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 specific ADA Center, your moderator for this series. This series 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. You can reach your regional ADA center by dialing 1-800-949-4232.

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This webinar series is intended to share issues and promising practices in healthcare accessibility for people with disabilities. Topics include effective communication and reasonable modification of policy issues under the Americans with Disabilities Act of 1990. The ADA.

Upcoming sessions are available at ADApresentations.org under the schedule tab and then follow to healthcare.

These monthly webinars occur on the fourth Thursday of the month at 2:30 Eastern 1:30 Center, 12:30 Mountain and 11:30 a.m. Pacific time. You are on the list to receive notices for future series. Those notices go out before the next webinar and open to registration.

You can follow along on the webinar platform with the slides. If you are not using the webinar platform you can download a copy of today's PowerPoint presentation at the healthcare schedule web page of 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 speakers and I will address them at the end of the session.

So feel free to submit them as they come to your mind during the presentation.

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Today's ADA National Network learning session is titled Department of Justice's Barrier Free Health Care Initiative. This will address healthcare organization's obligations under the ADA. This will include a discussion of the U.S. Department of Justice's Disability Rights Section recent work on healthcare access, including agreements related to interpreters, service animals, equipment, HIV, opioid use disorder and physical accessibility.

Today's speaker is Stephanie Berger. Stephanie is an attorney adviser in the Disability Rights Section of DRS of the Civil Rights Division of the U.S. Department of Justice. Within DRS she is a member of the regulations, interpretation and coordination team where she provides legal advice and coordination regarding the nondiscrimination requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

She also works on the section's efforts under the ADA to combat discrimination against people with opioid use disorder, who are in treatment or recovery.

Stephanie holds a BA from the Arizona State University and a JD from Harvard Law School.

Stephanie, I will now turn it over to you.
>> STEPHANIE BERGER: Great. Thank you so much. I'm so happy to have the opportunity to be here today and speak with you all about some of the department's recent work in the healthcare access area. We'll start out with some learning objectives for this session. So I hope to enable you to understand healthcare organizations' obligations under the Americans with Disabilities Act, to help you learn a little bit about the department's recent cases addressing barriers to equal access to healthcare.

And then you'll find out where you can go for more information about preventing barriers to healthcare access.

So first I want to start with a little bit of background. Bragdon v. Abbott in 1988 was one of the first ADA cases in the Supreme Court. And this case was about Ms. Abbott, whose dentist refused to treat her in his office, offering to conduct the work at a hospital instead because he was concerned solely because she had HIV.

So the DOJ filed a brief in that case about her right to regular care in a dental office, and the Supreme Court found that Ms. Abbott as a person with HIV was covered under the ADA. So we've come a long way since 1998 but this demonstrates that healthcare access has been one of the most important issues covered by the ADA.

In 2012, the Disability Rights Section started what it calls the barrier free healthcare initiative, and this is a concerted effort we have to partner with the U.S. attorney's offices across the country on healthcare access cases. We've had many, many settlements in this area and I'll just take this as an opportunity early on to plug our website, ADA.gov. You can go there and find all of our healthcare access cases, our settlements, and also find some great resources on a lot of the topics that we'll be talking about today.

So today we'll talk about some of our most recent agreements in the areas of effective communication, service animals, HIV/AIDS, opioid use disorder, equal access to services, and the built environment.

And these agreements all provide powerful evidence of the serious challenges that people with disabilities continue to face even 29 years after the ADA's passage. And I have mentioned before nearly all of these cases were done in partnership with our U.S. attorney's offices across the country, and we simply wouldn't be able to do the volume of fantastic work that we're able to do enforcing the ADA without the partnership of our U.S. Attorney's offices. We're very grateful for that work.

We'll start off talking about effective communication. I just want to start by providing some of the basics of the law under effective communication before we dive into talking about some of the recent settlements.

So both Title II state and local government, and Title III public accommodations must provide auxiliary aids and services to ensure effective communication with people who have hearing, vision and speech disabilities.

And some of the most common examples that you'll hear are Braille or tactile displays, providing large print materials, providing video remote interpreting, which is extremely popular in the medical field.

Qualified interpreters, transcription services, and assistive listening systems.

The type of appropriate auxiliary aid or service for each individual communication and each individual person will vary based on a number of factors. And they include the method of communication used by that individual, the nature, length, and complexity of the communication involved.

The context in which the communication is taking place.

So, for example, specifically in the medical services context, while it might be appropriate to communicate with a person who is deaf with written notes for, like, a quick intake questionnaire or perhaps in an emergency situation in which the person's request for an interpreter hasn't been able to be made and filled yet. It would be more likely that in a longer-term communication, that person would need to be provided an interpreter, if that's the accommodation that they requested.

So, for example, if a consent for surgery or explaining test results to a patient, more than likely an interpreter would be required.

Now, the requirement for effective communication is subject to the defenses of fundamental alteration and undue burden, which is defined as a significant difficulty or expense for the entity. The entity that claims these defenses has the responsibility to demonstrate that the undue burden would exist, and they must take all other actions that wouldn't result in a fundamental alteration or undue burden in order to ensure the individual receives access to services. For example, if it were to be determined that it would be an undue burden for a very small doctor's office to provide an interpreter, that doctor's office would still need to communicate with the individual in different ways, such as exchanging notes, as we mentioned earlier.

Another thing that is good to note in this context is that it matters whether the entity providing the services is a Title II state and local government funded entity, like a state hospital, or a Title III public accommodation entity like a small doctor's office. If it's a Title II state or local government entity, you can give primary consideration to the type of effective communication

requested by the individual with the disability. So if that individual says, I need an interpreter, it typically wouldn't be appropriate to try to provide a different kind of accommodation instead.

