accessible for him to be able to shower or to bathe independently.

And so he brought a suit under the ADA, and the Court found that this nursing home had violated the ADA by failing to modify the plaintiff's room and the bathroom and failed to provide evidence that the modifications weren't readily achievable. Many modifications had low cost, like adjusting fixtures and insulating pipes below the sink, and there was sufficient evidence that the requests were reasonable. So one reason I wanted to mention this case, when talking about facilities, I think people need to think broader. Oftentimes we think about hospitals and doctor offices, but we have seen litigation against nursing homes and facilities that people have long-term care. What is interesting there, sometimes you might not just have an ADA claim but you could also have a fair housing claim since that's where somebody is living as well as receiving services.

So you could have an argument that it's not just an ADA case but also a fair housing case.

And then the other one that I was just going to mention is kind of, again, a different twist on healthcare. This is a case out of Florida involving a man with paraplegia, and he drove cars -- his car with hand controls. And the garage attendant lost control of the car and so the hospital implemented

a policy that you could not have -- you could not use the valet service if your car had hand controls. He filed suit under Title III of the ADA because he didn't have access to the hospital valet services. Again, you're thinking about hospital, once you get in the hospital, but part of what the hospital offered, at least this hospital was parking and valet services. And so he filed suit under the ADA and they said, that's not really a public accommodation issue, and the Court denied that and said he did have a valid ADA claim and they said that, you know, the ADA is not just limited to removing architectural barriers but broader and prohibits unequal access to all the public accommodation services. And the other thing from a practical standpoint the Court noted is the car can be driven without using the hand controls, that was an optional way to drive the car. So it didn't mean that the valet attendants had to use the hand controls. It just meant that they had to, you know, include those hand controls -- cars that had hand controls as part of their valet services.

>> LEWIS KRAUS: Here you talk about nursing facilities brought one last question in. We'll do this one. Has there been litigation against nursing facilities for not using communication equipment or losing hearing aids?

>> BARRY TAYLOR: Hmm... I haven't seen any on that specific issue. There have been effective communication cases. So you might remember I talked about the Fairfax case involving providing interpreters, both residents and companions, those are the ones I have seen. So I think, you know, again, losing hearing aids, I'm not sure if that would be an ADA case. I'm just not sure. I haven't seen that. It's been -- what we have seen more is like more in the prison context where people don't have access to their own equipment and having to provide those kinds of assessments, hearing assessments and providing equipment because people are in a limited -- have limited access to that equipment. Whether you can apply that same argument to providing hearing aids in a nursing home context, I'm not so sure that would be effective. I haven't seen anything about, you know, losing hearing aids as an ADA claim.

So it feels to me like a bit of a stretch, but, again, I haven't seen it, so perhaps it might be accepted by a court, but I'm not -- I don't think that's going to be your typical effective communication case.

>> LEWIS KRAUS: Okay, great. Thank you. Well, we realize many of you may still have questions for Barry and haven't really thought them through yet or formulated them, so feel free to contact your regional ADA Center at 1-800-949-4232 as any of these ADA questions come to mind.

You're going to receive an email with a link to an online session evaluation. Please complete that evaluation for today's program. We really value your input and want to make sure that our funder understands the value of this. We want to thank Barry today for sharing his time and knowledge with us, a reminder again that the session was recorded. It will be available for viewing next week at [ADApresentations.org](http://ADApresentations.org) in the Archives section.

This will actually -- on our next webinar on October 24th, we will be join bid the Centene Corporation and National Council for Independent Living for a presentation on the provider accessibility initiative that is happening at Centene.

Watch your email two weeks ahead of time for the opening of that registration.

And one more reminder. This will be the last webinar using Blackboard Collaborate. Starting with our next webinar we'll be using Zoom as our new platform. It will not change the registration process but

you'll see a different layout and you may see -- it certainly will be a different start-up for you. But all the rest of it should be the same. But feel free to let us know if there are issues that you run into as we move over to this new system.

All right, Barry, thank you very much. And to all of you, have a good afternoon. Thank you! Good night!