

MEMORANDUM OF UNDERSTANDING
MASSACHUSETTS GENERAL HOSPITAL
AND

**BOSTON CENTER FOR INDEPENDENT LIVING, THERESA BAINO, STACY
BERLOFF, KELLYANN BINARI AND PAMELA DALY**

WHEREAS, the parties are engaged in negotiations to resolve claims concerning disability access at MGH, including potential claims regarding injunctive relief.

WHEREAS, negotiations have entailed discussions about the following: the process for identifying architectural barriers at facilities and developing proposed remediation plans; installation of accessible medical equipment; adoption of policies and procedures to improve access to health care for persons with disabilities; training for medical professionals, staff and volunteers in (a) use of accessible medical equipment, (b) provision of auxiliary aids and services, and (c) compliance with policies and procedures and training, implementation of existing or modified policies for providing access to health care for persons with disabilities, and provision of auxiliary aids and services for persons with disabilities.

AGREEMENT

NOW THEREFORE, Claimants and MGH agree as follows:

I. DEFINITIONS

1. "ADA" means and refers to the Americans with Disabilities Act as codified at 42 U.S.C. §12101 et seq, as amended by the ADA Amendments Act of 2008, P.L. 110-335, 122 Stat. 3553 (2008).

2. "ADAAG" means and refers to the ADA Standards for Accessible Design, commonly referred to as the Americans with Disabilities Act Access Guidelines, as codified at Appendix A to 28 C.F.R. Part 36. The Guidelines to be followed under this Agreement are the Guidelines in effect at the time the Architectural Consultant completes his survey, except that if amendments to or a different version of the Guidelines are adopted by the Department of Justice, MGH will comply with the amended or revised Guidelines. MGH shall not be required to make alterations to any work it has done pursuant to this Agreement prior to the effective date of the amended or revised Guidelines.

3. “Access” and “Accessible” mean and refer to conditions that comply with the relevant and applicable standards set forth in the Disability Rights Laws.

4. “Accessible Medical Equipment” means and refers to medical equipment that is accessible to and useable by patients with disabilities, including, but not limited to, examination tables, examination chairs, lift equipment, scales, radiologic and diagnostic equipment, dental chairs, ophthalmology equipment, and any other medical equipment used in the medical context for the provision of health care services.

5. “Agreement” shall mean this Memorandum of Understanding.

6. “Architectural Barrier” means and refers to a physical impediment to accessibility of patient-care services or other visitor services at an MGH facility, including, but not limited to, parking facilities, entrances, paths of travel, restrooms, patient bedrooms, examination rooms, waiting areas, treatment rooms, laboratories, counters, public telephones, drinking fountains, pharmacies, cafeterias, gift shops and any other fixed features within MGH facilities that are regulated by Disability Rights Laws.

7. “Auxiliary Aids and Services” means and refers to services and devices necessary for ensuring that no individual with a disability is excluded, denied services, segregated or otherwise discriminated against and includes those services and devices necessary for ensuring effective communication with Individuals with Sensory Disabilities, including, but not limited to, qualified sign language interpreters, TTY/TDD machines, qualified readers, taped texts, audio recordings, Braille materials, large print materials, Accessible websites, and audible prescription labels.

8. “Claimants” means and refers to the Boston Center for Independent Living, Theresa Baino, Stacy Berloff, Kellyann Binari, and Pam Daly.

9. “Claimants’ Counsel” means and refers to the law offices of Greater Boston Legal Services (“GBLS”) and Disability Rights Advocates (“DRA”) and the attorneys and other employees therein.

10. “Days” means calendar days.

11. “Disability” means and refers to the definition of disability in the ADA and implementing regulations.

12. “Disability Rights Laws” means and refers to the ADA and implementing regulations, the Rehabilitation Act of 1973, 29 U.S.C. § 701, et seq, and implementing regulations, and the Rules and Regulations of the Massachusetts Architectural Access Board (“MAAB”), 521 Code of Massachusetts Regulations §1.00 *et seq.*

13. “Effective Date” shall mean the date set out in Section III of this Agreement as the Effective Date.

14. “Expiration Date” shall mean the date set out in Section III of this Agreement as the Expiration Date.

15. “Facilities” means and refers to all portions of MGH premises where health care services are provided and to which the public is invited, including but not limited to: (a) the physical structures, such as hospital buildings, (b) exam rooms, patient bedrooms, public restrooms, waiting areas, treatment rooms, laboratories (to the extent they are utilized by patients), pharmacies (in areas utilized by the public), gift shops and cafeterias within hospital buildings, (c) paths of travel and entrances serving these physical structures and (d) parking facilities under the control of MGH. Attachment A to this Agreement sets out the specific facilities which will be surveyed pursuant to Section V.A. Attachment A also includes a clarifying statement which describes the parts of such facilities which will be surveyed and which will not.

