PACIFIC ADA CENTER

Zoom Webinars

Thursday, April 28, 2022, 1:15-3 pm(CT)

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>> Welcome to the health care and the ADA inclusion of persons with disabilities Webinar series.

I'm from the Pacific ADA center, your moderator for this series.

This series of Webinars is brought to you by the Pacific ADA center on behalf of the ADA national network.

ADA national network is made up of 10 regional centers that are federally funded to provide training, technical assistance, and other information as needed of the Americans with disabilities act.

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Or 1-646-558-8656.

And use the Webinar ID, 837-2204-3591.

Those numbers are in the chat if you want to copy and paste them.

I want to also remind everyone that this Webinar is being recorded and will be able to be accessed on the ADA presentations.org website in the archive section of the health care area next week.

This Webinar is intended to share issues and practices in health care accessibility for people with disabilities.

The 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 follow to health care.

These monthly Webinars occur on the 4th Thursday of the month at 2:30 eastern, 1:30 central, 12:30 mountain and 11:30 A.M. Pacific time.

And 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.

You can download a copy of those slides at the health care schedule page at ADApresentations.org.

Those slides will be available probably tomorrow at the moment.

I'm sorry for that.

At the conclusion of today's presentation, there will be an opportunity for everyone to ask questions.

You may submit your questions in the chat area within the Webinar platform and 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.

To submit your questions, you can type and submit them in the chat area text box as shown on the screen.

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Today's ADA national network learning session entitled "health care and civil rights during the COVID-19 pandemic."

Updates from the HH office of civil rights and the Department of Justice.

People with disabilities have faced a heavy toll in the COVID-19 pandemic compounded by discrimination in the health care system.

This Webinar will discuss recent guidance and enforcement actions from HHS and DOJ including the frequently asked questions or FAQ's for health care providers during the COVID-19 public health emergency.

The guidance on long COVID as a disability under the ADA, section 504 and section 1557.

Disability access in vaccine distribution.

And other critical issues.

You'll be learning more about the application of civil rights prohibiting discrimination on the basis of disability during the COVID-19 public health emergency and health policy issues that impact people with disabilities.

Today's speakers are Molly Burgdorf.

Molly is currently the section chief in the civil rights division of the office of civil rights at the department of health and human services or HHS.

She's an advocate, attorney and woman with disability.

Molly has served as the senior director of rights policy with the arc of the United States, the senior policy attorney at the center for public representation senior advisor with the administration for community living, and the administration on intellectual and developmental disabilities at HHS, among other roles.

John Wodatch is a disability rights attorney with over 50 years specializing in the section 504 of the rehabilitation act.

The Americans with disabilities act and the U.N. convention on the rights of persons with disabilities.

He served for 42 years in the federal government where he authored the government's comprehensive disability rights regulations and created and led the Department of Justice's office in charge of enforcing the ADA.

He is now serving as a senior disability policy advisor at the office for civil rights at the department of health and human services.

And Kathleen Wolfe is a special litigation counsel with the disability rights section of the civil rights division at the Department of Justice.

Member of the disability rights section's senior management team.

Kathleen works with the division's rulemaking and guidance team as well as its enforcement teams litigating under the ADA and section 504.

All right, you three, I will now turn it over to you.

Molly?

>> Thank you so much!

So as he introduced, we'll be discussing this afternoon healthcare and civil rights during the COVID-19 pandemic, updates from the HHS office for civil rights and the Department of Justice.

Next slide, please.

And just to set the table, our agenda will be the introductory remarks that just took place.

And then a series of COVID related guidance and policy by HHS and/or DOJ.

We say and/or because we have issued some guidance jointly.

Followed by COVID related work by HHS and/or DOJ and then an opportunity for you to ask your questions or provide comments.

Next slide, please.

And I should actually introduce myself again as he said, I'm Molly Burgdorf.

I work in the U.S. department of health and human services office for civil rights.

And in case you aren't familiar with OCR, we enforce a number of civil rights law prohibiting discrimination on the basis of race, color, national origin, age, sex, religion and disability.

And also enforce the hippa breach notification rules and today, you'll hear me talking about three laws in particular prohibiting discrimination on the basis of disability.

First, of course, the Americans with disabilities act and particularly title 2 of the ADA.

OCR is a designated agency to investigate complaints of discrimination on the basis of disability by state and local government, health and social service agencies.

If you're wondering about our role specifically on the ADA, we'll be talking about section 504 of the rehabilitation act and section 1557 of the affordable care act.

Which prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities.

So we're going to delve into these specific COVID-related guidance and policy materials specifically.

And of course, this is just a SNAPshot of some of the most recent work that we've been doing at our agencies related to COVID and disability issues, and there's a number of other disability-related guidance and, of course, civil rights enforcement guidance.

And we can share the general links to an archive of those resources as well.

But we thought this would be the most useful for current purposes.

Which include the FAQ is for healthcare providers during the COVID-19 public health emergency that just issued in February, just a few months ago.

Followed by the long COVID guidance issued by HHS and DOJ last July that they will be presenting on.

And a related fact sheet on disability access and vaccine distribution which we issued in April of 2021.

And we'll be sharing a little more detail about what these documents are, and what they cover.

And how they may be useful to you, so next slide, please.

So we're starting with the FAQ's for health care providers during the COVID-19 public health emergency which, as I mentioned, HHS issued and specifically covers protections for people with disabilities under 504 which is typically read by courts in conjunction with the ADA as well as section 1557.

So what is this guidance and why did we issue it?

Well, it's intended to provide information for healthcare providers so that they understand that civil rights protections continue to apply during the public health emergency so they can understand the rights of qualified individuals with disabilities who are protected under these laws.

And we wanted to be sure that entities providing services such as hospitalizations, long term care, intensive treatments, and particularly critical care services that have been important during COVID such as oxygen therapy and mechanical ventilators understand that the civil rights laws apply to them and what that means.

