Strengthening Systems of Care for People with HIV & Opioid Use Disorder
SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

CONNECTING CARE PODCAST // EPISODE #14 // TRANSCRIPT

What the Americans with Disabilities Act Means for People with HIV and Opioid Use Disorder

Alex Walley:

The Americans with Disabilities Act or ADA is a federal civil rights statute that was enacted in 1990 to protect individuals with disabilities from discrimination by employers, state and local government, and public-serving entities. The rights of people with HIV and opioid use disorder are protected under the ADA yet these rights are frequently violated.

Greg Dorchak:

The magnitude of discrimination that each facility engages in is just on an order that is really unlike anything we've seen in other disability rights cases. We were talking about hundreds upon hundreds of times that one particular skilled nursing facility would write, cannot accept this patient because of their history of drug use. Cannot accept this patient because they're on methadone. Cannot accept the patient because of Suboxone.

Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. This month, my colleague, Dr. Sim Kimmel, and I talk with Greg Dorchak, assisting US attorney in the civil rights unit at the US attorney's office in Massachusetts. Greg has led the charge in ensuring the protection of people with opioid use disorder. During our conversation, we cover the different ways providers, facilities, and systems violate the ADA, how these violations differ from other types of discriminatory policies and practices and how civil rights statutes can be useful tools in improving care systems for people with HIV and opioid use disorder.

Alex Walley:

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I am an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. I'm joined again today by my colleague Sim Kimmel. We're delighted to have a very special guest. We've had patients, nurses, and doctors as guests but today we're branching out. We're thrilled to be joined by Greg Dorchak, an assistant US attorney in the civil rights unit at the US attorney's office in Massachusetts. Greg is an attorney who is tasked with upholding the Americans with Disabilities Act and has led groundbreaking cases which establish opioid use disorder as a protected disability. Greg, thank you for joining us today.

Greg Dorchak:

Thanks for having me.

Sim Kimmel:

Greg, we're so happy to have you here. Your work has been a real inspiration for me. And so today I think we're going to have a chance to talk through the Americans with Disabilities Act. And to get us

started, can you explain to us what the ADA, as it's sometimes called is and what it means for patients with HIV or opioid use disorder?

Greg Dorchak:

Yeah, absolutely. So the ADA is a federal civil rights statute that was enacted just over 30 years ago now. We just celebrated the 30-year anniversary of the ADA. What the ADA does is it protects individuals with disabilities in three different areas. Employment protects you from unnecessary barriers or discrimination from state and local government and also protects individuals from what are called public accommodations. So discrimination by public accommodations. Public accommodations despite having that word public in it aren't public entities. They're entities that do business with the public. So and this applies to medical providers like hospitals and doctors. And what it really does is it protects individuals with a disability. So individuals with HIV or who have opioid use disorder are protected. They do qualify as having a disability under the ADA, and it protects them from discrimination from any of those entities.

Alex Walley:

So clearly the ADA has important implications for our patients. I've been taking care of patients for over 20 years, HIV patients and people with opioid use disorder. And I think in the beginning, I was always clear in the beginning for me meaning the early 2000s was pretty clear that the ADA applied to my patients with HIV and that it was illegal in some way to discriminate against people with HIV because they had HIV and further that there were accommodations that needed to be made by institutions for people with HIV. I think I had some sort of sense of that. And I now imagining that comes from the ADA but I have to say that it wasn't in my consciousness, even though I'm someone who's very interested in addressing stigma against people with opioid use disorder, I wasn't really clear that the ADA applied to people with opioid use disorder.

Alex Walley:

And I think that was some kind of internalized structural perception or understanding that people even though I believe opioid use disorder is a medical condition that's chronic and certainly disables people, I didn't really have a sense that the ADA would apply to them. And so where this came up for me first was not that many years ago, maybe three or four years ago. Sim and I were working together on the inpatient service and we were thinking about research ideas and really more so we were thinking about our patients and there's this very common story that happens over and over again in the hospital where we have people with opioid use disorder who have an infection, who require long term antibiotics. And what I mean by long term is four to six weeks, usually of intravenous antibiotics.