16. “Individual with a Disability” means and refers to an individual with a mobility disability and/or sensory disability. “Disability” means and refers to mobility disability and/or sensory disability.

17. “Individual with a Mobility Disability” means and refers to any individual who meets the general definition of “disability” and has any impairment or condition that limits or makes difficult the major life activity of moving his or her body or a portion of his or her body. “Mobility disability” includes, but is not limited to, orthopedic and neuro-motor

disabilities and any other impairment or condition that limits an individual's ability to walk, maneuver around objects, ascend or descend steps or slopes, and/or operate controls. An individual with a mobility disability may use a wheelchair or other assistive device for mobility or may be semi-ambulatory.

18. "Individual with a Sensory Disability" means and refers to any individual who meets the general definition of "disability" and has any visual disability that limits or makes difficult the major life activity of seeing, and/or any hearing disability that limits or makes difficult the major life activity of hearing, and/or any speech disability that limits or makes difficult the major life activity of speaking. "Sensory disability" means and refers to visual disability, and/or hearing disability, and/or speech disability.

19. "MGH" means and refers to the General Hospital Corporation, d/b/a the Massachusetts General Hospital, a Massachusetts nonprofit corporation.

20. "Parties" means and refers to MGH, BCIL and the Claimants.

21. "Removal of Barriers," "Alteration," "Readily Achievable Barrier Removal," "Maximum Extent Feasible," and "Undue Burden" mean and refer to those terms as defined in the ADA and its regulations. It is understood that among the considerations as to whether a particular barrier removal is readily achievable will be, but is not limited to, expense and patient care considerations, and that among the considerations as to whether a particular recommendation for a particular piece of Accessible Medical Equipment would result in an Undue Burden will be, but is not limited to, expense and patient care considerations.

II. TIMEFRAMES AND DEADLINES

It is understood by both parties that the completion of particular assessments or actions contemplated in this agreement may be delayed due to circumstances beyond either parties' control, and therefore both parties agree to consider requests to extend such timelines and deadlines in a reasonable manner, and to not withhold any agreement to so extend unreasonably. If either party believes that the other party is being unreasonable in either its request for an

extension or its refusal to agree to such extension, such a dispute will be subject to the Dispute Resolution procedure set out in Section VIII of this Agreement. If any stage of this Agreement is completed early, any time saved due to such early completion will be added onto the next related obligation as set out in this Agreement.¹

III. EFFECTIVE DATE AND DURATION OF THE MEMORANDUM OF UNDERSTANDING

The provisions of this MOU and the agreements contained herein are effective as of July 1, 2009 (the “effective date”) and shall remain in effect through June 30, 2015 (the “expiration date”). If MGH does not fully satisfy its obligations under this agreement, the expiration date shall be extended solely as to any particular obligation that has not been satisfied until such obligation has been satisfied. Determinations as to whether MGH has fully satisfied any obligations with respect to any section shall be subject to the Dispute Resolution procedure set out in Section VIII of this Agreement.

IV. REPRESENTATION OF INTEREST, CONFIDENTIALITY AND NON-DISPARAGEMENT

1. BCIL and its counsel are authorized to represent the interests of the Claimants with respect to the MOU.

2. The parties acknowledge and agree that certain documents provided by MGH to the parties prior to the execution of this Agreement may contain confidential business information of MGH and that such documents, in whatever form, shall be maintained as confidential and used solely for purposes of administering and enforcing the provisions of this Agreement. The parties further acknowledge that MGH, its agents, or its consultants shall provide documents subsequent to the execution of this Agreement that may contain

¹ For example, Task A must be completed within 120 days; Task B must be completed within 180 days of Task A’s completion. If Task A is completed within 90 days, then Task B must be completed within 210 days of Task A’s completion.

