UNEDITED TRANSCRIPT

**2019 Jacobus tenBroek Disability Law Symposium**

**“Department of Justice’s Barrier-Free Healthcare Initiative”**

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The National Federation of the Blind

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>>Steven Gordon: Hello, everyone. So I am Steve Gordon. I am with the U.S. Attorney’s Office in Alexandria. I coordinate the civil rights program which basically means I work full times on civil rights cases.

A lot of the cases I have had on the years have been in healthcare settings. I'm very interested in also knowing what is going to be helpful for people here to hear about.

I have to do a disclaimer before I start speaking about substance. This is basically that the opinions that I express are not necessarily the views of the department of justice. I have been doing that disclaimer for a while now.

I have a prepared PowerPoint presentation. It typically takes longer than an hour to give. I'm happy to focus on certain things if people would like me to focus on those things.

Some people can see the outlines. For others I will read it. I will go over the background on the ADA and the rehab act. I will talk about background on the barrier free healthcare initiative.

Big area that I have dealt with effective communication in healthcare settings. This is a huge issue that I see.

It is a chronic issue. It includes small providers and really big providers.

I recently settled a case with the Spotsylvania Medical Center. They are the largest hospital operator in the United States. They are having issues. It is not the first time that an HCA hospital has been investigated by the department of justice or by OCR at OSS for failing to provide sign language interpreters when they are supposed to.

Another area that I often cover has to do with equal access for individuals who are HIV positive or have AIDS. Another very important area in some regions of the country it is a big issue.

Physical access for individuals with disabilities is also another huge area that we at the department of justice see cases in.

I talk a little bit about a defense that I frequently see which people say I didn't know I was supposed to do that. Not a defense. The ADA has been around since 1990 and the react of 1973 have been around longer they are covered by the Rehab act correspondence in addition to the ADA. I talk about enforcement actions and I also do this presentation to providers. At the end of February I was in Phoenix and I did this presentation to the American Health Lawyers Association long‑term care conference. Basically folks that operate and lawyers who represent skilled nursing facilities also known as nursing homes.

It is a huge area in nursing homes as well. And what I do for them I talk about the things that they need to do internally to make sure that they have a good ADA compliance program.

I'll just tell everyone they have to do an audit and check what they are supposed to do. Through that audit process they learn about stuff. It is an overview of what I am going to cover.

I think a lot of people know some of the background. In fact, I am going to ask folks here, do you know most of the background on the ADA? If you have had several years of working in that area if you could shake your head or raise your hand. Give me an indication. Part of my slide presentation is background stuff on the ADA.

A lot of people I present to haven't seen it. I am not going to spend a lot of time on that today. That's one place I can take some of the slides off.

If you haven't been on ADA.gov recently it is the best place to go to learn about the ADA.

Again this is more by way of back grouped. I will give you an overview of the slides. I talk about the number of people in the United States with disabilities.

I think a lot of people know that and I'll just pull one particular statistic out. The slide presentation is also available on line for folks that aren't able to see all of my slides here, you can get access to them on the website.

56.7 million people at the last census in 2010 have disabilities. I also think that that number is probably a little bit low. Not everyone who has a disability is willing to identify themselves that way. So it is very important to know that.

A lot of people know there are various different titles to the ADA. A lot of the hospitals are run by title 2 entity. In Virginia we have the University of Virginia or they are run by Title III like the Spotsylvania healthcare center.

The ADA is clear hospitals are covered. It is in the status. It talks about nursing homes and professional offices of healthcare providers.

From a legal perspective there is no question that they are covered.

I think a lot of people here know the definition of disability. I can go over this relatively quickly and say it is part of the slide presentation. I actually have the law in there for folks that want to take a look at that.

I also want to mention even though I talk mainly about 3 different types of disabilities we have seen other disabilities issues come up in healthcare settings such as hospitals who will turn someone away because of an intellectual development disabilities. All covered. I care about that stuff as I do these cases. Little bit different issues but it is important.

Same thing with modification of policies, practices and procedures. Sometimes with a disability will need the healthcare provider to modify how they do a particular procedure so that they can have full access to it.

All important. It's covered by the ADA as well not just the ones that I am covering.

So the barrier free healthcare initiative is a partnership between the disability rights section and the U.S. attorneys' office.

It focuses on effective communication, mobility and HIV AIDS. The general prince pill is inclusion and equal access. I will pass over that and Section 504 of the Rehab Act has something similar to it.

Huge big thing I want to talk about the ADA and even people that know about it, unlike civil rights statutes, the ADA has affirmative obligations.

For example, under the civil rights act of 1964 it is mostly prohibiting. You are prohibited from turning people away. You can't tell people if you own a hotel. You can't stay here because I don't like your race. One of those things is providing auxiliary aids and services.

A lot of people have a hard time understanding that when you first approach them. They will say I don't dislike deaf people. I didn't do anything intentional.

But the issue you have to do something affirmative. That's really important when you are talking about the ADA.