Alex Walley:

And we complete their acute treatment, their workup, their diagnosis, they have a treatment plan in the acute hospital and they need someplace to go to get their antibiotics. And many of our patients don't have a safe home to go to. And so the best option for them is to go to a skilled nursing facility or what we call a medical rehab. And it's a big struggle in getting our patients admitted to these places. And it's become pretty clear to us over time that this was because they had an opioid use disorder and even more shockingly not just because they had an opioid use disorder but because they were treated with a medication for an opioid use disorder that these skilled nursing facilities wouldn't handle.

Alex Walley:

And so Sim and thought about this, thought about advocating locally with the case managers calling the facilities themselves, doing a research project to document this, but then it came into our head that this was like really, really discrimination and maybe we should talk to a lawyer. And so that's really how we connected with you, Greg. And so it turns out that you have had settlements with these institutions around discrimination and opioid use disorder. And so I wanted to hear you tell us a little bit about how you got into this, how you got to these settlements, and what you were seeing in the beginning and we'll get into what you're seeing now.

Greg Dorchak:

Absolutely. So I think I should start by taking that step back. And as I mentioned earlier, the ADA was passed more than 30 years ago, but even you who has been working with this population for some time did not necessarily make the same link that these individuals are protected on the basis of OUD as they were with HIV. And that is very common. And that frankly has to do with a lack of enforcement. So I'm here in the department of justice in the US attorney's office in Massachusetts and we entered into the first kind of settlement agreement with a skilled nursing facility for discrimination on this basis. And that was in May of 2018. So that is nearly 27 years after the ADA is passed before we actually advanced the first case that it's not necessarily that it hadn't been recognized that addiction and opioid use disorder was covered.

Greg Dorchak:

It's that what hadn't been recognized is how prevalent these cases were and it hadn't been recognized by attorneys that this is something that you're dealing with on an everyday basis. So right in the Americans with Disabilities Act, it says in the regulations, "Addiction is a disability." You cannot get more clear in legal terms than that phrase right there. Addiction is a disability and individuals with addiction are covered by the act. That is very clear yet it took 27 years to really make that connection to bring it to the next step to actually bring some of these cases. And frankly, it took having conversations between attorneys and medical providers to make that connection. You were explaining to me what you were seeing. I was making links to what we enforce under the act and that's really where that kind of synergy happened. So as I mentioned, May of 2018, we entered our first settlement agreement with it was a skilled nursing facility out of Norwood, Massachusetts called the Charlwell House.

Greg Dorchak:

And it was literally based on nothing much more than a message sent from the facility to a provider that says, "We can't accept your patient because of Suboxone. Change the medication and we will reconsider." That was it. And that's all we need to understand that, one, you have a policy of discrimination, two, it's based here on the medication that the person is using to treat their disability, and but for that medication, you would provide care to this patient. And that really just satisfies the elements that we need to demonstrate discrimination. So we required this facility to enter a settlement agreement that changes their policies, pay a small penalty. It was I believe, $5,000. And that was it. Since then, we have entered to eight more. I think at this point we have nine settlement agreements with skilled nursing facilities that are on the same exact fact pattern.

Greg Dorchak:

But one of the interesting things that we have learned through entering these settlement agreements but also the investigations is that any one of these facilities, the magnitude of discrimination that each facility engages in is just on an order that is really unlike anything we've seen in other disability rights cases. So for example, if somebody who is deaf goes to a hospital and is denied an American sign

language interpreter because they are deaf just for whatever reason, the hospital falls through on actually providing that interpreter. Those are situations that we see and we see pretty commonly and frequently, but we see one particular hospital might in a particular year do that 20, 30 times and that would be a bad actor. What we were finding in the skilled nursing facility situation is we were talking about hundreds upon hundreds of times that one particular skilled nursing facility would write, cannot accept this patient because there are a history of drug use. Cannot accept this patient because they're on methadone. Cannot accept the patient because of Suboxone.