confidential business information of MGH and that MGH shall mark such documents as confidential or otherwise indicate to the parties receiving such information that the information is confidential. In designating a document as 'confidential', MGH will exercise good faith judgment, and the Dispute Resolution procedure set out in Section VIII will be available to Claimants if they deem a designation not to have been made in good faith. Neither Claimants nor Claimants' Counsel shall disclose such information to any third party except as is reasonably necessary to administer or enforce the provisions of this Agreement or with the express consent of MGH. The parties acknowledge that among other things, "reasonably necessary," as provided above, does not include disclosures of MGH information to the press or to the general public in the form of a press release. In the event that Claimants or Claimants' Counsel receives a court-issued subpoena seeking production of any documents or information deemed confidential under this provision, the recipient of such subpoena shall provide MGH notice and a copy of such subpoena and shall make its best efforts to do so within three (3) business days of such receipt, and provide MGH an opportunity to protect its interests in court with regard to such subpoena. Beginning 60 days prior to the expiration of this Agreement, as set forth in Section III, above, MGH may request that Claimants and Claimants' Counsel destroy or return to MGH (at MGH's option) all documents and information remaining in their possession marked confidential pursuant to this provision, and all copies of same, and Claimants and Claimants' Counsel shall comply.

3. The parties recognize the importance of maintaining a constructive working relationship which serves the interests of the parties and MGH patients. Accordingly, as to any matter which could be addressed through the Dispute Resolution Procedure set forth in Section VIII, neither Claimants nor Claimants' Counsel which, for purposes of this paragraph, shall be deemed to include their respective Boards of Trustees and employees, will communicate to any outside person or entity, whether through press release or otherwise, anything which could reasonably be perceived as disparaging to MGH in any way. As to any matter which could not be addressed through said Procedure, Claimants and their Counsel will

notify MGH if they intend to communicate anything which could be considered disparaging to MGH and meet with MGH at its request to resolve the matter and avoid making any such statement. Nothing in this paragraph limits Claimants or Claimants' Counsel in communicating factual information regarding matters related to healthcare received by persons with disabilities at MGH to any outside person or entity, whether through press release or otherwise.

4. MGH shall appoint, or otherwise assign responsibility to represent its interest to an individual(s) to oversee implementation of this Agreement and to be principal liaison(s) and point(s) of contact for the Claimants. Such individual(s) shall report directly to senior management at MGH.

5. While not a contractual obligation, it is in the spirit of this Agreement that the representatives of the parties will endeavor to build an effective working relationship with each other in the interest of providing high quality health care services to persons with disabilities.

6. There shall be Claimant representation on a Council at MGH that has responsibility for improving services to individuals with disabilities.

V. ASSESSMENT OF ACCESS BARRIERS AND CORRECTIVE ACTION PLANS

A. Architectural Barrier Removal

1. MGH will engage Evan Terry Associates, P.C. ["ETA"] as an Architectural Consultant to provide an architectural barrier assessment for the MGH facilities specified in Attachment A. The scope of the assessment is set forth in Attachment B. If at any time MGH determines that ETA's contract with MGH should be terminated or if ETA becomes unavailable, MGH will engage a substitute Architectural Consultant satisfactory to BCIL. BCIL will not unreasonably withhold its approval of such consultant. All references to the

Architectural Consultant in this Agreement shall then be deemed to apply to the substitute expert.

2. The parties will identify specific MGH facilities and areas within those facilities for a pilot survey to be conducted within 120 days of the effective date of this agreement.

3. Within 180 days following completion of the pilot survey, MGH shall prepare and submit to BCIL a pilot survey report and barrier removal plan. The survey report will include: (a) a description of each major element that deviates from the ADA Standards for Accessible Design, 28 C.F.R. Part 36, App. A and the Rules and Regulations of the Massachusetts Architectural Access Board (“MAAB”), 521 Code of Massachusetts Regulations §1.00 et seq.; and (b) the Architectural Consultant’s rating of the severity of the identified barrier.

4. The barrier removal plan will identify all barriers which MGH proposes to remove under the readily achievable barrier removal standard or otherwise. For any barriers for which MGH determines removal is not readily achievable, it shall propose a readily achievable alternative solution, or provide an explanation as to why it concludes that there is no such readily achievable alternative. The barrier removal plan will include MGH’s proposed timeline for completing barrier removal and/or implementation of alternative solutions. The survey report and barrier removal plan may be produced as a single document at MGH’s discretion. Each year during the term of this Agreement, MGH will provide to BCIL a schedule of specific Barrier Removal projects scheduled to be undertaken during such year, which BCIL understands will be based upon capital budgets and other priorities and obligations of MGH, as well as its ultimate obligations under this Agreement. Each year’s schedule will include a reasonable percentage of the total barrier removal projects that will be undertaken that year.