However, if the entity is a small doctor's office, a public accommodation, then they need to consult with the individual, but the ultimate decision about what aid or service to provide rests with that entity. Now, they still need to provide effective communication. So if they say, well, we'll just exchange notes instead of providing an interpreter, and it would be shown that exchanging notes is not going to provide the level of communication that that individual needs, then that would not be considered effective communication.

So, some other important factors when looking at effective communication, specifically when talking about interpreters, you may not require an individual to bring their own interpreter. So it is necessary for the healthcare provider to provide the interpreter. They may not require an adult accompanying an individual to interpret unless in an emergency situation that arises or that individual has specifically requested that their companion be their interpreter. And even then it's important that that companion be appropriate to be the interpreter for the circumstance. For example, it may not be appropriate where a complicated medical procedure needs to be explained and the person doesn't have the vocabulary necessary to explain that procedure. It's probably -- actually, it would never be appropriate in a situation where an individual comes in and it's expected there is any domestic violence or abuse. In that case you would not want the person's companion, who may be the abuser to be the one who would be interpreting for them.

And then when it comes to children as interpreters, it's almost never appropriate to have a child interpret for their parents. The only situation which that is appropriate is an emergency, and an emergency does not mean that the healthcare provider hasn't had the time or doesn't have the budget to get an interpreter into the office. An emergency situation is really supposed to be reserved for something like a natural disaster or, you know, a really catastrophic event.

So, now we'll talk a little bit about some of our interpreter related settlements. And we really do have quite a lot of them. On this slide I have listed just the ones that we've had in the last couple of years. And we won't talk about all of them, but I just wanted you to be able to see that it is quite a few.

So we'll start by talking about Lincare, Inc. And this is a settlement in the Eastern District of Virginia just this month. And Lincare is a supplier of oxygen durable medical equipment and other respiratory care products and related services, and they go and deliver these products and provide these services in people's homes.

Lincare operates 800 centers in 48 states. So they're quite a large company. And what was happening was Lincare was not providing interpreter services to the individuals whose homes it was visiting who were deaf and were unable to communicate with the person who was coming to their home to provide the services. Often, you know, this would be a repeat thing, they would be coming on a regular basis, and so certainly they would know in advance they were about to visit somebody's home who required effective communication, but they weren't providing it.

So this settlement agreement is designed to ensure that Lincare provide the appropriate auxiliary aids and services, including sign language interpreting to individuals who are deaf or hard of hearing. And it puts some things into place to make sure that will happen. Now they will have an intake process that they use whenever a new patient calls up to assess whether that individual might need some reasonable accommodation or effective communication.

And it also designates an ADA administrator and at least one employee who will be on call 24/7 to answer questions regarding interpreters. So if an individual is not receiving services they need, they know they can call up right away and get somebody to respond immediately and not have to lodge a complaint and wait.

This settlement establishes grievance procedures. It requires Lincare to maintain records of patients who require auxiliary aids an services, so that they have a better sort of rosters of the services they need to provide on a regular basis. And then it requires them to provide notice of their ability to provide interpreters, to provide training to all their employees. And then they are paying $10,000 in compensatory damages and a $10,000 civil penalty.

The next interpreter case we'll talk about is Washington State Health Care Authority. This was a June 2018 settlement in the Western District of Washington with the -- what we'll call HCA. So HCA is a state agency that, among other things, administers the Washington Apple Health Program and Apple Health is Washington's Medicaid program. So Medicaid is the federally matched medical aid program under the Social Security Act that provides healthcare coverage for people with low income and disabilities.

And through Apple Care, HCA is supposed to ensure that people who need access to preventive care and other healthcare services get the services they need. So HCA has what they call an interpreter services program, and they hold themselves out to be a service by which healthcare providers can obtain sign language interpreters for Apple Health appointments where a patient or their companion requires that assistance for effective communication. But we heard the services weren't being provided and we determined that the service has had a few as 0 and as many as 10 sign language interpreters signed up at any given time. In many counties it had 0 sign language interpreters available. So obviously zero is not an acceptable number and probably 10 is not an acceptable number given how many patients this system was serving.

So as a result of this shortage, the number of times that the program has been able to provide a sign language interpreter for the number of times it's requested was only 30% since 2012. So imagine only 3 in 10 individuals who required a sign language interpreter were actually getting the services they needed.

This has led to a huge cancellation and rescheduling rate for healthcare appointments for these individuals. Or the requirement for them to use less effective means of communication during their appointments. And obviously, you know, an individual is trying to get medical services that often can be a very stressful time, so the last thing you want is to have difficulty communicating.

So, on the basis of our investigation, we concluded that HCA's administration of the interpreter services program violated Title II of the ADA because it failed to ensure that individuals are equally receiving services, and we found that individuals with disabilities were not afforded equal opportunity to obtain the same results and benefits under the program as others.

So, the settlement agreement is designed to improve the situation. It calls for the HCA to increase the number of sign language interpreters it has available and that's for both patients and their companions.

And then the number of interpreters under contract throughout the state will be increased from that number, which as you recall, 0-10, to at least 100. So definitely a ten-fold improvement in the number of interpreters.

This settlement agreement also provides requirements for video remote interpreting, if it's used instead of an attorney.