Same thing with accessible medical equipment. You as a medical provider have an affirmative obligation to go outs and purchase the right equipment so that people with disabilities can take advantage of the services that you are providing.

So let's talk about effective communication. The type of auxiliary aid or service that will be required will vary. It will vary by a bunch of things. The number 1 thing I talk about with folks is that you got to figure out how does the patient that you are serving communicate or how does the companion of the patient communicate.

Very important and a lot of folks think one size fits all. We have someone with a hearing problem we will get them an interpreter, sign language interpreter.

Not everyone who is deaf or hard of hearing knows American sign language. Sometimes they need CART which is I think being put out over here in front of me. Sometimes they need something else. So it is really important. I talk about that with the providers.

When it comes to sign language interpreters, there are 3 different things for someone who is deaf and uses ASL, you look at the nature of the communication, the duration of the communication and the complexity of what you are discussing.

In a healthcare setting, most interactions where you are interacting with a patient are going to require a sign language interpreter if that's the type of communication aid that helps that individual. Very important to know that.

And the department of justice puts out a variety of things that can help advocates working in this area.

One thing that's very helpful is if you take a look at some of the settlements that I have done, there is one important. Commonwealth health and rehabilitation center, if you look at the appendixes, there is a communication request form attached. We put this in all of our settles at the department of justice.

I often tell people, consumers when I am talking to them and I do presentations to consumer groups, take a copy of that with you when you go to a healthcare provider and fill it out. They may not give it to you.

I actually went to a healthcare provider and in conjunction with DRS we settled a case with them. I distribute know they owned labs in the area that did simple blood test. I go to check in for my blood test they hand me the form. I was thrilled to see it. That's exactly what they are supposed to be doing with everyone who comes in. Often hearing disabilities are invisible and people don't know it.

So it is a very important tool that's available. You can see that the form asks a variety of questions. And for folks that can't see the form, it is up on the website.

>> There is a whole bunk of different auxiliary aids and services beyond sign language interpreters. We have CART, do folks know what Captel phones. This is for people that can voice things very well but they have a hard time hearing. There will be someone typing out what the other person is saying.

There will be text going across the screen. Very important. Sometimes hospitals need to have these as an auxiliary aid if they provide phone service for other patients.

The other thing I want to mention for folks, there is a place in northern Virginia called the Northern Virginia Resource Center for deaf and hard of hearing. They have a technology room. If anybody is interested in learning about the different types of technology that are available for the deaf and hard of hearing communities it is a wonderful place to go and check things out.

So we know about CART. It's being used right now. PockeTalkers, hearing aid compatible telephones. How many people think TTY is an updated way to communicate? It is not updated any more. If you look at the deaf in addition of auxiliary aids and services in the ADA they will talk about it not be an exclusive list. If you look by the section by section analysis they anticipate there will be new technology.

It is important to point that out if you are an advocate that they are not stuck with technology from the '70s. Or even before. I don't know when TTY came into use. It's been around for tech aids.

There are lots of new ways of communicating.

Again, my presentation provides some examples. So for folks that can't see it on line there's an accessible version. Captioning is another very important thing for folks. You would think a hospital have to caption something. Obviously the TVs in the hospital room. A lot of hospitals have videos on their website. Those videos are providing education and information for parents of newborns. They might want to market one of their practices if they do a lot of oncology work.

They may have an educational video up there. All of this needs to be equally accessible to folks.

Here is a hearing aid compatible telephone. Captel phone.

I talked about simple communications versus the more complex communication. This is very important. If someone is simply going into a gift shop at a hospital and they are deaf, chances are good that they are not entitled to a sign language interpreter to pick out a gift for somebody who is in the hospital.

More complex communications including discussing a patient's symptoms. Medications, medical history, discharge instructions they will likely require an interpreter.

And if you are looking, again, for the practicing attorneys and advocates in the room, the section by section analysis which a lot of people overlook when they are looking at the regulations specifically discuss when exchange of notes are okay in a medical setting. It is for simple kinds of communication.

I highly recommend taking a look at the section by section analysis. Again, it is quoted in the presentation which is available. It's really worthwhile in understanding and in using it as you advocate to healthcare providers.

It is also technical assistance publications. And these provide helpful examples. The one that's up here right now someone goes to a doctor for b i ‑‑ weekly checkup. The nurse records the blood pressure and weight. Exchange of notes and using gestures are likely going to be good enough.

Upon experiencing a mild stroke the same patient returns to his doctor for a thorough exam and batteries of tests are requested and an interpreter provide.

At that point the doctor will be legally required to provide an interpreter under at ADA.

Really important to know. The doctors aren't the ones who get to decide whether or not the communication is too complicated.

It is something that there is quite a bit of guidance on. Because I have had doctors say it was only a 45 minute appointment where I went over the person's skin. It was a dermatologist. We just talked about a few moles. That's clearly going to be covered.

The doctor can't say it is not convenient or me or expensive for me to get an interpreter. I will decide it is not complicated enough. There are 2 department of justice publications that are helpful. One is an ADA brief communicating with people who are deaf and hard of hearing in hospital settings. Highly recommended.