5. Within 90 days of receiving the barrier removal plan BCIL may provide a report to MGH which identifies any barriers not scheduled for removal in the Barrier Removal Plan and which BCIL reasonably believes should be removed based upon BCIL’s good faith assessment that such removal (a) is readily achievable or (b) is subject to the Alteration

standard. BCIL shall identify in any such report whether it is challenging MGH's determination based upon "a" or "b", above. For any such determination that BCIL is challenging based upon "b", above, MGH shall, within 30 days, provide all information within its possession and control which shows what, if any, Alterations, have been undertaken in the portion of the facility where the barrier is located. If, after receiving the information, BCIL concludes that the barrier should be removed, the Parties shall follow the Dispute Resolution procedure in Section VIII. In the event there is a determination that the relevant portion of the facility has undergone an Alteration, removal of the barrier shall be undertaken as required by the Disability Rights Laws. Notwithstanding the foregoing, nothing in this Agreement shall obligate MGH to make more inpatient rooms, inpatient bathrooms and inpatient toilet rooms accessible than would be required under Section 6.1(4) of the ADAAG and/or 521 CMR 13.3.1. Further, nothing in this Agreement shall obligate MGH to make more patient examination and diagnostic rooms accessible than are required to provide equal access and equal benefits to individuals with disabilities.

6. Following completion of the pilot survey the parties will meet and confer within 30 days to determine whether the scope of the assessments as set forth in Attachment B should be modified to ensure a full identification of architectural barriers. If the parties cannot agree on modifications to the scope of the assessment, they will treat their failure to reach agreement as a dispute to be resolved in accordance with Section VIII.

7. Upon determination of the scope of the survey, MGH shall cause a survey to be taken of whatever portion of MGH existing facilities is necessary to identify barriers in all facilities identified in Attachment A, other than those areas covered by the pilot survey. The survey shall be completed by December 31, 2010.

8. Within 180 days of the completion of the survey a survey report and a barrier removal plan will be provided to BCIL. The survey report will include the following: (a) a description of each major element that deviates from the ADA Standards for Accessible Design, 28 C.F.R. Part 36, App. A and the Rules and Regulations of the Massachusetts

Architectural Access Board (“MAAB”), 521 Code of Massachusetts Regulations §1.00 et seq.; and (b) the Architectural Consultant’s rating of the severity of the identified barrier.

9. The Barrier Removal Plan, which shall incorporate the Pilot Barrier Removal Plan, will identify all barriers which MGH proposes to remove under the readily achievable barrier removal standard or otherwise. For any barriers for which MGH determines removal is not readily achievable, it shall propose a readily achievable alternative solution, or provide an explanation as to why it concludes that there is no such readily achievable alternative. The barrier removal plan will include MGH’s proposed timeline for completing barrier removal and/or implementation of alternative solutions. The survey report and barrier removal plan may be produced as a single document at MGH’s discretion. Each year during the term of this Agreement, MGH will provide to BCIL a schedule of Barrier Removal projects scheduled to be undertaken during such year, which BCIL understands will be based upon capital budgets and other priorities and obligations of MGH, as well as its ultimate obligations under this Agreement. Each year’s schedule will include a reasonable percentage of the total barrier removal projects that will be undertaken that year.

10. Within 90 days of receiving the Barrier Removal Plan, BCIL may provide a report to MGH which identifies any barriers not scheduled for removal in the Barrier Removal Plan and which BCIL reasonably believes should be removed based upon BCIL’s good faith assessment that such removal (a) is readily achievable or (b) is subject to the Alteration standard. BCIL shall identify in any such report whether it is challenging MGH’s determination based upon “a” or “b”, above. For any such determination that BCIL is challenging based upon “b”, above, MGH shall, within 30 days, provide all information within its possession and control which shows what, if any, Alterations, have been undertaken in the portion of the facility where the barrier is located. If, after receiving the information, BCIL concludes that the barrier should be removed, the Parties shall follow the Dispute Resolution procedure in Section VIII. In the event there is a determination that the relevant portion of the facility has undergone an Alteration, removal of the barrier shall be undertaken

as required by Disability Rights Laws. Notwithstanding the foregoing, nothing in this Agreement shall obligate MGH to make more inpatient rooms, inpatient bathrooms and inpatient toilet rooms accessible than would be required under Section 6.1(4) of the ADAAG and 521 CMR 13.3.1. Further, nothing in this Agreement shall obligate MGH to make more patient examination and diagnostic rooms accessible than are required to provide equal access and equal benefits to individuals with disabilities.

11. The Yawkey Center for Outpatient Care shall be surveyed in either the pilot or follow-up survey and any barriers identified shall be removed under the new construction standard in the Disability Rights Laws.

12. MGH shall complete the architectural barrier remediation contemplated by this agreement by the expiration date of the agreement.