So VRI services are video services where an interpreter is provided on a video screen instead of in person. As you can imagine, it's used quite a bit in the medical services context because it can sometimes be difficult to get an in person interpreter in the room every time a patient needs one. But there are sometimes issues with VRI, especially if the bandwidth or the Internet connection isn't working, so the video is cutting out or it's choppy or the audio is lagging, and sometimes there can be issues, like, for example, if it's being used in the situation where the patient needs to move around a lot, it can be difficult for them to be able to see the screen if the screen isn't also moving. One example is if a person is in labor. Obviously a woman in labor moves around quite a bit, so it can be hard for her to see a VRI screen.

So this agreement includes the requirements for VRI which are included in regulation, which is that it needs to be a realtime full motion video and audio connection that isn't laggy and doesn't cause bad images or pauses. And be a sharp image that is large enough to display the interpreter's face, arms, hands and fingers, and the participating individual's hands, arms, face and fingers, regardless of body position. And clear audio transmission of voices and adequate training for individuals who use it, which is important. Hospitals may have a VRI screen set up in every hospital room, but if the individuals don't know how to use that technology, then it isn't very helpful.

The third settlement I'm going to talk about in this context is Astria Health. This was a settlement in the Eastern District of Washington in January 2018. Astria is the parent nonprofit of medical centers and clinics, and the complainant sought treatment for his Type II diabetes and requested a tactile ASL interpreter because he's deaf-blind.

And for of his scheduled visits were canceled because they said, sorry, we can't get the tactile ASL interpreter in for your appointment. One of his visits wasn't canceled, but they didn't have the interpreter. He wasn't able to effectively communicate and he was forced to rely on the support service provider he brought. And so that is a situation which he didn't have a companion with him, but he did not want to use that companion as his interpreter, because the

companion was not proficient in medical terminology, so it was inappropriate for them to require him to use that individual as the interpreter.

The settlement agreement in this case uses a model communication assessment form to assess the appropriate auxiliary aids and services whenever an appointment is scheduled or upon the arrival of the patient, whichever is earlier.

Designates an employee to provide assistance, and to document each request for auxiliary aid or services. And establishes a grievance mechanism, a requirement that interpreters be provided in a timely manner. It contains information about VRI being acceptable, if it's effective. And then requires Astria to post policies about interpreters in print and online and train employees on the policies and the equipment.

And then the last case I'll talk about in this context is Highline Medical Center, in the Western District of Washington in August 2017. In this one the complainant is deaf and uses ASL. He alleges he is not provided an interpreter for his scheduled spinal surgery, and that no interpreter was provided for either him or his companion, who was his wife, who was also deaf. In this situation it may have been appropriate to even have two interpreters, but certainly not zero interpreters.

This individual alleged as a result he was unable to effectively communicate about the significant pain that he was experiencing and he was unable to receive the news from his surgeon that the surgeon had found more damage during the surgery than he had expected.

The settlement agreement includes a lot of the things from the agreements that we just talked about, the requirement to provide auxiliary aids and services, including interpreters, in a timely manner. And interestingly, this one lists out situations in which interpreters may be required. This includes discussing a patient's symptoms, conditions, medications and medical history, explaining conditions, treatment options, tests, medications and surgeries. Providing a diagnosis or recommendation for treatment. Communications immediately preceding, during and after a surgery. Obtaining informed consent. And providing instructions for medications, post-treatment activities, and follow-up treatments.

So these are all good examples of those types of communications that wouldn't be -- that would be appropriate for an interpreter to provide and probably wouldn't be appropriate for that sort of exchange of notes or providing of a handout sort of thing. These are a few of those ones that are probably necessary for an interpreter to be provided.

So now I'll move on to our second topic for the day, and that's service animals. Service animals in general tend to be one of the hottest topics that we have questions on through our ADA information line here at the Department of Justice. Once again we'll be talking through briefly about the requirements in the law. So a service animal is any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental health disability.

So this definition does a few things. It makes it clear that the animal has to be a dog. It makes it clear that comfort and emotional support animals aren't covered under ADA. And it also makes it clear that individuals with disabilities that aren't physical disabilities are also covered. So one situation in which we hear about people facing discrimination with their service animal is when it's not immediately clear upon looking at them that they have a disability. So a person who is blind and uses a guide dog, it's often clearly easily recognized that person is an individual using a service animal. But if a person has PTSD and they have a dog that can take to calm them or a person has a seizure alert dog, it may not be as clear that dog is a service animal.

So Title II and III entities must modify policies to permit the use of a service animal by a person with a disability. It's not appropriate for these entities to require written documentation of the need for a service animal.

Generally it's only appropriate to exclude a service animal when the animal is out of control and the handler does not take action to control it or the animal is not house broken, so the animal is having accidents.

Service animals are generally allowed in all areas of the facility where the public is normally allowed to go, but -- and this is an exclusion that makes sense in the healthcare services context more so than with others. It may be appropriate to exclude service animals from limited-access areas. And those can arise in things such as operating rooms or burn units in which extremely sterile atmospheres must be maintained.

So even if the animal can be excluded, the individual with a disability should be given the opportunity to participate without the animal. So you wouldn't say, you can't have surgery here because you is a service animal. You just perform the surgery on the individual with the service animal in the room and you can return the individual to the room with a service animal after the surgery is over.

We'll talk about a couple settlements in this area. The first one is our Letter of Findings with St. Joseph Hospital/SLC Health in July 2018. And this is the parent company of 8 hospitals and more than 100 clinics in Colorado, Montana, Kansas and Wyoming. And the patient was denied access to a clinic because of his service dog for PTSD.

So the clinic denied the dog entry because they believed it was a pet and not a service animal.

The Letter of Findings creates an animal policy that needs to be posted on website and public places. It includes staff training on what a service animal is and provides $2,500 in compensatory damages for the complainant.