Again, a lot of people look at the regulations and overlook these collateral documents. I love to come out and talk about them.

There is a second publication it may not look that way. It is simply called ADA requirements effective communications.

Both of them provide a wonderful amount of information. I recommend to consumers that they take these with them when they are going to a doctor and say this is department of justice information that tells you when you are supposed to provide an interpreter.

The business brief goes through a whole bunch of different types of interactions that are going to require an interpreter. It covers many of the things that I have already discussed.

But it is very important. It is not just the medical issues, which are obviously important, but also things like complex billing or insurance matters, explaining wills and powers of attorney, making educational presentations.

A lot of the hospitals in my jurisdiction give CPR and prenatal classes. Those classes at the hospital are covered by the ADA because of title 3 entity is providing those.

So it is very important that if the hospital is providing those and someone comes in with a disability and asks for some assistance, that the hospital provide it.

Again, you can look at this business brief. This is a direct quote from that.

Mental health treatments we just had a wonderful presentation by Ira. Someone who is deaf and needs mental healthcare when they go to group therapy or they go to psycho therapy or talk about their medicines with psychiatrist they will be entitled to a sign language interpreter.

What is a qualitied interpreter? Very important issue. This comes up frequently. The big issue that I see is that a hospital will have a staff member who took a couple of semesters of ASL in high school. It is great that high schools are now offering ASL, that doesn't make someone qualified as an interpreter.

I took 2 years of Spanish when I was in high school. You are not going to put me in an emergency room to translate for a Spanish‑speaking person who needs medical care.

You have to have someone who is effective. They have to be able to interpret accurately. They also have to be impartial. That's why it is really important not to have family mechanics. It is a big temptation of medical providers when a family member knows some American sign language.

They also need to understand the specialized vocabulary in that setting. These are regulatory requirements.

And when I say effective, they have to be able to interpret both receptively and expressively. When that means is the interpreter is not just there for the consumer who is deaf they are also there for the person who is hearing who needs to understand the consumer or the patient.

So the person needs to be able to interpret that way. I had someone who said to me, we had a deaf person on our staff. They knew ASL. Can't they interpret? Think about that.

How is that person going to be able to hear what the person is vocalizing and then be able to sign that back? It's ridiculous. Those are some of the excuses that I hear in these cases which, by the way, they are great cases to do because you can help people to get in the right direction.

In addition in order to be effective it needs to be in accessible format and it has to be timely.

If someone is delayed in getting an interpreter, it's like justice delayed is equality denied. It is the same could be September here.

Imagine you are in an emergency room and you have urgent medical needs. It takes 6 or 7 hours for the interpreter to get there. Or they don't get one for 3 or 4 days which happened in one of my cases. That is not an effective interpreting type of service under the ADA. Question over here.

>> Is it okay to ask a question? So what is timely in an emergency room? Is 2 hours timely?

>>Steven Gordon: In our settlements we require them to get an interpreter within 2 hours. Then they say, we can't do that. Well, one of the things that a lot of the hospitals in my jurisdiction are doing as part of their contract with the interpreting service they are mandating that they have someone available within 2 hours of notice.

In my Dominion Hospital case one of the things they said the admission was 11:30 at night. How are we supposed to get an interpreter at that hour? Are you open for admissions at 11:30? Yes. If you are open for admissions for people without disability you need to be open for people with disabilities.

Spotsylvania was 3:30 in the morning. They need to have people on call much like they have doctors and nurses on call. You know what interpreting services do that. I know they do that because I have talked to them. I can't get an interpreting service. I called them up will you do this? Yes, of course we know medical is a big part of what we do.

Protecting privacy and independence is another important aspect of effective interpreting. It's another reason if you have a 17‑year‑old deaf young lady who goes into the doctor and they say why don't we have your mom interpret. Not appropriate. It doesn't protect her privacy and independence.

We talked a little bit about staff members who can interpret pretty well. The technical assistance publication for title 2 and title 3 I have the one for title 3 up here quoted. It explains that signing and interpreting are not the same thing. Being able to sign does not mean that a person can process spoken communication into the proper signs nor does it mean that he or she can process ‑‑ possesses the proper skills to observe someone signing and changing that sign language or even finger spelling into spoken words. The interpreter must be able to interpret receptively and expressively.

That is the staff member that they want to put forward who has a lit bit of ASL. This is the legal cite that you can show them is the technical assistance manual.

Certification. Big issue in this area. Why is it a big issue? DOJ doesn't require certification because there is no universal certifying body.

The other thing is you can have someone who is certified by NAD or register for the interpreters of the deaf, RID. They may not be q to interpret in a medical or legal setting. Certification may not be enough to make that person qualified.

The issue that we look at DOJ whether they are qualified under the regulatory language which I went over, being able to interpret effectively, accurately and being there timely. Certification is not part of that equation.

So the Virginia Department of the deaf and hard of hearing also warns folks that it is a misperception that people have that having a little bit of knowledge of sign language. This is a huge issue I see in multiple cases.