Greg Dorchak:

And we were seeing this in each particular facility hundreds of times, and that is something that we just did not see in other areas. So it's something that quickly alerted to us. One of the reasons that we have nine settlement agreements in the three years since we filed that first one or entered into that first one is because it's so prevalent and we have not stopped with the nine. This is a cascading, continuing effort to really address this practice systemically but it is something that it is very open, very notorious, and it is very unlike the kind of discrimination that we see in other areas of the law.

Alex Walley:

So in our discussions about this, you introduced me to a new term which I think I remember it correctly was facial discrimination. And I think that's what you were just describing there. Can you say what facial discrimination is?

Greg Dorchak:

Yeah, absolutely. So I'll provide its contrast and the normal kind of discrimination that we see let's say in a housing context. In the housing context, a person who is Latino might show up to rent an apartment and the landlord says, "I'm sorry, I just rented that earlier in the day, it's no longer available." Two hours later, a white person shows up and they ask to see the same apartment the landlord says, "Come on in. Also, we're going to be knocking a $100 off the rent so it's only X amount of dollars." The first person experienced discrimination and yet that discrimination was not facial. And the discrimination was not facial because while they received disparate treatment, they were not told the reason that they experienced the disparate treatment. The landlord did not say, "I'm not renting to you because you're Latino."

Greg Dorchak:

The landlord said, "We're sorry, it's just not available." And that is the typical kind of discrimination that I as a civil rights attorney enforcing federal civil rights laws have to uncover and expose for what it actually is. We do often use testers or secret shoppers. You might call them to kind of unearth that exact kind of fact pattern. Here with this discrimination not only do the skilled nursing facilities tell you why they're turning you away, they are completely open and think it's completely fine to do so. So it is facial discrimination because on its face, they are providing the discrimination. They are showing you why they're discriminating. They are telling you the very reasons for this disparate treatment.

Alex Walley:

So, Sim, you did research on this. You actually looked at lots of the data that we have here at our own hospital and was able to look at the reasons why people were rejected and I just wonder if you could comment on what you saw really from the case manager's perspective because it was their database.

Sim Kimmel:

Yeah. So you described the scenario where there's a patient who's looking for a skilled nursing facility at the conclusion of their kind of acute care management. And we were taking care of a patient. I was talking to the case managers and they said, "Oh, we're having a really hard time placing this patient." It's a common scenario. And I happened to be in the case manager's office. And I saw up on the screen that it said rejection methadone. And I asked a little bit more about it and she showed me that there's this kind of transmission of reasons why, and through the electronic referral system we could actually download all of that information and evaluate how often there was this kind of what Greg described facial discrimination. And we found on that in 2018, about 15% of facilities that Boston Medical Center had referred a patient to had engaged in this facial discrimination.

Sim Kimmel:

And that touched a much larger number of patients. So I think it impacted more than a third of patients who were referred to skilled nursing facilities. Now that's just the facial discrimination. There's likely much other discrimination going on where the facilities are not actually telling you. So that was my experience and we were able to publish that and through appropriate channel share some of that information with Greg. One of the things there's stigma towards people who use drugs and in some ways, the facilities might not think they're doing anything wrong. They think that they're just engaging in normal stigmatizing behavior that is accepted. And there's even some confusion as I understand it, or maybe not confusion but there's some debate under the ADA about a drug use exception. And Greg, can you walk us through what that is and what it means, and how it applies to kind of scenario?

Greg Dorchak:

Yeah, absolutely. So what you're talking about is what's called the "current use exception." And the current use exception is as I mentioned, an individual with addiction is protected by the Americans with Disability Act. And then there's a clause that says, "Unless they're currently engaged in the illegal use of drugs." So once a person is currently engaged in the illegal use of drugs, they are no longer protected except because we're attorneys and we like to have exceptions to our exceptions. I think I once compared this one to the movie Inception because now we're like in our third exception going on here and in this, there's an exception to that exception to the extent that an individual currently engaged in the illegal use of drugs is still protected when seeking care from a medical facility.