So next slide, please.

The FAQ's cover a few specific areas.

Particularly standards of care, visitation policies and testing and contract tracing programs.

And I'm going to start with the application to crisis standard of care plan.

Crisis standards of care plans typically help hospitals and other healthcare entities triage scarce resources in times of crisis or public emergency.

And what we wanted to help providers understand is that when they are allocating scarce resources or care during a public health emergency, they have to still take into account how these protections against discrimination apply.

So, for example, when analyzing the patient's ability to benefit from the treatment that is sought, they must do so in a way that's free from stereotypes and bias about disability.

And that includes prejudicial preconceptions and assessment of quality of life or judgment about a person's relative worth based on the presence or absence of disabilities.

And that also means they are not prohibited to make categorical exclusions on the basis of disability.

For example, if a person -- hospital can't have a categorical exclusion, denying life saving care to people with down's syndrome based on a judgment people without down's syndrome would be a greater benefit to society or experience a richer or fuller life than people without down's syndrome.

Or in resource allocation decisions, they have to be based on current medical knowledge or the best available objective evidence regarding effectiveness of treatment.

So, for example, a hospital can't deny care during the public health emergency based on the idea that the care is unlikely to be effective for a particular patient unless it's specifically based on analyzing that patient's ability to respond to that treatment being sought.

So a person's disability or pre-existing diagnosis should not form the basis for a decision regarding the allocation of scarce treatment unless that specific underlying condition is so severe that it would prevent the treatment sought from being effective or would prevent the patient from surviving until discharge from the hospital or shortly thereafter.

So to bottom line that, there are a few limited situations where a hospital or provider can take into consideration a person with disabilities and how it might play out to the effectiveness of treatment, but it's only in a very limited category.

And it can't be based on long term guess about the life expectancy of a person in the long term.

We also talk about the need for reasonable modifications for people with disabilities and crisis standards of care.

So, for example, in using an assessment tool, a hospital can't unnecessarily screen out or even use a tool that tends to screen out people with disabilities from having the opportunity to benefit from an aid or service and may need to make reasonable modifications and the use of the assessment tool unless doing so would cause a fundamental alteration or impose an undue burden.

And as an example, this is a real life example, providers in part of their decision making process of allocating resources were using a scale that considers motor, eye and speech abilities.

And, for example, somebody with cerebral palsy may have difficult speaking or moving as part of the underlying disability, but that's not the condition that has them seek treatment for COVID.

It's to ensure that a person's pre-existing condition or disability and the symptom of that condition or disability are not considered when using this tool, this Glasgow coma scale to consider whether the person qualifies for treatment.

And the usual protections and defenses of fundamental alteration or undue burden do apply in these situations.

We always want to highlight providers there is a limit to these requirements.

However, they are incredibly important and they must be first and foremost when these decisions are being made particularly for people with disabilities.

The guidance then goes on to pose a series of pointed yes or no questions and essentially these are to help health care providers understand what is prohibited.

So spoiler alert, the answer to all the questions is can I do this?

And the answer is no.

So, for example, I'm a health care provider and I'm concerned that an individual with a disability or an individual likely to have a disability after treatment will have a lower quality of life.

Than a person without disability who also requires treatment.

Can I take this into account in prioritizing the health care or services to provide to a person with a disability?

The answer is no.

As we discussed already, these types of decisions can't be based on stereotypes, preconceptions, prejudice or generalization about the relative worth or quality of life or value to society of a person based on his or her disability preor post treatment.

And there's a number of questions along those lines.

I'm happy to discuss those at greater length, but there's more to this guidance and there's more to cover here.

So I'm going to keep moving to the next slide, please.

Which is where the guidance gets into discussing applications of visitation policies.

Oh, I'm sorry.

Can you go back a slide, please?

Oh, no, I'm sorry.

Still go ahead, please.

We're past the application of crisis standards of care and going to application of visitation policies.

Great, thanks.

So we talk about in the guidance, the necessity to provide reasonable modifications to visitation policies.

So -- and this comes up actually you'll see in several of the pieces of guidance that we're talking about today because initially, in the COVID-19 era, healthcare providers to try to keep everybody safe, wanted to prohibit everybody but the affected person from being admitted to a facility or an activity or program.

But people with disabilities sometimes do require reasonable modifications to those types of programs to receive services that's equal to other people.

So may need a support person to be admitted to a facility or other types of modifications to these visitation policies to make sure that people are receiving equal access, and we do flag in the guidance that providers can put in place legitimate safety requirements.

But those have to be based on actual risks, not mere speculations, stereotypes or generalizations about people with disabilities.

And on the flip side, government entities can require a support person or interpreter even where there has been a modification to the visitation policy to comply with safety requirements such as requiring them to participate in temperature checks or other screening measures or requiring them to use personal protective equipment and they can refuse entry to those who fail to meet these requirements.

We also talk about the effective communication requirements that are still in force so that people with disabilities have to receive communications that are as effective as communication with others and this includes providing appropriate purposes where necessary to provide equal opportunity to participate from and benefit from COVID-19 treatments.

And we include the specific examples of what that may mean.

Hopefully, these are types of making information available that folks are familiar with.

But we're talking about accessible to information technology, braille, large print materials, audio descriptions, sign language interpreters, telecommunications relay services, video relay services, video remote interpreting and other tools to facilitate effective communication.

And then finally, we talk about the category of guidance covering application to the testing and contact tracing programs.

We flag that effective communication requirements still apply in those circumstances and we want to make sure that the programs understand that they have to be usable by individuals with disabilities and so the covered entity has to comply with applicable accessibility standards.

And that may mean, for example, where an indoor vaccine or testing site is not accessible, the covered entity should consider offering mobile testing services for individuals with disabilities who are not otherwise able to obtain testing.

Or reasonable modification to policies, practices and procedures may be necessary to permit people with disabilities at higher risk of contracting COVID-19 or at increased risk for severe illness or death to be able to safely access these services.