What about companions? Patient goes to the hospital. Patient can hear just fine. But her daughter is deaf and patient wants the daughter to be involved in what is going on. Daughter has been her caretaker for years. Is she entitled to an interpreter?

Well the answer is yes. This is in the regulations. This is not some kind of thing that is a made up thing. It is a very important aspect of the regulations something that the hospital industry fought.

If you take a look at the section by section analysis of the regs, the hospital industry did not want companions to be entitled to sign language interpreters. You know what, they haven't given up that fight.

I still hear from hospitals, that person wasn't the patient it was the daughter, it was the spouse, it was the sibling.

They are entitled to an interpreter as well because they are entitled to equal communication that someone in that role would have if they didn't have a disability.

By the way, it is not only surrogate decision makers. The hospital industry when they put their comments in during the notice and comment rule making when they lost the idea that campaign I don't knows would be entitled to sign language interpreters. They said only surrogate decision makers. EOJ rejected that. It can be someone who just happens to be there because people who just happen to be there are often getting communication if they are not disabled.

So often companions have their own independent need for effective communication. It might be a parent. They want to make sure that the care that their child is getting is good.

Same thing with spouse. It involved an emergency admission to a psych hospitals. The parents wanted to know. They were suicidal. They wanted to know that the child would make it through the night. They wanted to talk about the presenting issues, why they brought the child to the psych hospital that late at night and why it was an urgent issue. They had their own independent needs. This is really important to emphasize.

Companion is broadly defined as well. Family member or associate to an individual seeking access to a participating accommodation. They have a definition that is very similar.

The section by section analysis explains effective communication with campaign I don't knows is particularly critical in healthcare settings where miscommunication may lead to misdiagnosis or improper or delayed treatment.

It is a high stake environments. Effective communication with companions described why it was so important to have it.

What about the cost of getting the interpreter? This is another big thing that I have seen come up. I will get a complaint in and the healthcare provider will say I don't mind if you have an interpreter. Bring your own.

This is one of those areas where the ADA requires them to do affirmative things. They have to absorb the cost. It is part of their overhead. It is part of doing business.

Again, the technical assistance manual discusses that. It is also in the statute and in the regulations.

Common pit fall, someone is in the hospital in the emergency room. They are there with a couple of family members. The patient is the person who is deaf and they are communicating to their family members using sign language. The nurse comes up and says who are you? The person self identifies I am her daughter.

Will you tell her ‑‑ that is a violation of the regulations. The regulations say that a public accommodation and also talks about public entities in Title 2 shall not rely on an adult companion, ‑‑ excuse me accompanying an individual with a disability to interpreter facilitate communication.

That is the rule. There are 2 exceptions. The first exception is in an emergency involving an imminent threat to the safety where there is not an interpreter available. That doesn't mean if you run an emergency room that suddenly you have an exception.

What that means is if a tornado is bearing down on a hospital and you have someone in the emergency room who is deaf, and you don't have an interpreter available, you can go up to accompanying person and let them know they have to go down to the basement.

That's what that means. If you are set up to deal with emergencies, same thing with fire department and police, you need to be set up to deal with emergencies for people who are deaf.

So this is not some kind of big hole in terms of exception.

The second exception I have hospitals use this as an excuse because the person who is deaf has gotten so frustrate that had they do rely on a family member who happens to be there. But in order to do that the individual with a disability has to specifically request it.

It can't be that they have been coerced. The adult they have to voluntarily agree to it. It can't have coercion because you failed to what you are supposed to do. That means they need to assess what is going on and make sure it is appropriate.

I have been asked by healthcare providers well what happens if we don't understand what the person is saying and we don't know this person. We didn't hire them and check them out to make sure they can interpret.

Well, they can bring in another interpreter for themselves if they so choose because the interpreters are not just there for the consumer they are also there for the person who is communicating with the consumer.

I tell them it's fine to bring someone else in if the doctor needs that person to feel comfortable that they understand or the nurse to understand what is going on.

But it is really important. Again, this is not some big wide exception that you can just go to someone else if it looks like it is okay. You have to meet these criteria.

If you look in the section by section analysis, it says that the consent has to be freely and voluntarily given. And freely and voluntary is when a hospital fails to do something.

>> It doesn't have to be in writing?

>> Steven Gordon: It does not have to be in writing. That is a really good question. Some hospitals have a policy that says if a person waives their right to an interpreter, they need to fill out a form. If they fail to fill out that form, I then say, well, in hospital settings if it is not documented it didn't happen.

That's something which is well known in medical settings.

>> That is something we run into a lot with the hospital saying the deaf person said they wanted to use their mother, sister, brother. But we have no way to prove. It is a factual issue then.

>>Steven Gordon: It is a fact issue. I would say they have the burden of proof on that defense. When I do slide presentations to the other side, it says very clearly if it is not documented, it did not happen.

>> Nurses treatises?

> Steven Gordon: This is the scholarly works out there for nurses. For lawyers who do malpractice and other things in medical settings -- I used to do quality of care cases -- that was a well-known thing.