Greg Dorchak:

So think of that current illegal use exception as more of applying to let's say an employment scenario. If somebody with addiction is engaged in the illegal use of drugs, their employer might be able to fire them for the illegal use of drugs, but that same person seeking medical care could not be turned away from medical care if they're engaged in the illegal use of drugs. So it's there is an exception that people are not covered once engaged in the illegal use of drugs, but that does not apply in the medical setting.

Sim Kimmel:

What does current mean with respect to the law? I've heard nursing facilities sometimes say, "Oh, well, the person has to have not used for 30 days in order to be accepted." Does that hold up?

Greg Dorchak:

So it doesn't hold up because again, it goes back to that point that because a skilled nursing facility provides medical care, that exception would not apply to them. Courts have answered this question though of what does current mean and again because we're attorneys, the answer is, it depends on any individual situation like in some cases you might say a single day is enough to count as current use

because they used yesterday. Some cases the court said, "It was months ago." It's a court-by-court/case-by-case analysis. But here I do want to point out one thing that I think is important here. There is this other exception to the Americans with Disabilities Act that is not about the current illegal use of drugs. It's about this thing called the direct threat. Now here is where facilities are allowed to exclude somebody or deny treatment if that individual poses a direct threat to others. Okay.

Greg Dorchak:

And so some facilities might say, "Okay, this patient of yours is a direct threat because they have illegally used drugs." That in and of itself though is not a direct threat and that would be a misapplication of this notion of the use of direct threat. And it's because direct threats can't be based on stereotypes, stigma, or myths about people with the disability. And I give you the perfect example is that if somebody had brownies with marijuana two days ago, marijuana under the federal law is illegal. I know under state law, there is many states including Massachusetts where it's decriminalized, but still, under federal law, it is illegal.

Greg Dorchak:

So from the ADA perspective, still illegal. If somebody were to eat those brownies two days ago, are they a direct threat? No, they're not a direct threat. Now, if somebody were to be actively attacking a nurse in a particular hospital setting, that person is a direct threat but they're not a direct threat because of the drug use, they're direct threat because they attacked a nurse, and it's a very distinct analysis. So somebody can't just use the fact that somebody currently engaged in illegal use of drugs as a proxy for that person being a direct threat.

Alex Walley:

I need to go back and just dwell on one detail that Sim described in his story which is the word that he saw on the screen, the reason for rejection was methadone. And methadone is a life-saving treatment for opioid use disorder. This would be like if it were a person with HIV in the old days, it wouldn't be saying HIV on the screen, it would be saying antiretroviral therapy as a reason for excluding somebody.

Alex Walley:

So as an addiction specialist, it particularly irks me that people are not only discriminated against because they have the underlying medical condition, but they're specifically discriminated against because of the treatment for that condition, which just tells you that not only do we stigmatize people who use drugs, not only do we stigmatize the illness of a drug addiction, but we stigmatize the treatment of the disease. And so that's where we're starting from. So just hammering home that point of facial discrimination and also how the spirit of the exceptions really play out in different ways with this particular population. So anyway, I just wanted to hammer that point home as one that is a B in my bonnet, basically.

Greg Dorchak:

I really want to address that last point because what you said about the fact that this discrimination is about the medication and not necessarily to everybody with the addiction, this was actually the original defense that was used by entities in saying, "Well, we're not discriminating against the addiction, we're discriminating against the medication." Which is something completely different. Now under the Americans with Disabilities Act, every disability is different meaning every individual's disability is a distinct disability. There's not one general category of disability. And because of that, the treatment used to treat a disability is inherently linked to the disability itself. And so courts have ruled that there's

no separation between barriers to the thing that treats the disability as opposed to barriers to the disability itself. It's like having a restaurant that says, "We are fine with people who have mobility impairments just no wheelchairs. If you want to bring your walker that's fine but not your wheelchair." It's the same theory here. And so this is a crucial link that medication is also protected.