13. When the Building for the Third Century is completed the Architectural Consultant shall conduct an architectural barrier survey to identify each major element that deviates from the ADA Standards for Accessible Design, 28 C.F.R. Part 36, App. A and the Rules and Regulations of the Massachusetts Architectural Access Board (“MAAB”), 521 Code of Massachusetts Regulations §1.00 et seq. If any barriers are identified they shall be removed.

14. If at any time while this agreement is in effect, MGH plans to undertake a renovation, modification and/or improvement to any part of the Facilities or to undertake new building construction or renovation of existing or newly acquired or leased buildings, any of which exceeds Ten Million Dollars (\$10,000,000) in construction costs and which affects the renovation, modification and/or improvement of inpatient rooms, inpatient bathrooms or toilet rooms, exam and treatment rooms or bathrooms associated with exam and treatment rooms, all relevant documents shall be submitted to the Architectural Consultant or some other architectural consultant acceptable to BCIL for a plan review sufficient to show compliance with Disability Rights Laws prior to commencement of any work and within an early enough timeframe for a meaningful review. Such architectural consultant shall complete the plan

review within a reasonable period of time. MGH will review any recommendations for changes and will either accept them, reject them or propose alternative means for addressing the issues identified in the plan review. If MGH accepts the recommended changes they shall be put into effect forthwith. If MGH rejects them or proposes alternative solutions, the parties shall promptly meet and confer regarding such determination. If the parties cannot agree on a final plan, they will treat their failure to reach agreement as a dispute to be resolved in accordance with Section VIII below. Any renovation, modification and/or improvement project to any part of the Facilities that does not reach the threshold identified above shall be reviewed internally for compliance with the Disability Rights Laws and any variances from such laws will be addressed. The tool used for such internal review will be shared with BCIL when developed.

B. Policies and procedures and ADA Training

1. MGH shall retain an Access Policy Consultant or consultants satisfactory to BCIL to assist it in its policy and procedure and ADA training review and development process. BCIL will not unreasonably withhold its approval of such consultant(s).

2. Within 60 days of the effective date of this Agreement, MGH will furnish to BCIL copies of any MGH policies which relate to the following subject matters and which apply to persons with disabilities: alternative formats; communication access; service access; scheduling exam rooms and patient room access; location, maintenance and use of accessible medical equipment; weight measurement; auxiliary aids and services; accessible websites; lifting and transferring patients with mobility disabilities; maintenance of accessible features, aids and services; and patient complaints.

3. Within 120 days of the effective date of this Agreement, MGH, in consultation with its Access Policy Consultant, shall review all existing policies and procedures relating to the services, treatment and care provided to individuals with disabilities (including, but not

limited to, patients, their guests, and other visitors) for consistency with the ADA and this Agreement in order to determine whether any additional policies or procedures, or changes to existing policies and procedures, are necessary to comply with the ADA or to effectuate the purposes of this Agreement. The subject matters to be considered in such review shall include, but not be limited to, the subject matters set forth in paragraph 2 above.

4. After MGH and its Access Policy Consultant have completed the necessary preliminary work in gathering and assessing information regarding MGH's policies and procedures, MGH, together with its consultant, will meet with BCIL to discuss MGH's plans with regard to the revision of its policies and procedures and to receive input and suggestions from BCIL regarding the same. Such input and suggestions from BCIL will be considered in good faith as part of MGH's review process hereunder.

5. MGH shall then prepare new and revised policies and procedures, as necessary, and shall submit all such new and revised policies and procedures to BCIL.

6. Within 60 days of receiving MGH's new and revised policies and procedures, BCIL will review and comment on them and, if necessary, propose revisions. MGH shall consider any proposed revisions and make appropriate changes in good faith. If the parties cannot agree on the modifications and/or additions to the policies and procedures, they shall follow the Dispute Resolution Procedure set out in Section VIII of this Agreement. Within 150 days of reaching agreement with BCIL on the policies and procedures, MGH shall finalize them and disseminate them to the appropriate personnel, provide copies of each to BCIL, and begin to implement them.

7. MGH, in consultation with its Access Policy Consultant or other training consultant, shall develop a training program for all employees whose practice or job responsibilities include patient and/or family contact. After MGH and its training consultant have completed the necessary preliminary work and before preparation of the program, MGH, together with its consultant, will meet with BCIL to discuss its plans regarding the training program and to receive input and suggestions from BCIL regarding the substance and format

of the training program. Such input and suggestions will be considered in good faith as part of the training program development process.