If it isn't documented it doesn't happen. I would expect them to document it. In our settlement agreements we require them to document.

What about children? Someone's 8‑year‑old is at the hospital and they are a CODA, a child of a deaf adult. What about using them as an interpreter? The regulations absolutely prohibit that except for that one exception that the tornado is bearing down.

There was an 8‑year‑old and literally the hospital wanted him to come out of school so they could use him to interpret for his dad. I think for people who have read the case ‑‑ the dad was having a limb amputated.

It was a serious thing going on. The court found this was outrageous behavior. DOJ has this now in the regulations that minors are not to be used as communication facilitators.

So the preamble, that is the original ADA regulations and section by section analysis, they recognized that this was a common problem that public entities and public accommodations were relying on accompanying people to facilitate communication.

And, again, I have this in my presentation, so if you are doing something for the other side you can show them this.

Video remote interpreting. Everyone know what that is? Howard Rosenbaum does a wonderful presentation on all of the pitfalls with VRI. It can be a wonderful thing in the middle of the night in the middle of nowhere when it is working. I under line when it is working. I have had cases they couldn't find the extension cord. The staff didn't know how to turn it on.

A case involving George washing hospital. They had 2 patients. One was in labor and giving birth. Think that is appropriate to have VRI? Second one had neck surgery. They kept moving to move her head around so she could see the VRI and she started bleeding out.

I emphasize this issue when I talk to healthcare providers. A lot of folks like the easy answer.

It is easy to order VRI and have it available. It is harder to get it working and make sure it is working for that individual.

The regulations include certain things in there. One of them it needs to be dedicated band width. I watch stuff on my computer as I am about to go to slope at night. Little video clips.

You know the stuttering and the freezing and all of the other stuff that happens because our band width is not really quite there yet.

Imagine you are having a discussion about open heart surgery and the interpreter freezes on you. Then 3 minutes later they continue. How frustrating that can be.

So it is really important. What I tell folks if the VRI is not working, give me examples. Explain to me how it is not working.

It is a lot harder because VRI is in the regulations and it is contemplated. I need to know why it wasn't working. It wasn't simply a preference. Title 2 entities you have to give primary consideration to the consumer in terms of what they ask for.

But it is important to get the details on what was going on. Then the national association of the deaf has an interesting white paper about VRI for people that want to learn more about the issues that have come up.

>> Steve, is there any direction that the DOJ going into in coming up with limitations for VRI, when you shouldn't use it? I got to tell you with the language that is out there with VRI that is the primary issue for all of us in this field.

In fact, it has been ‑‑ a judge in Florida decided it was perfectly appropriate for child birth.

So without us having limitations, we put it in our settlement a agreements there are no regulations that say it is not appropriate when they have low vision or when there are multiple people in the room.

>>Steven Gordon: I understand that. I'm not part of the regulatory writing section. I will say that you may want to write to the folks who do the regulations. I say this not just with this issue but any issue with limitations on the ADA regulations.

There are people that work on this full time and let them know. You may also want to talk to Howard. He has been doing a lot of work in this area. He and I met with the joint commission that accredits hospitals.

I was out there and we met with him to talk about issues. He spent most of the time discussing how VRI is a big product with the a crediting folks. They talk communication not just deaf and hard of hearing. As part of their standard and they have a standard section that looks at hospitals.

I encourage you to let folks know that this is out there.

The regs do talk about some things. It is mainly technical stuff.

>> They do have some limitations. It is not specific enough. It is a real problem with hospitals.

>>Steven Gordon: I'm aware of that. That's why I also tell people I need specifics so that I can do it. I have had it before. I have had the hospital write in their notes we can't find the extension cord. To me that is wonderful when I have that kind of evidence. You don't always have it. It looks like you have a question and a couple more back here.

>> So a lot of the deaf people that I represent say I don't want VRI. I want an ASL interpreter. So what I advise them to do try the VRI if there are problems you have evidence of why it is not effective. Then you can use that to ask for an in person ASL interpreter.

Do you agree with that strategy? Should I just tell them to say I don't want the VRI? The burden is on them to say why they don't want VRI. Not I don't like VRI maybe without reasons.

>>Steven Gordon: How I analyze it. If someone says I am not using VRI I have a harder time with that case. If they come in and they have 4 or 5 E‑mails to the provider explains this happened with the VRI. I was in your office. Here is what happened. Please don't use it again and they list through all of the problems that's a lot better case for me when I am analyzing it.

That's what I can tell you in that regard.

>> Should I continue to give that advice?

>>Steven Gordon: I don't want to opine on the advice. That's how I analyze it so you can judge. I have limitations giving legal advice is something I have to be careful about.

>> We just got a call a hospital. The default is VRI. It is a 2 week stay. We have documented 50 instances of using VRI. I know you mentioned detailing the specifics where the problems are.

After the fact on a 2‑week stay the nurses are not going to document it was lagging and delayed and blurry. From a litigation standpoint we can detail generally in those 2 weeks the problems he had. But it is largely a fact situation.