The second settlement we'll talk about is with Hardin County Emergency Medical Services in the western district of Kentucky in March 2018. In this situation, an EMS refused to let a service dog ride with a patient needing to be transported in an ambulance. And an ambulance

would not typically be one of those places where it would be inappropriate to allow a service animal because they're not typically super sterile environments.

So this settlement agreement designates an ADA coordinator. It requires the company to modify policies to permit the use of a service animal. It requires them to post a nondiscrimination notice and to train their employees, and then to adopt and publish a grievance procedure.

Our third topic will be HIV/AIDS. And the basis of the law here are that healthcare providers may not refer a patient with HIV or AIDS to another provider simply because they have HIV or AIDS. And they can't exclude a person with HIV or AIDS unless that person poses a direct threat to the health or safety of others. And a direct threat analysis must be individualized. So it must find that there is significant risk to the health and safety others that cannot be eliminated or reduced to an acceptable level by reasonable modifications to policies, practices or procedures.

And then the healthcare context typically a direct threat is not present when an individual has HIV/AIDS because standard medical protocols for handling of bodily fluids and for maintaining a sterile environment usually already accounts for any risk that that would be, you know, created by a person having HIV or AIDS.

So let's talk about a few cases here. The first is advanced plastic surgery solutions. This was a settlement in the Northern District of Georgia in December 2017. And the patient in this case alleged that she was denied a consultation as a new patient for a plastic surgery office when she revealed she had HIV, and the doctor told her that she just wouldn't perform surgery on her just because of her HIV status.

So the settlement agreement required the nondiscrimination policy, that any denials based on HIV be documented, that training be provided to all employees about HIV and AIDS and discrimination, and then they were required to pay compensatory damages of $25,000 and a civil penalty of $10,000.

Our second case is Aurora Health Care in the Eastern District of Wisconsin in July of 2017. Aurora is a nonprofit healthcare system that was headquartered in Milwaukee and serves more than 90 communities throughout Eastern Wisconsin as well as areas in northern Illinois. And this is over 30,000 caregivers who serve more than 1.2 million patients a year through a network of facilities and service providers, 15 hospitals, 150 medical clinics, a laboratory system and 70 pharmacies, so a big, big entity. There were a couple complainants in this case. The first went to see an orthopedic surgeon who was in the Aurora Health Care Network, and that surgeon advised him that he needed hip replacement surgery but said he wouldn't perform surgery on the complainant because he had chosen not to perform surgery on anyone who had HIV just due to the risk that he felt existed with blood-borne pathogens.

The second complainant went to an Aurora Medical facility to get a catheter removed and the urologist that he saw took his medical history and saw in his medical history that he had HIV and then expressed hesitance about performing the procedure and said he wanted to talk to the complainant infectious diseases doctor first. And that complainant had his daughter with him and his daughter was very well-versed in doctor's requirements and requirements under the ADA and she informed that doctor, you know, no, actually you don't need to talk to infectious diseases doctor. If you follow standard protocol using standard precautions that will be just fine. And the doctor said, I still don't feel comfortable doing it, I'm not sure.

So the complainant left and he ultimately had his catheter removed at a different office.

And so obviously there were both situations in which there were discriminatory denials of service.

The settlement agreement requires that Aurora Health Care maintain and enforce nondiscrimination policies and post those in their reception areas and website and provide training to all employees about HIV and AIDS and discrimination.

The next topic we'll talk about is opioid use disorder, and this is the topic that is very important in our recent climate with the opioid epidemic. You're no doubt hearing quite a lot about the opioid epidemic and opioid use disorder in the news. And the Department of Justice has a three-prong approach to addressing the opioid crisis. Prevention, enforcement and treatment.

So when you think about the Department of Justice and the opioid use crisis, you're probably picturing a lot of the criminal enforcement work that is being done, where there are prescribers of opioids and bad producers of opioids are being prosecuted in criminal court.

Our approach or our role comes in more on the treatment end of things. So people with opioid use disorder frequently face stigma and discrimination related to being former or recovering users of drugs. And the Americans with Disabilities Act can be a tool when this discrimination serves as a barrier to their employment, their recovery, and their use of public services programs and activities and their equal access to accommodations.

So when it comes to opioid use disorder, as a drug addiction, it's generally considered to be a disability under the ADA. The ADA generally covers people who are in recovery from substance use disorder or opioid use disorder if they're not currently engaging in illegal use of the drug. The big if is the individual has to not currently be engaging in illegal use of drugs in order to fall under the coverage of the ADA.

So this includes individuals who are using medication assisted treatment or MAT, which is treatment for opioid use disorder that combines the use of medication, and some of the common ones are methadone, buprenorphine and naltrexone.

And it includes counseling and behavioral therapies. These individuals are typically covered under the ADA and not currently engaging in the use of illegal drugs.

One other thing that I think is important to mention in the opioid use disorder context, since this is a webinar on healthcare, is that even if an individual is engaging in the illegal use of drugs, a healthcare provider cannot deny them services if they're otherwise entitled to them. So this means, for example, that an emergency department couldn't say, we're noting the to take any more people who are experiencing symptoms of overdose or withdrawal. We're sick of having to deal with this opioid crisis, take them someplace else. No, a medical provider needs to treat an individual who has opioid use disorder.

If they are otherwise entitled to those services.

So when it comes to this context, healthcare providers may impose legitimate safety requirements necessary for the state's operation of its service, programs and activities. However, a public entity must ensure that its safety requirements are based on actual risks and not on mere speculation, stereotypes or generalizations about individuals with opioid use disorder.