Sim Kimmel:

Thanks for highlighting that, Alex and Greg, I want to go back now to talking about some of the other kinds of cases that you've worked on. So what you've described so far is people who were declined services because of their opioid use disorder or treatment for opioid use disorder. And we know that those practices are quite widespread. This is a situation where the standard of care essentially violates the ADA, where you can go to anywhere around the country and find these violations. Are there other kinds of protections under the ADA? I know you've entered into a settlement related to a lung transplant recipient. Can you talk us through that and how that is different or similar?

Greg Dorchak:

Yeah, this is a really important distinction and a really good case that kind of highlights the distinction. So with skilled nursing facilities, what we're talking about is just a complete policy and denial that you have a policy at the skilled nursing facility that says, "No patients on methadone." With our case with Mass General Hospital, this is also all of our settlements are available on ada.gov and you can find a link in the enforcement section there to this settlement agreement specifically for your own reference. But with our settlement with Mass General Hospital, this involved a patient who had opioid use disorder and also cystic fibrosis. This patient needed a lung transplant. Now in assessing the patient's candidacy for a lung transplant, Mass General Hospital, the transplant team there, did not consult with the addiction specialists that were treating this patient. However, it was in their standard operating practice to normally consult with a specialist in whatever area of care that the transplant team doesn't necessarily have a specialty with.

Greg Dorchak:

So here, let's say somebody had an underlying heart condition. The transplant team would consult with a cardiologist on how to best accommodate this patient and to assess that patient's candidacy. In the Mass General Hospital case, they did not do that with the addiction treatment team and then denied him on the basis of the fact that he was taking Suboxone. So our investigation here and our settlement didn't necessarily focus on the denial, it focused on which very well at the end of the day may have been appropriate. Now, this patient ended up receiving a transplant elsewhere showing it was completely capable but our case here focused on that deviation of the transplant team's practices. The fact that their normal routine operating practice is to consult with the specialist in that area of care, here they didn't. And it was that deviation from the practice that for us represented the disparate treatment which is what we look for in any case of discrimination. So it's subtlety different but I think just as important to understand.

Sim Kimmel:

That seems like it would have really important implications for other areas of care. So for instance, if a patient comes into the hospital to the emergency department with suicidality, that patient would get a psychiatric consultation and potentially admission to a psychiatric facility. If a patient comes into the emergency department with an overdose, typically patients will be monitored until they're no longer have respiratory failure and then be discharged quite often without any treatment with medications for

opioid use disorder without offering any treatment with medications for opioid use disorder and often without even Narcan in hand. Would that be a violation in a similar way?

Greg Dorchak:

So it's a really interesting back pattern and it's something that I hesitate to opine on whether or not it definitely is a violation but it's something that is within the realm where if that is a fact pattern that you saw, I would file a complaint with my office or with the Department of Justice at ada.gov because it's something that is worth looking into. Now, every fact pattern has its own individual mitigating consequences but this is one I would definitely if you were to see this fact pattern, I would file a complaint.

Alex Walley:

Greg, you've done so much to advance this work. And I know a lot of US attorneys from other jurisdictions are looking to you and some of this has spread to other jurisdictions. So I'm interested to hear a little bit about that but then also what are the other institutions in our society that are responsible for holding up the spirit of the ADA? Is it just the department of justice or is it also public health departments? A lot of people who listen to this podcast are connected to public health departments. So what should they be thinking about as far as the ADA and people with HIV and opioid use disorder?

Greg Dorchak:

Yeah, absolutely. So going back to the first question, I have colleagues across the country who are playing catch-up but doing so very quickly in terms of finding the Alex Walleys and Sim Kimmel's in their own jurisdictions. And it's easy for me to learn about this issue because of advocates like yourselves who are in Boston right down the road from me. I know that for example, my counterparts in Louisiana, my counterparts in Rhode Island, my counterparts in Kentucky have all been doing great work here, counterparts in New Jersey. And they all have engaged in settlement agreements, investigations, and are pushing this forward. So it is something that's beginning to spread. But to get to the other area that part of your question, it's not just medical facilities. I know that's been the crux of our discussion so far. I would say that there's three different areas where the ADA and also analogous civil rights statutes come into play one of them being the Fair Housing Act.