So this could include, for example, allowing individuals to enter our facility at a time or through an entrance that would reduce their contract with others.

And we do once again flag that these types of modifications aren't required where they would constitute a fundamental alteration of the program or service.

Or impose an undue financial administrative burden.

And I think much more to say on these FAQ's because it was the summation of a lot of what we have seen in complaints received where folks, unfortunately, were facing discrimination from healthcare providers during public health emergency.

And we're having to talk more about it at length in the Q&A.

Next slide please.

I'll turn the conversation to my colleague, John Wodatch.

>> Thank you very much, Molly.

I'm delighted to be with the ADA national network and all of you once again.

And good afternoon and I believe probably good morning and aloha to some of our participants as well.

I'm going to talk about one guidance document, the guidance on long COVID as a disability under the ADA section 504 and section 1557.

This is a document that is a joint document between the Department of Justice and the department of health and human services.

And you can find it on the websites of each of our agencies.

And it's dealing with long COVID and why did we do this?

At the beginning, this came out on the anniversary of the ADA last year.

And it was in response to a lot of the questions that were coming up about long COVID.

People didn't know what it was.

The CDC and the department of health and human services is analyzing it.

They continue to do this.

It's a new condition.

Much is unknown about it.

So we were trying to bring some certainty to the question, can someone who has long COVID be protected by our civil rights laws?

So the first question is what is long COVID?

And we rely on our healthcare professionals for definitions and really long COVID is a range of symptoms that can last weeks or months after a person has been infected with the virus that causes COVID-19.

So what are some of these symptoms?

And there's quite a laundry list.

It's tiredness or fatigue.

Difficulty concentrating or thinking which I think people now understand and know is brain fog.

Shortness of breath or difficulty breathing.

Having a headache, dizziness when you're standing.

A fast beating heart.

Heart palpitations, that range of conditions.

Chest pain, continued cough, joint or muscle pain.

Depression and anxiety.

Fever, and the loss of taste or smell.

So the main point of this document and it reduces itself to this notion is long COVID can be a disability under these laws.

And it would be a disability if it substantially limits one or more of major life activities of a person.

Keep in mind that the guidance that we're talking about only deals with actual disability, the first prong, if you look at the extended definition under 504 and the ADA.

And it is the guidance is under title 2 and 3 of the ADA under section 504.

And under 1557 of the patient protection and affordable care act.

It does not address employment discrimination or title 1.

That is a separate issue.

And you can get guidance on that from the EEOC.

Basically, what the document does is apply the statutory definition of disability to what we know about the condition known as long COVID.

So the first step in this is that long COVID is a physical or mental impairment.

So what are the impairments?

It can be lung damage, heart damage, damage to the circulatory system, lingering emotional illness as well.

These are all impairments.

The next issue, though, under the ADA and 504 is does this substantially limit one or more of a person's major life activities?

And when we're looking at substantially limits, keep in mind that the ADA amendments act of 2008 clarified the thinking on the subject and so substantially limits is to be construed broadly and should not demand extensive analysis.

It doesn't require something to be long term or permanent, and keep in mind especially it doesn't have to be determined -- it can be determined without regard to medication, treatments or any other kinds of ameliorating conditions or devices.

OK, let's go to the next item, please.

So here, we have some examples of the diverse ways that long COVID can become a disability.

So first example here, person who has long COVID and they have lung damage.

OK, so there is the physical impairment.

Does it substantially limit a major life activity?

And so here, we're looking at the person's respiratory function which is a major life activity.

And you have shortness of breath or fatigue and the related effects.

These can be a substantial limitation.

And therefore, if they are, if you do an analysis and they are for people with long COVID.

Someone with intestinal pain, vomiting nausea that have lingered for a long time, for months, is really substantially limited in the gastrointestinal function.

Another example here that deals with brain fog and the -- you have memory lapses or difficulty in thinking or concentrating.

So this is also a person with long COVID.

These are examples of how you would apply the symptoms and apply them in terms of what is the limitation.

Is it substantial?

What is the major life activity that is applied?

Question is long COVID always a disability.

And the answer is no.

It's not always a disability.

You have to do the individualized assessment that is implied here.

You have to look at the impairment and what is the major life activity?

Is it substantially limited?

Keep in mind, also, that we are dealing with a new condition, long COVID is a new condition.

We are really still learning about it.

And we'll have to be aware, we'll have to keep following the CDC and the academic research.

And action that occurs as we go on.

Next slide, please.

So what does this mean?

Clearly, if someone has long COVID as a disability, they are protected.

It qualifies them as a disability, and they have the same protections as any other person under the ADA section 504 or section 1557.

And I think what's most important is that, therefore, brings about the obligation to make reasonable modifications to policies, practices and procedures unless it's a fundamental alteration.

So entities covered by title 2 or title 3 or entities receiving federal funds under section 504 or 1557 have an obligation to make reasonable modifications.

And there's some examples here that are very helpful.

You have a student who has difficulty concentrating.

It's long COVID.

They may need additional time on an exam.

I think that's fairly straight forward.

It's similar to other areas, other types of disabilities.

It applies in the same way for someone with long COVID.

Someone who find it tiring to stand in line can seek a reasonable modification some place to sit down and maybe sitting down inside as opposed to outside location.

And without losing their place in line.

So you can think about this if you're talking about voting as an activity that is covered.

You might be getting a license renewal at the DMV.

Any place you have a line, it can be at a title 3 entity that is a concert.

You're waiting in line in the ticket line and it is incredibly long.

These are areas where reasonable modifications can be triggered.

And the last example here is getting refuelling assistance at a gas station.

Clearly, a customer will prevent them from getting out of the car and pumping gas.

This is similar to the kind of reasonable modification that is available.

Let me conclude by at least mentioning some resources.

I think they will be put in the chat.

There's a CDC document that provides a CDC website really that provides updated information about long COVID.