In addition, the defenses of fundamental alteration and undue burden also apply here. And some healthcare providers may be concerned that an individual with opioid use disorder poses a direct threat to the health and safety of others, however, in determining whether an individual poses a direct threat, they need to make an individualized assessment. And so it's important, especially in this context that the entity evaluate the individual in that individual situation and how they're doing in treatment and what sort of threat that individual may pose, not just make blanket assumptions about individuals who are in recovery from drug use.

So we have a couple recent settlements in this area. Our most recent is Selma Medical Associates in Winchester, Virginia, January of this year. And this was a medical facility that provides primary and specialty care and a patient called up and said, I would like to switch to you guys as my primary care providers and allegedly they said, are you on medications? Yes, I'm on medications to treat my opioid use disorder. And he said, no, we don't see patients on suboxone or medications for that treatment.

So in this settlement agreement, some of the medical associates agreed not to deny services on the basis of disabilities, including opioid use disorder. They agreed not to apply standards or criteria that screen out individuals with disabilities and to adopt a nondiscrimination policy and train their staff and pay $30,000 in damages to the complainant and $10,000 as a civil penalty.

The second case in the context is Charlwell Operating, district of Massachusetts settlement in May 2018. And in this case, a skilled nursing facility allegedly denied admission to a patient with opioid use disorder, so that patient needed to have long-term care in a skilled nursing facility for an unrelated medical condition when that person called up and tried to be admitted, once again they asked about medications that that person was on and the individual revealed he was on suboxone and they said we don't take anyone on suboxone.

And so the theme here is that blanket denial of individuals who are on medications for treatment -- or really any medication for that matter is typically going to raise red flags.

So this settlement agreement required them to adopt a nondiscrimination policy, provide training on the ADA and OUD to admissions personnel, and then pay a civil penalty of $5,000 to the United States.

The next topic we'll cover is equal access to services. So the ADA requires that a hospital or healthcare provider make reasonable modifications to policies, practices, and procedures when necessary to ensure that its services are fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services. So, they are not required to take actions resulting in undue financial or administrative burdens.

A provider cannot deny services to a patient whom it would otherwise serve just because he has a disability.

So for an individual whose disability requires the use of a wheelchair, this may mean, where appropriate, providing an accessible examination table or other medical equipment, having a patient lift available, which is often call a Hoyer lift, and having available trained staff who can assist the patient to make the transfer so that patient can be examined or treated.

We have a couple cases in this context. The first is Thomas Jefferson University Hospital. This was a case in the Eastern District of Pennsylvania in April 2019. And in this situation, the complainant uses a wheelchair and he came in for a DEXA scan, which is a bone density scan as a walk-in patient. And he was told that nobody there was trained in how to transfer him, so he was going to have to go get his scan somewhere else.

The settlement agreement requires that staff be trained on how to appropriately interact with patients and how to safely transfer patients. And that staff be made available who can assist with transfer at all times when patients are accepted. This includes walk-in patients. This is our first settlement regarding walk-in medical services, and that's exciting, because it's one thing to require that services be -- acceptable services be provided when someone schedules in advance and the entity has time to accommodate it. It's another thing to say, this service is being provided to everyone else on a walk-in basis, anyone else can walk in off the street and get the treatment, so an individual with a disability also needs to be access that same level of services.

And this settlement requires that compensatory damages of $5,000 be paid.

The second case I'll talk about is Charlotte Radiology in the Western District of North Carolina in August of last year and the complainant was an individual who used a wheelchair and was denied a DEXA scan and this complainant was told she needed to bring someone else to assist her out of the wheelchair. So that's not appropriate. the radiology office needs to provide the person who can do the transfer.

So the settlement agreement adopts a nondiscrimination policy and it requires it schedulers ask if a patient needs a modification in order to be prepared. It provides training for employees on the ADA and appropriate transfer method, that it acquire patient lifts and provide reasonable modifications and then also remove architectural barriers in the office and provide compensatory damages.

And finally we'll talk about the built environment and how the built environment of a building can make it so that a healthcare service can be inaccessible to an individual, because if somebody literally can't get in the door, then they can't get access to the medical services they need.

So both public entities, state and local governments, and public accommodations, and commercial facilities need to follow the relevant provisions of the ADA standards for accessible design for newly constructed and altered facilities.

The standard is a little different here when the entity is a Title II versus a Title III entity. So for Title II state or local government organizations, they need to provide program access to all services, programs or activities when viewed in their entirety and use other methods to provide such services which may include modifications to features and elements of the buildings or facilities.

So a brand-new building, that building needs to be built to ADA standards and requirements. But a Title II entity is offering healthcare services out of an older building which then wouldn't be required to meet those ADA standards, it still needs to provide the services. They need to find a way to provide those services using other methods. And this can often be as simple as relocating the location from where the services are providing. So if the intake interview for a new patient would typically be held in a second floor exam room and there are only stairs going up to the second floor, then hold that intake interview on the first floor for the individual who can't use the stairs. Now, for Title III for existing facilities, public accommodations must remove architectural and communication barriers to access only where it's readily achievable to do so without significant difficulty or expense. There may be situations where it's easy for that entity to use the location of the service or provide some sort of accommodation. If it was expensive or it wouldn't be readily achievable to do so, they don't have the same level of obligation.