>>Steven Gordon: Some of the things I would look at when were the kinds of communications they needed to have started and how long was the VRI operating? If they operated the VRI for 2 minutes they were trying to get informed consent for a complex surgical operation I would go 2 minutes?

The one thing they will document is all of the communication they supposedly had.

I will give you guys another case what I did I looked and they got consent for some really serious stuff. That was in the medical notes. The individual involved was a campaign I don't know. She was texting her friends and relatives. Both the text messages and the medical documents have date and time stamps on them the exact date and time stamps.

I looked at what is it they wrote in their notes and her text messages to her friends and family there was variance between the 2. 180 degrees the nurse said I talked about the following and got consent to do XYZ. Her notes said the opposite. Her text messages to her friends and family.

Sometimes you have to be creative and go deeper down. I think VRI is a tough one. I have had cases like that. It is a tough one. I talk to the consumers. I go out to the community to do outreach. I tell this so I get people thinking about it. If they go to the hospital they do that.

You may not have that option available with your clients. But it is something that I try to do.

>> I agree with what you are saying, Steve about doing that and matching up medical records and going on with the VRI records. If the person was in the hospital for 2 weeks and you have 50 entries of VRI use you are not going to be to get over the difference.

>>Steven Gordon: It is a limitation. I know what the law is. I give you the best ideas I have. I know that this is a very challenging area. And something else, I encourage consumers to do as much in writing as they can so that folks know.

>> It just occurred to me. I never thought about this, is there a way to look at the VRI machines to see how ‑‑ when they were turned on and off? Do the devices themselves have records?

>>Steven Gordon: That is a really good question. What I have found they have billing records because they bill by the minute. Those billing records tell you when it was turned on.

So I had records, I had text messages when the person requested VRI. It took them 6 hours to turn it on for the first time. I had medical records saying the VRI arrived in the room 2 hours after she requested an interpreter but it took them another 4 hours to turn it on.

I knew there was a problem something going on. I think the issue was they didn't have stuff that knew how to turn it on. I know this is a very hot area and I think that maybe this is one of those areas we can all creatively think about how to address it.

There are limitations. Many people talking in a room. That's something that, again, a person wants to memorialize 4 or 5 different people in the room talk. In nursing home settings you have a care planning after they have been there 7 days. Care planning meetings have occupational therapist, a nurse sometimes a doctor, sometimes multiple family mechanics. VRI will be very difficult to use in that kind of a setting with that many people.

Room layout. A lot of hospitals particularly in urban areas, they convert some of their closets and other things into patient room and the room layout are strange. And it will not work for VRI.

Poor eyesight. Obviously who has vision issues VRI is going to be a problem. You need to get a tactile interpreter or it might mean you need on site interpreter because they don't have full vision. There are a lot of different vision issues. People can talk about that as well.

Physical limitations of the person who needs the interpreting. Someone who has had a stroke and is paralyzed on one side of their body but can sign with one hand they are likely going to have difficulty with VRI because the VRI has to see the entire body. This is where the regulations talk about this. It is really important to think about the physical limitations. That could be a reason they shouldn't be using it. They rely on it.

>> Are there regulations on these limitations?

>>Steven Gordon: I believe they are. And I don't remember ‑‑ I have to go back and see the origins of this slide. It may be they are in the section by section analysis.

>> Section by section.

>>Steven Gordon: Okay. For hard of hearing, another huge issue for medical settings. It is not sign language interpreting. And I get complaints from people. Again, we are all going to lose our hearing as we get older. It is almost universal. Really important that healthcare provider figure out a way to communicate.

I am running low on time. So one of the pigs that I want to do is make sure that I also get to some of the other issues that I have in here. So I am going to skip ahead a little bit.

You can see some of my recent cases. I am going to point that out. These are all on ADA.gov. The most recent Spotsylvania Medical Center. I have also done medical offices.

HIV and AIDs. This is a compromise of the immune system. It is covered by the ADA. There are Supreme Court cases. Braxton v. Abbott. They are entitled to equal treatment. Big issue that comes up is folks say well, you can come to my office just be the last appointment of the day so you don't infect other people.

That is a violation of the ADA. Really important to know that. Again, I ever a lot of slides in here and this is meant to be educational. There is a part of ADA.gov that deals with HIV and AIDS. I recommend if you have a case like this to go through that.

Other thing I want to talk very briefly about, minute clinics. Do you know what a minute clinic is at CVS or Rite Aid. A pharmacist was refuse to go give a flu shot because they were HIV positive.

Minute clinics are covered by the ADA. Pharmacies are covered for that matter.

Again, there is a bunch of locations here and these are other folks from throughout DOJ that have done these. You can take a look.

Access to medical care for individuals with mobility disabilities. Really important area. There are regulations that are being developed. I think the access board has some things. It is not quite yet into the regs.

But it is a really important area. DOJ has a really helpful publication on this. I highly recommend it if you get a case involving someone with a mobility issue, look at that publication. The regs are not fully developed in this area.