Greg Dorchak:

So there's medical facilities which we've discussed. There's the criminal justice system which is an absolutely huge area. So a lot of people don't realize that jails and prisons are required under the ADA to maintain individuals on methadone, to maintain individuals on buprenorphine, to maintain individuals on injectable naltrexone when they're in their facilities. This maintenance is required by the ADA. And we just have a litany of court cases that have ruled as such since late 2018. The very first case happened here in Massachusetts with the Essex County Sheriff's Office. It was a case called Peshy B. [inaudible 00:30:37]. And the court was very clear in that particular case that facility had a Vivitrol only policy and the court ruled that wasn't enough. You had to maintain this particular individual on their methadone throughout the duration of their stay in your facility.

Greg Dorchak:

And that is something that I think has changed the landscape in the criminal justice setting to me at kind of a lightning speed from how the legal setting typically works. Since that ruling in, it was either October or November of 2018, now every jail and prison in Massachusetts, for example, either already has their

programs in place to provide all forms of medications for opioid use disorder or has already started the approval process. That is just absolutely huge to get 14 county sheriffs to get the entire department of corrections and the federal system onboard into that. That's just Massachusetts. I think that it's safe to say New England has kind of led the charge here. Rhode Island is already there, Maine already if they're not already there is on their way, same with New Hampshire, Vermont. These systems since late 2018 are just completely changing.

Greg Dorchak:

And I think that that kind of goes to the possibilities in what civil rights statutes in this area can bring. And then the third area that I really want to highlight which is kind of behind the pack is housing situations. So there are so many sober homes that I've heard about where the sober home might have a policy in their homes saying, "Nobody on Suboxone in their home. Nobody on methadone in our home." That is completely unlawful under the Fair Housing Act. It is something that I know that we are actively looking into but it is something that where the landscape has yet to move but I think that you'll start to see that cascade as well.

Alex Walley:

That's so clear and helpful. I want to ask specifically about public health departments what role if any can they play? So for example, I mean, one thing that comes to my mind is taking a role in their regulatory capacity. So I don't know what sticks they have, but and then another would actually be a more carrot approach where they offer education or potentially offer funding for these institutions to comply.

Greg Dorchak:

So I have built a great relationship with our state's department of public health and specifically the Bureau of Substance and Addiction Services where I communicate regularly with issues that I'm seeing on the ground because they do have that regulatory framework. Often that relationship has led to, I think, a real movement going forward. I'll give you the perfect example is as I was working with the various correction facilities in order to have them comply with the ADA, providing methadone and buprenorphine in a jail system is not like flipping a switch. There are so many regulatory burdens and hurdles that need to be overcome that I would say aggressively it takes anywhere between six months and a year for a particular jail or prison to be providing all forms of medication from moment of wanting to do it to moment of being able to do it.

Greg Dorchak:

I have worked with our bureau of substance and addiction services to bring them on boards so they know enforcement action is happening here to help achieve this compliance, but we also need to work in order to help them on the regulatory end in order to bring in that compliance and so between that and other areas, I think that there's a lot of area for collaboration between that kind of carrot and stick approach whether or not it's through funding, through helping somebody navigate this Byzantine regulatory system with the threat of enforcement action which is what my office brings.

Sim Kimmel:

It's interesting to hear about the jails and prisons where there's been really quite rapid change and nursing facilities where I think the change has been more slow. When I talk to doctors and I talk to public health people, they say, "Well, the way that we create change is we train people, we increase capacity, we develop the appropriate relationships, the individual relationships that we connect with one facility

and have an outlet, and then that demonstrates it's possible and then it will spread." And then when I talk to you and other attorneys, I hear people talk about the case and the case law and the precedent and how if we can just get a case decided by the courts that this will lead to change. You've alluded to some of this but how does policy and training and carrots and sticks, how does it all fit together? How do we make change? I mean, $5,000 as a stick to a nursing facility probably doesn't seem like very much if it's going to disrupt their entire business model.