The case we'll talk about here is called McLean Hospital. This was in the District of Massachusetts in 2016. And in this case the complainant sought admission to a program at the hospital that provided therapeutic and residential services for women with borderline personality disorder. The facility was a three-story townhouse with common space on the first floor and bedrooms on the second and third floor. And the complainant uses a wheelchair and she was denied admission because they said you're not going to be able to get to the second and third floors. The settlement agreement required that the first floor common areas be altered to meet the 2010 ADA standards, that offsite accessible housing and transportation be provided and that there be training for all staff on these new policies.

So this concludes my presentation, but it would not be a webinar about the ADA without me plugging our website. As I mentioned before, ADA.gov is a fantastic resource. This is both where people can go to file a complaint and also where you can go tore just a wealth of information on both our healthcare related work. You can look up all the settlements that I mentioned here today, and then also the general requirements of the ADA. So we have some technical assistance resources on effective communication, HIV/AIDS, pretty much all the topics that I have discussed today.

You can also call our ADA information line, 1-800-514-0301 or the TTY line is 800-514-0383.

We have ADA specialists on the phone nearly 9:00 to 5:00 Monday through Friday. I believe on Thursday it's actually 12:30 to 5:00, but pretty much all the time you can get someone on the phone and ask them questions and they can help you work through any questions you may have.

And, of course, also, you know, contact the specific ADA center, local, regional ADA centers which also have fantastic ADA specialists who can often provide you with even more specific and granular information about, you know, local facilities and local information about the questions you have.

My contact information is here on the screen. Stephanie.berger@Usdoj.gov, and my number is 202-616-2447. I think you'll probably get better information if you call our ADA information line because those folks are better at answering questions than I am.

And with that, I would be happy to try to answer any of the questions you have today. Once again, thank you so much for giving me the opportunity to be here and talk to you about this topic.

>> LEWIS KRAUS: Thank you so much, Stephanie. That was fantastic. Well, everyone despite Stephanie said she isn't as great at answering questions, you have an excellent opportunity now to ask questions of Stephanie and the DOJ that you may not have in other circumstances. So take advantage of this if you can. Remember to submit your questions in the Chat window, and we'll get to those in a moment.

So here is a couple that are coming in already, Stephanie.

Regarding service animals, this person writes, I thought miniature horses were covered. Is this wrong?

>> STEPHANIE BERGER: Great question. So miniature horses are also allowed in many of the same circumstances that service animals are. The difference is that miniature horses... so service animals as defined under the ADA, which are the dogs that perform a task for an individual with a disability, are always permitted under the ADA, whereas miniature horses can sometimes be seen as reasonable modifications, and that's based on a number of factors, so their size, their weight, the ability of the disability, to accommodate them. Most situations it would be appropriate to have a service animal it probably also would be appropriate to permit

miniature horses, but they just aren't seen as sort of a, per se, allowance. They have to meet that reasonable modification requirement.
>> LEWIS KRAUS: Okay. The next question, this person says, "Hi, thank you for your presentation. I'm a deaf public health professional now working in policy. Too often doctor's offices and hospitals reviews or avoid scheduling interpreters regardless of what the law requires, although many deaf and hard of hearing individuals try to fight for our rights and file complaints, healthcare facilities still aren't accessible. We're fighting against them for our health and gambling lawyers, and the health of community. I worked in research a significant number of deaf and hard of hearing individuals across the U.S. have increased understanding and quality of care experiences in healthcare if they have in-person certified ASL interpreters instead of VRIs.

Even if hospitals and doctor offices will willingly provide interpreters, it's usually VRI, which is almost never considered effective communication. Healthcare is such a critical field, it should be attended to, however the deaf and hard of hearing population are much more likely to experience adverse health outcomes.

How can we better advocate for ourselves without having to move forward with a lawsuit? And how can DOJ help enforce accessibility in healthcare more effectively and timely?

>> STEPHANIE BERGER: Wow, that's a great question. And I'm so glad to hear there are individuals working on this topic in the policy sphere. Because I think this is one area where, you know, the legal requirements and the regulations can only take us so far. We also need advocacy from the community.

And so I think that's a very important component of it.

You mentioned the issue of VRI being provided and it not providing effective communication versus, you know, the better communication that would be provided if an interpreter was there. We hear about this issue all time as well. I would just emphasize that the legal requirements, the regulations, say that VRI is used instead of an interpreter and used to provide as effective communication. So VRI is being used and it's not providing that same level of service, then it probably is not meeting the effective communication requirements. So, you know, this is definitely an area where we would encourage people to file complaints with the DOJ, you know, as you saw from some of the cases we talked about, this a frequent area in which our U.S. Attorney's program will actually go out and, you know, try to negotiate settlements. So please file the complaints with us and then keep doing the great work you're doing on the advocacy front and hopefully together we can make it so that people can get access to mental services.

>> LEWIS KRAUS: Okay. Great. And the next question is: What are the requirements for counters at reception and check-out areas of doctor's offices?
>> STEPHANIE BERGER: You know what... that is a great question, and that is one I would definitely punt to your ADA center or to one of our specialists. I am not as well-versed in the specific requirements for counter height and things of that nature, but it would be -- you would look to the requirements in the ADA, the 2010 ADA standards.

>> LEWIS KRAUS: Yeah, and let me add to that. This is something that you can call us at 1-800-949-4232 and the ADA center technical assistance staff will be able to answer that kind of question for you for sure.