And there will be a site to that, and there's also an ACL document, ACL, I'm sorry.

The administration for community living, at the department of health and human service has a document called "how ACL's disability and aging networks can help people with long COVID."

And that information has been put up in the chat.

And keep in mind, also, if you -- if a person who has long COVID feel they have been discriminated against under the statutes, they can file a complaint with the Department of Justice.

Or they can file a complaint with the department of health and human services.

And that is it for long COVID.

I think I now turn this over to -- do I turn this to Molly?

Or do I turn this over to Katie?

>> It's Molly and me again.

>> OK!

>> Please.

>> All yours.

Thanks.

>> Thank you, John.

So we're just flagging two additional resources on COVID and specifically access to COVID vaccinations for people with disabilities that HHS issued in April of 2021.

So why did we put these out?

There was a push from HHS to develop resources to help states vaccination providers and other leading COVID-19 response activities to improve access to people with disabilities and older adults.

And the purpose of these types of resources is to clarify the legal requirements, illustrate some of the barriers to vaccine access faced by people with disabilities and provide strategies and examples of how to enschourek -- ensure accessibility.

The guidance outlines legal standards for the federalsivity rights law providing concrete examples of the application of legal standards in the context of the COVID-19 vaccine programs.

And this particular piece of guidance goes through the general prohibition against discrimination and then talks about some specific examples and and one here, it talks about discrimination and criteria are methods of administration of vaccines.

And specifies that a covered entity may not use criteria or methods of administration that have the effect of subjecting individuals with disabilitys to discrimination on the basis of disabilities.

A mouthful.

But as an example, what a provider should not do is, for example, include an inflexible requirement that people have to perform certain tasks for themselves as part of the process of receiving the vaccine.

For example, requiring that they complete paperwork at the vaccine site while standing up.

Or require them to roll up their own sleeve to get vaccinated which could have a discriminatory effect on people with disabilities.

And there's a related fact sheet that we flagged here which also includes, and it's a shorter and sort of more boiled down version for providers about what's required in disability access and vaccine distribution.

And it touches again on the need to eliminate discriminatory barriers through requirement to provide effective communication and I think includes hopefully helpful best practices.

So, for example, in ensuring program access, the fact sheet suggests as a best practice, a covered entity may wish to locate vaccination distribution sites in areas accessible to communities with limited transportation options.

And gives some examples of how to do that, how to conduct that outreach.

And the idea to consider partnering with local organizations that serve people with disabilities in order to facilitate acceptable communication.

So it's strategies to build in at the front end to ensure the people with disabilities have access in the vaccine distribution rollout.

Next slide, please.

We wanted to be sure before we left the HHS resources around vaccination and testing to offer a specific very concrete practical example of how that HHS is trying to improve and facilitate this work to ensure that people with disabilities are included.

And the administration for community living actually in partnership with the centers for disease control and prevention, have developed this dial, the disability information and access line.

Which is available to help people with disabilities get vaccinated and access COVID-19 tests.

And the purpose of COVID -- no, the purpose of DIAL is to help people with disability find the vaccine locations.

Help connect people with available testing options including help ordering free at-home test kits the program.

Assisting with making vaccination appointments and connecting callers to local services.

And we included the information of how to contact DIAL here.

The number is 888-677-1199.

The hours are Monday through Friday 9:00 A.M. to 8:00 P.M. eastern.

And you can also E-Mail DIAL at usaginganddisability.org.

And we can drop that information in the chat as well.

But for your awareness, DIAL accepts calls from anyone including people who are deaf or hard of hearing.

They're able to use relay services.

They're trained to work with people with various communication abilities.

And can spend as much time as needed to ensure effective communication.

So if you're looking for ways to access these services specifically, vaccination and COVID tests, it's a resource that HHS has developed specifically to support the needs of people with disabilities.

Next slide, please.

So we're now into some of our work.

We do compliance in addition to enforcement.

And what we had seen since the beginning of the COVID public health emergency is alleged discrimination in the implementation of crisis standard of care plans.

So I talked about this a little bit with the disability FAQ's.

The disability FAQ's, in part, were our effort to collect together our best recommendations where we're seeing ongoing discrimination in the COVID public health emergency and try to provide information for healthcare providers so they could understand the requirements, what they aren't allowed to do.

And also, to help people with disabilities to understand their rights.

And I'm just going to get into a little bit of the actual work we did to resolve the complaints we got around the crisis standards of care.

As I mentioned over the course of the COVID-19 public health emergency, a lot of states, regions and provider organizations and hospitals adopted crisis standards of care guidelines which are issued to reflect the changes between usual healthcare operations and the level of care that it's possible to deliver in a public health emergency.

As a result of a number of complaints that we received and requests for technical assistance, OCR worked with states and other entities to address crisis standard of care plans and standards.

So we received a lot of complaints.

We tried to work with folks in states because that's also one of the faster ways to get these types of issues resolved.

And ween -- ended up working in a number of states.

We included a list here and there are others as well.

Helping COVID entities, hospitals and states that were issuing crisis standards of care understand what the requirements were and the limitations were in terms of being sure they were not discriminating on the basis of disability and other protected categories, we saw a number of complaints on age discrimination as well.

Particularly regarding their triage and definitely their allocation policies.

But we also saw other things like the visitation issues that I was mentioning earlier.

And the idea was we had to be sure that nondiscrimination was insured an allegation of scarce treatment resources in the midst of the public health emergency and COVID entities understood that full enforcement of civil rights laws were still in effect.

And we became aware through this process of multiple states that may have had or still have ventilator rationing guidelines, for example that would discriminate against people with disabilities by categorically excludeing them or excludeing people based on specific diagnosis in this time of crisis.

Even where people with disabilities would still have been well served.

For example, having access to ventilator use.

And so we moved to help educate folks to be sure that resource intensity or long term survival specifically were not used as an allocation criteria because those practices tend to either borrow or generally screen out people with disabilities from equal access to services, and we also helped folks understand best practices around the principles of nondiscrimination.