It is on ADA.gov like everything else I have been talking about. The section that I find informative is the Q&A in there.

Big question that comes up is it okay to examine someone in their wheelchair. If you are doing an examination of their face that is okay. Most of the time it is not okay because that is not equal service.

So you need to examination the person the same way you would exam them if they were not disabled.

Can I tell someone with a physical disabilities I just don't have the equipment so you can't come here? No. You need to get the equipment. That's right there in the publication.

Is it okay to tell someone with a disability you have to bring someone else? The answer is no. That is just like telling someone who is deaf you have to bring an interpreter. You the provider has an affirmative obligation to help the person who is using a wheelchair and has mobility issues to get the proper care.

>> Where are you deriving all of this from? From the CFR or general ADA equal treatment?

>>Steven Gordon: This is the questions and answers.

>> I have read this before. In terms of regulations. Is this coming from the CFR? This is the general interpretation of equal treatment for everyone?

>>Steven Gordon: I would look at the publication in the beginning and describe how DOJ describes it. I want to be careful. If you look at the regs, asking someone else to come to an appointment, that particular issue that is not equal. A person without a disability they don't have to bring someone with them.

I think a lot of these you can go back to probably general prohibitions under the ADA or other types of things that are in there.

>> But there is nothing specific in the implementing regulations like the CFR?

 >>Steven Gordon: There is nothing as granular as this publication.

>> I'm Charlie Brown. I'm living in Winchester now.

>>Steven Gordon: We miss you at our round tables.

>> I missed the last one. I had cancer surgery.

>>Steven Gordon: I'm sorry.

>> I'm getting along. When I was doing this for a living, he we always had the answer from the doctor we are not going to have our people read the consent documents to somebody because then they will say we didn't read it right and sue us.

I heard that so many times. Somebody would call me, I went into the dentist and doctor and there was a form that I had to sign. I asked them to read. They said they would not read it to me.

Of course you could sue them and 10 years later ‑‑

>>Steven Gordon: It is problematic. I didn't talk about effective communication with folks that are blind. It is very important.

>> In the medical setting that is out there.

>>Steven Gordon: The other thing is kiosk. It is a generalized term for when they have an iPad or something else and they put it in front of you. What are some of the things they ought to be doing? I will throw it out there. They ought to be sending the documentation ahead of time so you can read it on your reader at home.

I have been thinking about some of these issues but kiosks are used everywhere. CVS has them. I just ordered one of these at a convenience store. They wanted me to use the KIOSK to use it. The person helped me because I had no idea what their software was.

Charlie, I appreciate ‑‑ Charlie comes to our round table which we do in my office. It is great to have you in my presentation.

>> As a follow‑up, a case involving accessible documents in a hospital setting right now. I'm not aware of any other cases or settlements dealing with that. I'm curious if the DOJ has expertise in recommending a system for hospitals to timely provides formats in braille et cetera,

>>Steven Gordon: This is one settlement, it is the Orange County Hospital. It is Orange County, Florida. I think it is a descent case. If you look at the definition of auxiliary aids and services there is a whole section in there for people that are blind.

I talk about the people who are people who are deaf. Braille is the one of the auxiliary aids and services.

Readers is another one. Scribes is another one. There is another section that they need to adhere to. I have time limitations so I have to focus somewhere. I apologize. I didn't spend enough time on the blind issues.

>> We have an agreement with Keiser.

>> Okay.

>>Steven Gordon: Thank you, Linda.

>> Related I was working for the city in setting up all aspects of their healthcare system and one of the problems, this was several years ago, we had they were creating a patient portal. I know there are regs that require it, but half of the providers we looked at were not accessible.

>>Steven Gordon: Portals are like kiosks.

>> You go to the website. It provides information you enter your forms. You can exchange information with the doctor.

>>Steven Gordon: I welcome cases like that if folks have it. I think that comes under the equal access. If it is equal access under Title 2 under 3 it is equal services.

I welcome hearing about that and DOJ took a position in NAD v. Harvard and MIT about this issue.

>> One of the biggest problems with the inaccessibility about the information and services that are delivered electronically through websites and kiosks is because the electronic medical provider doesn't really care about access built. They are the worst. They are the largest electronic medical care provider in the United States. Keiser uses them, UC Medical Center uses them. So many other healthcare providers use them.

That's what the department of justice should be doing going after Epic.

>>Steven Gordon: The kindle was our example of this. We often need to get an entity covered by the ADA go after them and them to figure out how to get the right stuff.

Kindle was the big example. I know there was a dear colleague letter. DOJ is not doing those. That was in 2011‑2012. I welcome complaints because I'm happy to have as much impact as I can. My footprint is the eastern district of Virginia. I can force a provider to do what they are supposed to do.

I am trying with my settlement agreements to make them cover as much as I can. Question back then they have we have a question over here.

>> Quick question. In regards to the affordable care act some of us practitioners including ‑‑ it allows some of the primary consideration to come under title 3 for hospitals. But my question is those complaints are specifically are they sent to HHS? Are DOJ and HHS working together if pro se decide to file a complaint? How is it going to work when it is ADA 504 and ARCA violation?