Hold on. Okay. In reference to government services, in your opinion, do you feel that many of the settlement requirements can also be mandated in the provision of services, particularly the training requirements for staff and other areas in healthcare such as public transportation or housing?
>> STEPHANIE BERGER: I'm not sure that I understand the question. Lewis, maybe you can let me know if you think that needs a different interpretation. I just know that we try to incorporate training requirements into most of our settlement agreements. Certainly it's one thing to have requirements under the law, but if the actual staff and providers and doctors who are working with patients aren't trained in these requirements, then, you know, they're not likely to make sure they get carried out.
>> LEWIS KRAUS: And I would just add, if the question is about -- if there is an ADA settlement in areas outside of healthcare, whether training is a requirement or should be a requirement for staff, I think generally, given the situation of the case that probably would be a "yes."

But it does have to be an ADA issue, and so you... that's what we're dealing with here. And some of the examples you use may or may not necessarily connect with the ADA.

Okay. Next question. Are you starting to see any cases around online medical records available through a patient healthcare portal not being digitally accessible or digital kiosks available at patient check-in areas not being accessible.
>> STEPHANIE BERGER: That's a great question. I honestly don't know if we've received any complaints in that area specifically. I know we are definitely getting complaints generally about website accessibility, the accessibility of kiosks, and the -- you know, all the services that a Title II or a Title III entity provides do need to be accessible regardless of whether they're providing paper records or online records. So while we don't have specific accessibility standards on that, and I can't speak to whether we received any complaints specifically in that area, I would definitely say that those things are required to be compliant with the ADA.
>> LEWIS KRAUS: And, you know, let me just try to say one more thing for your input, Stephanie. These patient healthcare portals is something that is like the communication between the doctor and -- or the healthcare professional and the patient through a proprietary email system, and so sometimes that doesn't work in the same way as a regular email system. I think that's part of the accessibility question that is being raised here.

>> STEPHANIE BERGER: Yeah, so I would say they need to make sure that the technology in the portal they are using are providing alternative means to make sure that the patients they are seeing are able to get the information they need.

>> And sort of a follow-on question to that, somebody else just wrote, do you have any thoughts or guidance about accessibility in telehealth?
>> STEPHANIE BERGER: Yeah, telehealth is a big area now where we're hearing lots more about -- I've heard quite a bit about it in the opioid use disorder context, and it's so hard for

some people who are really out in rural areas to be able to get access to services, and so telehealth is really able to increase those services. I would imagine that some of the same requirements there would apply that apply to VRI. So if you're using, you know, a means to provide services where an individual is, you know, appearing in video or computer screen, then the communication provided needs to be as effective as it would be if it was in person.

>> LEWIS KRAUS: Okay. Next question. Should standalone mobile vans offering government funded mammographies in localities such as shopping mall parking lots be ADA compliant?
>> STEPHANIE BERGER: So, I think the answer is yes, but I know that there are specific requirements for some mobile facilities that can apply. I'm thinking of our work that we've done in emergency management services and mobile facilities, they're sometimes used in that context. This is another one where I will say call up either your regional ADA center or our ADA line and they can provide more of the specifics to you.
>> LEWIS KRAUS: And I would just add that your question is great but there's probably the devil might be in the details there, so talking with somebody on the technical assistance line would help.

Next question. This is a good one. I would like you to spend a couple minutes clarifying this one. This person writes: Undue financial burden is a gray area. What does the DOJ consider undue financial burden? Either by dollar amount or percent.

And this is where I think we might want to say something about, you know, undue financial burden for a Title II entity or a large Title III entity.
>> STEPHANIE BERGER: Yeah, I mean, I'm trying to pull up our... I don't have it memorized off the top of my head, but when you are. Different factors need to be considered, including sort of the overall budget of the company, so, you know, if there's a doctor's office that belongs to a private network and that one doctor's office says, we can't afford to provide the services... [indiscernible]... and you look at a number of doctors to make that determination and then when somebody makes a determination that it would be an undue burden, it needs to be basically an entity that makes a determination. It can't just be some medical secretary or one doctor who says it's too expensive. The decision needs to be made at a high level. So it is a difficult challenge to meet, and usually if an entity has a legitimate undue burden defense for providing one sort of modification, it often would be able to provide a different kind and would be obligated to do so. For example, if the person can't afford to provide an interpreter, they may be able to provide written materials or written exchange of notes or some other reasonable modification.

>> LEWIS KRAUS: All right, and I think there was that other point that I have heard recently is that if you brought undue burden as your defense and you're a very large organization across the nation, probably -- wouldn't you say that's not going to stand very well?
>> STEPHANIE BERGER: Yeah, that's typically, you know, it's very fact specific and certainly you would listen to it on a fact specific level, but if you are a large, you know, multi-state company or organization operating facilities out of many different places, then you probably have a substantial budget, and so you probably would have enough in your budget to be able to provide all that is required.

>> LEWIS KRAUS: Right.

Let's get... let me get... ah!

Okay, so how can those enforcing the ADA in local government educate other entities that they're required by code or law to enforce the ADA standards when they're a modeling facility to make it ADA compliant regardless of the cost?
>> STEPHANIE BERGER: I'm not... I mean, you know, I think it's important that outreach be done. I think, you know, they can point to the resources we have on ADA.gov about the ADA standards. We have some great guides on our website about how people can make disabilities accessible. But as far as governments making sure that entities, that they have control of, do the things they need to do, I would just say that is a requirement, and how they go about doings it sort of probably is something that makes a determination on a regional level but is certainly an obligation.

>> LEWIS KRAUS: Okay. How do you assess whether a service animal would pose a substantial health risk to limit contamination?

>> STEPHANIE BERGER: There are some situations in the healthcare context where it would sort of always make sense that a service animal would pose a threat. That would be the example in an operating room that needs to be extremely sterile, a burn unit, which needs to be an extremely sterile environment, but most cases it would be an individualized assessment, and most places where it's appropriate for members of the public to go, it also would be appropriate for the service animal to go.