So we weren't always just talking about what role was required under the law.

But what were best practices for medical care that doesn't deny care and equal access to the basis of stereotypes, assessments of quality life or a person's relative worth as we discussed earlier.

We have been successful, most recently, at least an example of a relatively recent effort was technical assistance we provided in Arizona in the crisis standard of care context.

We used a collaborative process and the state of Arizona revised their guidelines to reflect both the legal requirements that we have discussed and best practices regarding the needs of people with disabilities and as a result, they updated their crisis standard of care plan to prohibit the use of long term life expectancy as a factor in allocating and reallocating scarce medical resources instead of requiring individualized assessments based on what we would say are irrelevant categories or providing categorical exclusions.

Arizona shifted to using the best objective available medical evidence which is what we definitely encourage.

And other important changes including reasonable modifications where they were necessary as we talked about in their use of clinical instruments for assessing patients with disabilities and making decisions about who got what care.

Protections against unnecessarily influencing patients into agreeing to the withdrawal or withholding of life sustaining treatment.

So, for example, requiring do not resuscitate agreements before care would be provided.

Those types of things were made clear were not either good practices.

Or in some cases, prohibited discrimination and we were able through these productive collaborations to help resolve some of the issues that had led to the complaints that we had received alleging discrimination.

Also plenty to say about our crisis standard of care work.

But we can save it for the Q&A, next slide, please.

Finally, a lot of our policy priorities have been targeted towards updated ruling.

So right now, we're working on two important rules, section 1557 and section 504 to protect the rights of people with disabilities.

Section 1557, some folks may recall, we have been through this process before.

We issued a final rule in 20167 and we issued a final rule in 2020.

And now, we are undertaking another proposal of making to make changes to the previous rule and reinstate broad protections from discrimination on the basis of race, color, national origin, sex, age and disability in health programs and activities.

And right now, we're still in the internal review process, but we're hoping to issue a notice of proposed rulemaking under 1557 in the near future.

This is me talking, not our official position.

But we're hoping to get it done by May.

And then secondly, we are also actively working on updating the section 504 regulations to address discrimination on the basis of disability by recipients of HHS funding and we may look as well at HHS conducted activities.

So we're hoping to clarify obligations, address issues of non-enforcement experiences and under case law.

And conform with changes in the law that have happened since the regulations were promulgated originally in the 70's under 504 and the ADA and other relevant laws.

If you look at the entry in the unified agenda, we found that some of the topics that we may consider, nondiscrimination requirements in the rulemaking include life of care, accessibility medical equipment, integration, crisis standard of care and a number of other areas so you'll definitely have a chance to publicly comment when those are published in the federal register.

And we really hope that you will.

And thank you so much for your time and attention.

I'm now going to turn it over to Katie to talk about some of DOJ's work in this area.

>> Hi all.

Next slide, please.

Good morning and good afternoon to everyone.

Again, I'm Katie and I'm a special counsel in the disabilities rights section here.

And I want to say that it's always wonderful to join the Pacific ADA center any time you can.

And to support the amazing work that they do in educating and providing technical assistance to the public in the disabilities space.

I also want to thank John and Molly and everyone for their work from day one of this pandemic.

It's been a pleasure working with them on some projects and supporting and cheering them on in others.

My focus today is to share with you some of the updated COVID related enforcement work and in particular, I want to focus on our work.

Regarding vaccine registration websites.

The disability rights section has been working diligently to ensure that individuals with disabilities are not left behind as the country gets vaccinated against COVID-19 whether through initial doses, boosters, the addition of vaccines for the 5 to 11 age group and in the future, those under 5.

Ensuring equal access to the potentially life saving VAK nation including by ensuring that individuals can independently and privately make vaccine appointments on line.

It's a key civil rights issue that's emerged from this pandemic.

The disability rights section working together with our U.S. attorney partners completed compliance reviews of the website a number of national pharmacy chains and identified issues preventing people with disabilities from having full and equal access to information about the COVID-19 vaccine and vaccination appointments.

People with disabilities especially those who use screen readers or have difficulty using a mouse were routinely blocked from making COVID-19 vaccine appointments on their own.

So I want to talk about some of the barriers that we identified in this space to really illustrate how significant those were and what folks were facing.

I want to talk about the results that we have seen.

But before I do that, I want to jump to the end so next slide, please.

And just give you a preview of what the end result looks like.

Where we are, where we landed as of this stage.

In the last five months, you'll see, we entered into title III settlement agreements with five pharmacy chains, CVS pharmacy which has 9,000 plus locations in all states and D.C.

Mejier that has approximately 250 stores in the upper midwest.

Kroger which has approximately 2800 locations in 35 states and D.C.

Hy-Vee which is a big midwestern hub and some in my home state of Iowa.

Go, Hawkeyes!

And riteAid that has approximately 2500 stores in 17 states on the east and west coast primarily.

So our approach to this from the very beginning was that we wanted to ensure that the impact of our work in this space would reach as broad of range as possible.

And I think this reflects that and let's say we just worked with Hy-Vee.

That's a regional chain and addresses only the midwest.

Maybe, you know, CVS or Rite AID would not pay attention so much, see it as a bit more targeted or one up.

By doing these compliance reviews and reaching this agreement with five -- with five pharmacy chains, we have in a way blanketed the country in terms of the relief that we sought.

Next slide, please.

I want to now on the next couple of slides just give you examples of the types of barriers that we identified when we were doing our investigations of these sites.

On the Rite Aid website, the calendar used for scheduling vaccine appointments did not show screen reader users only available appointment times and people who use the tab key instead of a mouse could not make a choice on a consent form that they needed to fill out before SKEJ UMing their appointment.

On the Hy-Vee website, people who use screen readers could not hear the questions on the medical screening forms.

And People who used the tab key instead of a mouse could not select available appointment times.