>>Steven Gordon: I know from my perception I am only getting things sent to DOJ. I get a lot of complaints also because people know I am out there.

I have not really seen ‑‑ occasionally I will talk to OCR at HHS. It is often when we are looking at the same provider about something.

I'm not sure. I would have to talk to people at OCR to figure out what they are doing with the 1557 type complaints. I don't know a lot about them. I hear a lot about it from folks. I don't know if that Answers your question. That is the best knowledge I have. Question back here.

>> Quick question. Are you going to make this presentation open to questions at the end? Are you done with the presentation.

>>Steven Gordon: You are welcome to ask it right now. People are doing that.

>> I just wanted to make sure. I didn't want to take up everybody's time if they had more questions about the presentation.

So first of all my name is Kelby, I work for the Governor's office in Maryland. So we definitely get calls from different businesses who have complaints and concerns about deaf people who threatened to sue them because their sign language interpreter wasn't qualified or was a fake interpreter, insufficient in some way. They asked me how to know if an interpreter is qualified.

I recommend they look at the certification because the businesses are not qualified to evaluate their skill level. But the problem is that it is always like we are forcing it back on the DOJ because they are saying that the certification isn't required.

So what do you think the answer should be that I can give if a medical provider or business asks me how they are supposed to know if an interpreter is qualified or not?

If the answer is not certification what should it be?

>>Steven Gordon: Yesterday at Deaf Law Day I had a similar question. When I hire interpreters I want to know I am getting good services. What I do is I ask the consumer for feedback. For example I met with the folks at NAD. I meet with them periodically I do a lot of work with them. I brought interpreters with me. It was our contractor.

I asked them afterwards I said, please ‑‑ I talked to Caroline. Would you please ask people for feedback. Caroline is a certified interpreter. I asked her what do you think? What I do if you really want to know you have to ask people.

It is that interactive process which is a title 1 concept, employment. But I do know this is a challenging area. I get similar questions from folks.

I don't know ‑‑ even if they are certified and this is why DOJ decided not to include that, it doesn't mean they are qualified for that setting. But I think the best thing they can do is ask questions.

They can ask the service, what did you do to check the quality of the employees that you are hiring? I do that also now. That's actually honestly something that Caroline suggested to me that I ask.

So these are some of the questions that they can ask. I don't think there is a perfect way of doing this because there isn't a defined standard other than the functional standard that they got to be able to interpret expressively receptively and you know the definition.

I do have one case where the person wasn't qualified that the doctor hired.

I found out about it and in Virginia they have quality standards for accuracy. And I don't know if you have seen the VDDDH website. You know the quality standards. They were qualified at 65% accuracy level. That was my reaction too. I understand your sign there.

So I think it is a tough problem because there is isn't a defining way.

Maryland established their own standards. As you know, the ADA is a floor it is not a ceiling. Maryland has that right. Maybe you could be on the forefront of making sure that interpreters have some skill.

You know there are some CODAs out there that may not have a lot of formal training but they are really good at interpreting, too.

>> Not necessarily.

>>Steven Gordon: That I get. But there are some. One of the people who was really good at my meeting at NAD was a CODA. That was something that helped.

But I get it that not everyone. You need formal training. It is a 4 year program for people that don't know this, it is a 4 year program to learn the ASL. After that 4 year program you start learning how to interpret which is a whole another academic area.

It is really important to understand that. Northern Virginia community college offers a program. We have gone over. I understand if people need to get something to eat.

>> You didn't get to this. I'm Leslie Francis from the University of Utah. I have a specific reason for asking this. There is a symposium at NYU on intellectual property and race. They invited other kinds of disadvantaged populations. With a colleague who is an IP person we put in a paper on mammography machines and disabilities.

Basically we are looking at how the original way the patents were issued has continued to impact. So what I'm curious about. Does anybody have mammography cases? The DOJ withdraw the regulations that were based on the architectural barriers.

>>Steven Gordon: You mean the Access Board.

>> Yes.

>>Steven Gordon: So I have many mammography cases in effective communication area not physical access area. But the other area that's really hard is the radio logical tables because they can't be raised and lowers because the machine is underneath.

There are workarounds. If someone is in a wheelchair you put a gurney down.

I don't know if you go to the ADA symposium. Folks from the access board do a presentation there on accessible medical equipment. They are in June in Dallas this year.

It is a really useful thing to hear about. They have been talking to folks from the access board working on that stuff. And there is real hope this will be available for DOJ to start thinking about rule making as well. I'm not part of that process.

>> I just wondered if anybody had knowledge that would be helpful.

>>Steven Gordon: I have gone over if people have other questions I am happy to answer them. I want to be sensitive to that issue. It is meant to be 90 minutes, 120 minutes. It is a little bit longer. I welcome folks downloading, looking at it and sharing it with others. It is helpful to have all of that information packed in there that I can't cover in an hour long.

So thank you so much.

[Applause]