So, for example, you know, something that comes up a lot with service animals is, there can be people who are allergic to pet hair and pet hair and dander can pose a problem. Should you not allow the service animal because of that? And that's a situation where the needs of the person who has allergies needs to be balanced with the needs of a person who has the service animal.

And in most situations you're able to find a way to accommodate the person with a service animal without saying that that service animal can't be there. So, you know, scheduling the person who has an allergy to come at a different time. Or if it was the nurse who had an allergy, assign a different nurse to that patient. You can get creative about making sure that an individual is able to have their service animal with them.
>> LEWIS KRAUS: Okay. Great. And staying with the service animal issue, because it is the most frequently asked question. Do you have any good probing questions to discern an emotional and support animal versus a service animal?
>> STEPHANIE BERGER: Usually when it comes to a person's service animal you're only permitted to ask the two questions. You can ask if this is an animal required because of the person's disability, and then you can ask, what work or task does the animal perform for you. Often if you ask the second question, what work or task is the animal providing for you, if the person says emotional support or they make me feel better, I like having them with me, that's probably an emotional support animal that can properly be excluded. If that person says, this is an animal for my anxiety or something of that nature, then it is appropriate to ask a follow-up

question in order to get the information you need to find out what work or tasks that animal performs. If somebody says, this animal is for my anxiety. You can ask again, what does the animal do for your anxiety? If the person says, the animal is trained to put its paw out or to lick me to help calm me or it places its body in front of me when somebody is making me anxious, then that would be a service animal, because that's been trained to do a specific task to alleviate that anxiety.

If the person says, oh, well, he hasn't been trained to do anything, he just makes me feel better, that's an emotional support animal.
>> LEWIS KRAUS: That's great.

All right, another question here... we're wandering all over the place with you, Stephanie. Here we go.

Current use of illegal drugs is not considered a disability. What does "current use" mean when determining someone is in recovery from the illegal use of drugs?
>> STEPHANIE BERGER: That's a great question, and unfortunately we don't have a clear answer to it.

So there is different case law in different districts about that, and you could look to that case law. Some courts have found that as many as several months of not using any illegal drugs can still be considered current illegal drug use because there's sort of that ongoing risk that person may relapse so they may reengage in the behavior, but some courts have found as few as 30 days of no illegal drug use which qualifies as no longer illegally using drugs. It is extremely fact specific and there's no really sort of clear satisfactory answer, but certainly if the individual was -- this is more employment contract, which is not really as what we were talking about today but it comes up a lot and if the person was using drugs and they were fired, service was given to them and then they entered rehab after that, certainly that would not be covered in ADA because they were illegally using drugs when the action was taken.

And so, you know, then it just gets very fact specific as to whether they're currently considered to be illegally using drugs or not.
>> LEWIS KRAUS: Okay. Great. The next question. Can VRI support tactile as well as visual?

>> STEPHANIE BERGER: You know, I don't know the answer to that question. I would think not. But I am not an expert in VRI or tactile ASL. So Lewis, maybe do you know?
>> LEWIS KRAUS: I don't know that we have any distinct question or answers about that ourselves, but you can certainly call the ADA hotline and see if people have answers in the specific areas about that.

Okay. Here is one more question here.

Are there standard penalties associated with willfully not complying with ADA barrier-free requirements within state and federal levels? Or as a clarification this person is now writing, can entities be fined?

>> STEPHANIE BERGER: Yes. There is standard penalty built into the law or signs, but certainly if that was a complaint that was brought to the DOJ and we were to investigate it, or if it's a private lawsuit as well, if it's found that the violation was willful and the entity knew it was violating the ADA and didn't care or take the actions needed, then I would imagine there would be higher penalties involved with that. So certainly, you know, don't violate the ADA. Definitely don't willfully violate the ADA.
>> LEWIS KRAUS: And maybe even let's expand this question even further. So what... you know, let's say that there's already an agreement or a settlement in place and then the organization is not complying with it. What happens then

>> LEWIS KRAUS: So typically we build an assessment period and recording and monitoring requirement into most of our settlements. So we require entities for a year or two or three to report to us and let us know how things are going and what they're doing, what steps they're taking to comply with agreement, and if they don't comply with the agreement, then, you know, the next step could be potentially to then go to court and ask a judge to require them to comply with that agreement.

>> LEWIS KRAUS: Okay. That's great. Well, thanks so much, Stephanie.

All right, everyone, we realize that many of you may still have questions for Stephanie and I apologize if you didn't get a chance to ask your questions. I'm going to put her contact information back up, if you want to contact her, or you can call the ADA center at 1-800-949-4232, if you have a regular ADA kind of question, and we do collaborate with Stephanie's office, so if there is a question that the ADA centers don't exactly know, we may actually contact them and get the right answer back to you.

You will receive an email with a link to an online session evaluation. Please complete the evaluation for today's program. We value your input and want to demonstrate the value of this series to our funder.

And we want to thank Stephanie today for sharing her time and knowledge with us. It was really great, Stephanie.

Our reminder to all you that the session was recorded or is being recorded and it will be available for viewing next week at ADApresentations.org /archive, in the archive section. Our next webinar, July 25th, we'll be joined by Carol Bradley from Sutter health for discussion on implementation disability access in a healthcare setting and their experience doing that at Sutter Health. We hope you can join for that. Watch your email two weeks ahead for the announcement of the opening of the registration for that webinar.

Thank you once again, Stephanie, and thank you all for attending today's session, and with that, I will bid you all a good day and a good weekend.

Bye-bye!