The result of this on the next slide is that we were hearing, that people who could not -- well, two things, first.

If you'll think back on various points in the pandemic, it all seems a bit more civilized in terms of getting vaccine appointments now.

But there were times when it really was a race to get those appointments.

And if you couldn't get an appointment, you had to be able to navigate these websites to have a real chance of getting an appointment.

So people with disabilities who could not successfully navigate the websites had very few options at that time the appointments filled up extreme quickly.

And their only options for then to go to one of these pharmacies or another provider.

And hope that they could be seen at that time.

Maybe have to wait an extremely long time in a public space thereby incurring more risk.

Or go there, make an appointment and return sometimes multiple times.

So those were the kinds of complaints that we were hearing.

And really underscored that the alternative to using the website wasn't necessarily popping in to the Rite Aid and immediately being seen.

It really was causing harm, inconvenience harm and additional risk for people with disabilities.

Next slide, please.

Couple more examples.

On Mejier's website, those using the tab key instead of a mouse could not proceed past the very first step of the vaccine registration process.

Moreover, the portal did not always tell people who use screen readers what information they were supposed to put on scheduling forms including their first and last name, birth date and zip code.

They were often stopped in their tracks at some point during the process.

And on Kroger's website, critical medical screening questions about current COVID related symptoms, allergies, and reactions to previous vaccines were not read to screen reader useers.

When a screen reader user selected an available appointment time, the website said the appointment was unavailable instead of selected.

Next slide, please.

Finally, on CVS's website, the types of vaccine appointments offered for the flu or pneumonia or COVID-19 were not read audibly to screen reader users at the beginning of the scheduling process.

And on the page where you could pick a time for their appointment, screen reader users were told that all available times were checked even though the user had not made any selection.

Additionally, those who use the tab key instead of a mouse were not able to navigate past a request for insurance information in the registration process.

Next slide, please.

Again, this is a snapshot of who the players were here.

The five INTITSZ, CVS, Mejier, Kroger and Rite Aid.

We want to talk a bit about the agreements.

Next slide, please.

OK, these settlements provided relief that will enable individuals with disabilities to access COVID vaccine appointments on a level playing field with others.

The requirements include generally, all five there are, of course, some distinctions between the five.

In general, they all require the entities to make their vaccine registration portals conform with web content accessibility guidelines versions 2.1.

These are the agreement to require conformance with 2.1 as opposed to 2.0.

As you know, there are no technical specifications under the ADA for website requirements.

So again, in this enforcement space, every enforcement matter.

Every investigation, every negotiation is a matter of itself.

And so we're looking at the functional barriers that people are experiencing.

And what the best response in this instance is.

And in this particular case, we agreed on 2.1 on level AA.

They also agreed to make automated testing for accessibility truly an integrated and routine part of website development and quality control processes for their vaccine related content.

The entities will use an automated testing score that we approved, you know.

Automated testing are not perfect and some are much worse than others.

And some are better than others.

And so, you know, our approval authority under the agreement, gives us some assurance that results will be reliable and successful.

But for that very reason, these tools are not a total solution.

The agreements are for requiring it to perform manual testing of their vaccine content including testing by people with disabilities.

This was an important piece of the relief for us because we want to make sure that they include people with disabilities where we use assistive technology, because those individuals have the perspective that a consultant might not have.

Especially if the consultant is not a person with a disability.

It can really bring the guidelines to life, so to speak, and help prioritize the, you know, the rehabilitation or repair of various barriers.

They are required to provide training about web accessibility to people who have responsibility for vaccine website content.

And again, there is quite frequent reporting throughout their agreement to the United States so that we really can, given the import of this particular function, and the need for this service being provided by these pharmacies, we want to be able to monitor closely and get in there and ensure that the entities are quickly repairing and quickly objecting barriers to identify either through the automatic control or through the general.

That's our approach to that.

Other than that in the COVID space, you know, our traditional approach to complaints continues here.

We continued to receive a constantly 30,000 complaints a year.

Every one of those is what can we do?

What's the appropriate disposition?

Many are shared with our U.S. attorney partners.

Over 90 plus offices of those are doing affirmative ADA enforcement as well.

Many are shared with our federal partners that they implicate the 504 and title II entity.

And that is where I'm at in the COVID enforcement nutshell.

I'm going to go to the next page because I have you as a captive audience.

And I want to share a little bit about some of our other recent DOJ work in the healthcare or healthcare adjacent space.

I'm excited about it.

And I hope you will be, too.

First of all, I'd like to talk a little bit about how do we have work on combatting the treatment space for opioid use disorder?

This is really a concerted effort by the division and by the department to address the opioid crisis.

And the opioid epidemic that this country is facing.

The first thing I want to note for those that may not have seen it yet is our guidance on opioid use disorder and the ADA.

Which actually was just published on April 5th, not March 18th as I have on this slide.

This guidance explains the AD,'s protections for people with opioid use disorder, statement of recovery, including those who take medication, legally prescribed medications for OUD.

The publication is intended to people with OUD who aren't in a recovery to understand their rights under federal law.

And provide guidance for entities with the ADA on how to comply with the law.

The document is very plain language oriented.

It's meant for lay readers.

It includes examples in the -- health care, employment, corrections space.

Really the point is that when a layperson, non-lawyer, maybe non-medical provider were to look in this document, that they might see something that says to them, oh, I didn't even realize that I was covered by the ADA, you know, because of my opioid use disorder which I am in treatment for.

I'm doing very well on it.

I didn't realize that I was so protected.

But they are.

And this guidance goes -- our first one on this issue does a great job of explaining that.

Also done and continue to do a significant amount of complimentary enforcement work on this space.

And I just wanted to highlight very quickly for you, it's all available on ADA.gov.

On March 25th, the department issued a letter to the Indiana state board of nursing advising them of our findings that they violated the ADA by denying a nurse the opportunity to participate in a substance use disorder rehabilitation program because she takes medication for OUD.