8. BCIL will be furnished a copy of MGH's Disability Training Program upon its completion, which shall be no more than 180 days after dissemination of new and modified policies and procedures, as set forth in paragraph 6, above. Within 60 days of receiving the Program, BCIL will review and comment on the Program and, if necessary, propose revisions. MGH shall in good faith consider any such proposed revisions and make appropriate changes. If the parties cannot agree on the modifications and/or additions to the Program and the dispute involves a claim that either the content of the Program fails to address a legitimate training need or MGH is failing to fulfill its training commitment described above, or BCIL can demonstrate that the training methods adopted by MGH will not achieve the training objective, they shall follow the Dispute Resolution Procedure set out in Section VIII of this Agreement. The Disability Training Program will begin to be implemented within 60 days after its adoption.

9. MGH will ensure that all employees whose practice or job responsibilities include patient and/or family contact are provided appropriate training on disability awareness and on providing equal access to medical services for patients with disabilities, including, among other things, the particular needs and concerns of patients with mobility and sensory disabilities. MGH shall also provide and promote opportunities for contractors whose practice or responsibilities include patient and/or family contact to participate in the Disability Training Program. It is anticipated that the Disability Training Program may vary for different categories of employees, and training methods will be adapted as necessary.

10. MGH will make its Disability Training Program available on an on-going basis for the duration of this Agreement. MGH shall require all newly hired employees providing direct patient assistance to be appropriately trained in their responsibilities under the Disability Rights Laws within a reasonable time from their initial hire date. MGH shall also provide opportunities for new contractors to receive similar training.

C. Accessible Medical Equipment

1. MGH will engage an Accessible Medical Equipment [“AME”] consultant satisfactory to BCIL to evaluate the need for additional AME at MGH. BCIL will not unreasonably withhold its approval of such consultant.

2. Within 90 days of the AME consultant’s appointment, the consultant shall develop a survey tool to assess the existence and effectiveness of MGH’s medical equipment to provide health care services to individuals with disabilities. MGH shall submit the survey tool and list of equipment to be surveyed to BCIL for approval, which approval shall not be unreasonably withheld. BCIL shall review and comment on the survey tool and/or make recommendations for revisions within 30 days of receiving the survey tool. If BCIL recommends any revisions, MGH shall consider in good faith making appropriate changes. If the parties cannot agree on the survey tool, they shall follow the Dispute Resolution procedures set out in Section VIII, below.

3. Within 180 days of receiving BCIL’s approval of the survey tool, MGH shall complete a survey within the Facilities of equipment that is utilized in the care of patients. This equipment shall include but may not be limited to examination tables and chairs, lifts, radiologic and diagnostic equipment, wheelchair scales, positioning equipment, specialized air mattresses, or other adaptive technology for patients with disabilities, such as accessible call buttons and water sources.

4. Within 180 days of the completion of the equipment survey, MGH shall submit to BCIL a report which includes (a) the current equipment surveyed; (b) a description of any barriers to providing equal access to medical services, including, but not limited to, barriers posed by the existing equipment, or the lack thereof, its placement, installation, and/or operation; (c) recommendations for the purchase of additional equipment, relocation, supplementation, or modification of the existing equipment, and other methods to eliminate barriers, or, if no new equipment or modifications to existing equipment would overcome a

barrier posed by the existing equipment or it is an undue burden to purchase or modify equipment, what alternatives should be utilized to ensure that individuals with disabilities receive equal access to medical services; and (d) a schedule for the recommended purchase and modification of the equipment and the implementation of other related barrier removal efforts. Within 45 days of receiving MGH's report, BCIL shall review and comment on MGH's recommendations and/or propose revisions. MGH shall consider in good faith making appropriate changes. If the parties cannot agree on the recommendations, they shall follow the Dispute Resolution procedure set out in Section VIII of this Agreement. Upon agreement, MGH shall immediately begin purchasing equipment in accordance with the schedule.

VI. OUTREACH

MGH agrees to review and, if necessary, update or modify its community relations policies and procedures to ensure that the community is aware of MGH's continuing commitment to providing equal access to patients, regardless of disability.

VII. REPORTING

A. Status Reports

1. During the term of this Agreement, on a semi-annual basis, commencing on December 1, 2009, MGH shall provide BCIL with status reports describing the work done in the prior 6 months and work to be done in the 6 months following the report to implement the terms of Section V.A, V.B and V.C above.