Greg Dorchak:

It's interesting because and I think the backstory to our approach was this is the first facility that we're going after. We need to demonstrate and tell people what we're doing here $5,000. Our most recent settlement agreement was $92,000, but the bulk of that would be forgiven if after a year they demonstrated that they haven't screwed up again. And so we've had this kind of escalating cascade. So now we don't have this belief that the skilled nursing facilities should feel like this is coming out of left field. This is actually something that they should be aware and know about. But we combine that with I mentioned the restaurants earlier, and I think a great example is every restaurant I walk into for the most part is inaccessible and it's why I can't go into restaurants. But I walk into a restaurant and most of the bars, that's a big area, the bars are inaccessible.

Greg Dorchak:

You don't have an area for somebody to be at a wheelchair at a bar. Is it better for me to go after each of the restaurants in Boston in Massachusetts one by one or should I sit down with the board of whatever the board of restaurants would be, the trade organization, sit down with them and say, "Hey, when you're building these things, these are the kinds of things that you should all look into and think about?" Which is something that we are willing to do with the skilled nursing facilities. And frankly, I have spoken with the Massachusetts Senior Care Association in order to help bring along this compliance. I think it's the combination to get from zero to a hundred, it's the combination of doing all of this education, outreach, enforcement, bringing it all together in order to push that forward. With the jails and the prisons it was about getting 14 people, the sheriffs of Massachusetts into one room And to have that conversation.

Greg Dorchak:

That's a little bit of easier of a lift even though it has that broader range in consequences by affecting the whole criminal justice system than looking at every skilled nursing facility one by one, which is something that we're able to do, but there are better ways in order to achieve the same result. And at the end of the day, that's our goal is achieving the result of this compliance, not playing gotcha with assigning a penalty. And I think that movement is starting to happen in the Skilled Nursing Care Association because now people are finally from that trade organization are starting to reach out to me to say, "Hey Greg, what can we do on this?" And I know that they're reaching out and creating other educational opportunities for the skilled nursing community. And so I think that it's a combination of everybody working together to really move the ball forward.

Sim Kimmel:

So we've heard a lot about the ADA and the way that it can protect people with opioid use disorder. For our listeners who are seeing things on the ground where they want to report a particular circumstance, how do they go about doing that?

Greg Dorchak:

Absolutely. So the easiest way, the simplest way is to go to ada.gov where you'll find a link to fill out a form and you can file a complaint there. Every single complaint that is filed is read by somebody and it will be assigned to the appropriate person. So if you file a complaint there, it'll make it to either me if it's in Massachusetts or the analogous me in another state. However, you could also email me directly gregory.dorchak that's D-O-R-C-H-A-K @usdoj.gov. I can help facilitate either if it's a complaint in Massachusetts, I can talk to you about it. I really want to demystify the process here and put a face to the name. I know it's sometimes hard to fill out a box online and think that it's going to be read. So if you get in touch with me, I can help facilitate that connection to the analogous me elsewhere.

Sim Kimmel:

Thanks so much for sharing all that information.

Alex Walley:

Well, wow. This was, you took us on a tour, Greg, and we really, really appreciate it. We've known each other now for several years and we feel progress but also a long way to go on this particular topic. It does, at least in my mind show how rewarding it can be when we work across disciplines, the law, and medicine. And so I look forward to our ongoing efforts in this area. And also you're just been a real champion and I'm glad that the rest of the country, at least the US attorney offices are waking up and seeing what you've accomplished. And like you said, I hope they are able to link up with their counterparts in their part of the country to help build change.

Alex Walley:

And through this podcast, that includes people who are focused on public health for people with HIV and opioid use disorder. So thanks so much and I hope folks will join us next time on Connecting Care. You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA funded project strengthening systems of care for people with HIV and opioid use disorder. The project aims to enhance system-level coordination and networks of care among Ryan White, HIV/AIDS, program recipients, and other federal state, and local entities. You can learn more about the project and find resources at www.ssc.jsi.com.