The program is required for the individual to reinstate her nursing license and accordingly, this refusal to allow her to remain on it really is serving as an absolute barrier, a gateway barrier to her continued work in this profession that she loves and some of these are even more difficult to understand in light of the shortage of healthcare workers that we're facing in this country.

On March 17th, the department entered into a settlement agreement with a ready to work LLC, a Colorado based employment residential and social services program for individuals experiencing homelessness.

The agreement resolves allocations that the program denied admission to an individual because he takes medication for OUD.

That agreement along with that, includes compensatory damages.

And the -- on February 24th, the department settled a lawsuit against the unified judicial system of Pennsylvania alleging that it prohibits participants in its support supervision program from using medication to treat OUD.

So that matter is an active litigation.

The New England orthopedics surgeons settlement agreement from May 2021, allegations that the entity under title III is turning away patients who are also being treated with medication for OUD.

That agreement then includes also monetary damages.

And finally, I wanted to highlight in this space a Summer 2020 agreement with Massachusetts general hospital.

Which resolved allegations that the hospital denied a patient with cystic fibrosis for a lung transplant because he was being treated with prescription medication for opioid use disorder.

The patient was ultimately able to receive a lung transplant from a different hospital, not in the same state.

Part of this process of organ transplant is that the patient needs to stay in the area where the hospital is for, I think a period of six months before and after the surgery and must have a dedicated person or caretaker who can provide support throughout the rehabilitation process.

In this case, this person's mother, and because he had to relocate to another state for his lung transplant that he could not get, she had to as well, had to leave her job and move from her Massachusetts home to another hospital.

While the patient recovered from the surgery.

The family and home community are both considerable financial and emotional distress.

So again, the recommendation involves a comprehensive and thoughtful relief and had to put in place processes and considerations that does not happen in the future.

But it also includes $250,000 in monetary relief for the emotional stress and out-of-pocket expenses experienced by the family.

Next slide, please.

Just a couple of other quick things andful -- hopefully I can do it in two minutes so we can get to questions and comments.

Other recent lawsuits is an expanded lawsuit in the eyecare center in the southwest, PROITS multiple eye surgery, eye care centers mostly cataracts surgery in the southwest.

We've just added a minimum complaint to add allegations against American business partner which is the management organization that provides training, policies, guidance and staff for Barnet Delaney Perkins and a number of other eyecare companies.

So American vision partners expanded its scope potentially over 80 to 100 centers across multiple states in the southwest.

In the original complaints, the department alleged that ADP required patients with disabilities who need transfer assistance to use and pay for third party medical transports and transfer assistance as a condition in violation of the ADA.

The amended complaint adds allegations that they have also denied surgery outright to patients who need transfer assistance.

As you may know, the department has long standing technical assistance explaining that the need for and the reasonableness of providing transfer assistance for people with disabilities and ventures into a numerous settlement agreements around this issue.

In February 2022 of this year, we entered into two decrees to resolve lawsuits against two health care providers in California who denied routine gynecological care to a patient because of her H.I.V.

Routine care included a pap smear.

Very routine work.

The consent decree involves some relief, monetary damages for the complainant and civil penalties to the United States.

And the last matter, I wanted to highlight for you.

Was an October 2021 resolution that kaiser foundation helped.

This is an effective communication agreement similar to ones that I'm sure you've seen many times.

You know, comprehensive inJUKTive relief.

The investigation revealed that approximately 400 instances over a four-year period, an interpreter was requested either by staff at these kaiser facilities or directly by patients and companions or in addition to that.

And none was provided.

So the investigation really revealed systemic significant violations that resulted in, you know, significant ways to communicate.

In addition to the relief, this settlement establishes a $1 million fund to pay claims to both patients whose rights were violated.

And last thing on my list is I wanted to make sure that folks had seen the department issuance I have this, I don't.

But very recently, guidance on the website accessibility and the ADA and again, this guidance discusses a range of topics including the importance of what accessibility, it discusses barriers that inaccessible websites create for people with disabilities.

When the ADA requires accessibility and some very plain language with helpful tips on making web content accessible.

And other information.

It again is also a reader friendly layperson friendly agreement.

So that is it for me!

And I want to make time for questions and answer period and hear from you.

Thank you all for letting me share.

Some of our work.

>> Thank you so much, Molly and John and Katie.

And your incredibly wonderful presentation of information for everyone.

All right, everyone.

This is the time for you to submit your questions in the chat window if you have not already.

And we'll get to those right now.

So here's -- we'll start here.

And we'll go back to some questions from the beginning.

This was aimed at Molly.

Can you review more specifically which entity will address accessible medical equipment?

And when we might see this?

>> Sure, this is Molly.

Thank you for the question.

And I want to echo John and Katie's thanks to everyone for your time today.

And inviting us here and listening and talking to us about these important issues.

I had mentioned specifically that OCR had included in the entry on the section 504 regulation in the unified agenda that we were considering including accessible medical equipment.

Both of these regulations are currently under development so I'm not at liberty to pinpoint which, if either, of the section 1557 or 504 will include a provision on accessible medical equipment.

I can tell you it's something that we're looking at very closely and take very seriously.

In terms of the sequence and in coordinateing with our other federal partners as appropriate as well, in terms of the sequence, 1557 should be out the door, fingers crossed that everything goes well in the near future.

Meaning publishing the federal register for public comment.

504, we are working on it feverishly and we hope to have it published as soon as we can.

But I can't give you a specific date.

You can look for an updated date in the unified agenda for spring of 2022 which should be released fairly soon as well.

I hope that's helpful.

And thank you for your interest and we really, again, encourage folks to comment on both rules when you have the opportunity.

You can also ask for meetings with OCR or the director or HHS and the secretary if you have specific issues or concerns that you think HHS needs to consider.

>> All right, thanks for that.