2. The status reports shall include the following:

- a. The extent to which MGH has completed the work under this agreement;
- b. The extent to which MGH has modified the work under this agreement and the reason(s) for such modifications;

c. A list of any renovation, modification and/or improvement project to any part of the Facilities that exceeds Two Million Dollars (\$2,000,000) in construction costs and that was reviewed internally pursuant to Section V(A)(14) during such time period.

d. What problems, if any, MGH has encountered that has resulted in a delay of or modification to proposed work; and

e. MGH's proposal to remedy any problems that have resulted in a delay of work required under this agreement.

3. Status Reports shall be reviewed by the Architectural, Access Policy and AME Consultants, or other qualified consultants acceptable to BCIL, who shall validate MGH's compliance in the Status Report regarding its obligations under Sections V.A, V.B and V.C of this Agreement. The Consultants will be provided with access and information required for such validation to be meaningful.

B. Final Report

MGH shall submit to BCIL a final report 3 months before the expiration date of this agreement. This report shall describe MGH's compliance with this agreement, and any unmet obligations under this agreement, the reasons they are unmet, and the proposed resolutions.

C. Complaint Reporting

MGH shall, consistent with any applicable patient confidentiality obligations, include a summary of written and oral complaints made to MGH through its Patient Advocacy department regarding architectural barriers, policies, practices and procedures, and accessible medical equipment as they relate to disability access. These complaint summaries will include the following information about each complaint:

1. The date of the incident that is the subject of the complaint;

2. The facility that is the subject of the complaint;
3. The issue raised in the complaint;
4. The form of the complaint (phone call, letter, email, in-person complaint, etc.);
5. The relief requested in the complaint; and
6. MGH's response to the complaint, if any, any actions taken or planned to be taken, including the timeline for completion of any action still in progress.

VIII. DISPUTE RESOLUTION

Except as otherwise specified, the Parties agree that any dispute arising out of this agreement relating to its interpretation and application, including the performance of obligations set forth herein shall be addressed in the following manner:

1. Any party complaining that a violation has occurred or that a dispute has arisen as to the interpretation and application of this agreement will give notice to counsel for the other party. Such notice shall set forth the complaint/dispute and shall propose a resolution.

2. Within two weeks of delivery of the written claim of such alleged violation or dispute the parties shall meet and confer in an effort in good faith, through informal negotiation, to resolve the issue.

3. If the issue remains unresolved after a reasonable period of meeting and conferring, the parties will attempt to resolve the matter in mediation, using a mediator who is jointly selected by the parties.

4. If mediation does not resolve the dispute, it will be settled by means of arbitration. The matter must be submitted to arbitration by the complaining party within 30 days after the conclusion of mediation. Any dispute arising under the Agreement shall be submitted to Gordon Doerfer, Elizabeth Butler, or Rudolph Kass, individually on a rotating basis, and shall be conducted pursuant to the Judicial Arbitration and Mediation Services (JAMS) Streamlined Arbitration Rules and Procedures. A fourth arbitrator may be added to the panel after

execution of this Agreement upon agreement by both parties. The arbitration shall take place in Boston. The award of the arbitrator will be enforceable in a court of competent jurisdiction. If any named arbitrator is no longer serving as an arbitrator, the parties shall name a mutually agreeable replacement.

5. All communications, negotiations and/or documents exchanged by and between the parties in the course of an arbitration shall be confidential, except for communication of information that is generally available to the public. No evidence of any communications, negotiations and/or documents or any admission made or recommendation agreed to during the course of any arbitration will be admissible or subject to discovery outside of the arbitration proceeding or adjudication, civil action or other legal proceeding. The Arbitrator shall issue such protective orders as may be necessary to protect confidential information from unnecessary disclosure and shall specifically designate information subject to the protective order as Confidential and Sensitive Information. On a reasonable date after the termination of jurisdiction over an Action, and consistent with the Parties' Counsels' obligations to retain case documents pursuant to their malpractice insurance policies, each party shall return or destroy all documents obtained from the other party during the course of the arbitration, and shall provide to the other party an authorized representative's attestation indicating that all such information has been returned or destroyed.

6. Attorneys' fees and costs attributable to dispute resolution pursuant to this arbitration, including costs for the services of any arbitrator, will be awarded as follows:

a. If Plaintiffs prevail on all claims raised in the dispute resolution process, they shall recover their reasonable attorney's fees, expenses and costs in full;

b. If Plaintiffs prevail on some but not all claims raised in the dispute resolution process they shall recover their reasonable attorneys' fees, expenses and costs excluding time, expenses and costs in accordance with *Hensley v. Eckerhart*, 461 U.S. 424 (1983) and its progeny and offset by the reasonable attorneys' fees, expenses and costs

incurred by MGH for time spent defending Claimants' unsuccessful claims that the arbitrator finds to have been frivolous, unreasonable, or without foundation; and

c. If MGH prevails on all claims raised in the dispute resolution process, MGH shall recover its reasonable attorney's fees, expenses and costs in full from Plaintiffs for time spent defending Claimants' unsuccessful claims that are found by the arbitrator to have been frivolous, unreasonable or without foundation.