The next question and maybe for everyone, beyond COVID, can you review more specifically the new stronger rules that are needed to accelerate future compliance and what monitoring and enforcement changes are needed to embed and sustain these lessons for the future?

>> Hi, this is Katie.

I can say that one of the things that we're thinking a lot about is how to -- how to create the relief so it does ensure that the changes needed are embedded and sustained.

And that can go into how long should this agreement be?

Should it be a consent decree where there's courts, where there's a quick way to get to the court if we see violations or if we see things going down the wrong path.

But, you know, again, it's really that is the goal when we're crafting these agreements is not just to get whatever it is immediately fixed but so often, you also need complimentary sort of culture change and education.

Certainly education and training and not just a one shot training at the beginning of the agreement.

But we'll see, I think, routinely these agreements will have annual training or -- and various ways to, again, try to do exactly that embed and sustain whatever the needed change is.

>> All right.

Thank you for that.

And maybe even a related question to that.

But specifically, about the one thing that you covered for how many years will you be monitoring the website agreements?

>> The website agreements, I believe they range in terms between maybe 30 months and three years.

Three years is typically what our agreements tend to be around.

But yeah, so I think, you know, that does give us a chance to sort of ride out some of these ebbs and flows in the pandemic, you know, space.

Which is something that we also wanted as well.

Want to make sure it wasn't too short of a time.

We weren't too optimistic about where this COVID-19 was going.

>> Great.

The next question arose when you were discussing the case about being denied a transplant.

Does this mean that unvaccinated people cannot be discriminated against and denied a transplant?

>> That is a great question, and I think it implicates all kinds of things.

It feels a little bit like the analysis that Molly was talking about in the crisis standards of care space.

It's still a little bit like my case, you know.

I think you would analyze it in the same way.

A reason a person cannot be vaccinated because they have a disability which would pull them into the protections of the statutes.

And then you would have to look at, you know, the reason that were offered as to why it is that an unvaccinated person could not successfully, you know, be a transplant patient.

So these are -- all of these cases in this space are very, very, you know, have a lot of medical stuff.

And then as well, you know, seen experts and dive deeply into what is involved in, say, in this instance I believe it was a liver transplant.

So I think that's the bottom line is the general rule is that a person cannot, should not be denied a transplant on the basis of disability.

Barring some truly valid objective medical reason why it is that that transplant was not possible for that person.

In our matter, what I believe, you know, if I recall, there was a concern for with interactions between the opioid use medication and pain management afterwards.

There were concerns about compliant concerns with the post treatment.

There have been a real absence of communications between the transport, transplant team, and the patient's OUD treatment team.

Both of those were within the same hospital.

But there was no talking so there was a lot of, you know, assumptions and misinformation being relied on, we felt in the medical transplant space that was not accurately informed or not sought from those who could have provided the expertise in the OUD space.

Again, it's going to require a holistic approach or a whole team approach to these issues.

>> All right, thank you very much.

The next question -- has the department issued any guidance about healthcare providers needing to provide effective communication to people who benefit greatly from lip reading?

Lip reading is used by many people who are deaf at the higher speech frequencies to "supplement" what they can hear.

Masks have greatly hampered the ability of many people with severe hearing loss to lip read.

>> Right.

I will say, though, that the CDC has information on its website which I believe even where masks are required, if there are guidance now contemplates what people can pull down their masks where needed to allow people who need to lip read to do so.

So, you know, I think that is a really good question.

And I do think that it is an issue that we've seen on our technical assistance line and things like that.

So, you know, I agree that would be helpful to have some guidance or technical assistance.

>> This is Molly.

I can just add that I'm not aware of any specific guidance that either OCR or HHS generally has issued on that issue in terms of nondiscrimination requirements.

I can tell you it is something that we've seen in some of our complaints and have thought about.

And so appreciate you bringing it to our attention and we'll give it some thought.

>> I think that the variability of the -- of the disease has made it hard, and, you know, the changing CDC guidance.

At the beginning, it was thought that the risk was so high that any removal of masks, I mean, I think sometimes with the evolving science, it's a little bit harder to ascertain like what is the violation vs. What is the best practice?

In this space.

>> All right.

Very good.

Next question.

Curious if most of the complaints about emergency care standards were about actual denials of care or objections to discriminatory standards?

>> This is Molly.

And I think what the question is getting at is the crisis standard of care context.

So person asking the question, if this isn't getting what you are wanting to learn about, then definitely follow up.

But the types of complaints we received were both sort of systemic of what the policies were on paper.

And I guess if I had to say, if it was one of the other, I would say primarily the complaint that we received were about policies that were written that on their face excluded people with disabilities on a discriminatory basis.

But, unfortunately, there are, you know, real life applications of that that we saw impacting people.

>> And let me also mention that there has been a previous Webinar that we had on an analysis of strength, of crisis standards of care that we did about a year ago.

And so you can go back into the archive and look at that to get more detail about how people were looking at crisis standard of care at that moment in time.

If that's helpful.

All right, well, we realize that many of you may not -- may still have questions for our speakers and apologize if you didn't get a chance to ask your questions.

They have put their contact information there.

And you may be able to ask them a question by E-Mail.

Or if you know that this is a -- if your question is specifically an ADA question, you can also contact our -- your regional ADA center at 1-800-949-4232.

And our TA's will be able to answer those questions.

You will receive an E-Mail with a link to an on-line session evaluation.

Please complete that evaluation for today's program as we really value your input and want to make sure they are aware of the value of these Webinars.

We want to thank our speakers today for sharing their time and knowledge with us.

It was a really great presentation.

Reminder that today's session was recorded and it will be available for viewing next week at adapresentations.org in the archived section of healthcare.

Our next Webinar will be on May 26th.

We hope you can join us, you can watch the E-Mail for the announcement of the opening of registrations for that session.

And thank you all again for attending today's session.

Thank you again to Molly, John and Katie for your great presentation.

And have a good rest of your afternoon, everyone.

>> Thank you, good afternoon, to everyone.