IX. MISCELLANEOUS PROVISIONS.

7. Notice or Communication to Parties

Any notice or communication required or permitted to be given to the Parties hereunder shall be given in writing by email and first class United States mail, addressed as follows:

To Claimants:

Daniel S. Manning
Greater Boston Legal Services
197 Friend Street
Boston, MA 02114
E-mail: dmanning@gbls.org

To Massachusetts General Hospital

Joshua Abrams
Office of General Counsel
Partners Healthcare
50 Staniford Street
Boston, MA 02114
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8. Modification in Writing

No modification of the Agreement shall be effective unless in writing and signed by authorized representatives of all Parties.

9. Agreement Binding on Assigns and Successors

The Agreement shall bind any assigns and successors of the Parties. Counsel shall be notified in writing within thirty (30) days of the existence, name, address and telephone number of any assigns or successors of MGH.

10. No Admission of Liability

In entering into the Agreement, MGH does not admit, and specifically denies, that it has violated or failed to comply with any Disability Rights Laws.

For Massachusetts General Hospital:

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President
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Brent L. Henry
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Counsel for Massachusetts General Hospital

For Claimants:

Bill Henning
Boston Center for Independent Living

Theresa Baino
Claimant

Stacy Berloff
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Disability Rights Advocates
Counsel for Claimants

ATTACHMENT A

Buildings with Licensed MGH Occupancies To Be Included in Survey (Owned and Leased)

Building Name	Address	Location	Status	Comments
Bartlett Building	40 Blossom Street	Boston	Owned	
Bartlett Extension	40R Blossom Street	Boston	Owned	
Blake Building	273 Charles Street	Boston	Owned	
Bowdoin Square	1 Bowdoin Square	Boston	Leased	
Bulfinch Building	66 Blossom Street	Boston	Owned	
Burr Proton Therapy Center	30 Fruit Street	Boston	Owned	
Charles River Plaza East	165 Cambridge Street	Boston	Owned	
Charles River Plaza South	175 Cambridge Street	Boston	Owned	
Charles Street Parking Garage	165 Cambridge Street	Boston	Owned	
Cox Building	100 Blossom Street	Boston	Owned	
Edwards Cardiopulmonary	60 Blossom Street	Boston	Owned	
Edwards Research	60 Blossom Street	Boston	Owned	
Ellison Tower	267 Charles Street	Boston	Owned	
Founders House	265 Charles Street	Boston	Owned	
Fruit Street Parking Garage	Fruit Street	Boston	Owned	
Gray / Bigelow	90 Blossom Street	Boston	Owned	
Gray / Jackson	80 Blossom Street	Boston	Owned	
Holiday Inn Select	5 Blossom Street	Boston	Leased	
MGH Back Bay	388 Commonwealth Ave	Boston	Leased	
New Chardon #25	25 New Chardon Street	Boston	Leased	
Parkman Street Parking Garage	10 Parkman Street	Boston	Owned	
Professional Office Building	275 Cambridge Street	Boston	Owned	
Wang Ambulatory Care Cntr	15 Parkman Street	Boston	Owned	
Warren	275 Charles Street	Boston	Owned	
Wellman-Thier	60 Blossom Street	Boston	Owned	Exclude floors 2 up
West End House	16 Blossom Street	Boston	Owned	First floor only; DPH waiver to provide services in other MGH facilities
White Building	55 Fruit Street	Boston	Owned	
Yawkey Center Outpatient Care	32 Fruit Street	Boston	Owned	Includes Parking Garage

Other Locations

Building Name	Address	Location	Status
MGH Imaging Center	13th Street, # 149	Charlestown	Leased
Charlestown Healthcare	73 High Street	Charlestown	Leased
MGH Charlestown Mental Health Clinic	76 Monument Street	Charlestown	Leased
Chelsea Adult Med	100 Everett Avenue	Chelsea	Leased
Chelsea Health Center	151 Everett Avenue	Chelsea	Leased
Emerson Hospital	131 Ornac Road	Concord	Leased
MGH North Shore ACC	100 A Endicott Street	Danvers	Owned
Everett Health Center	19 Norwood Street	Everett	Leased
Revere Health Center (Ocean)	300 Ocean Ave	Revere	Leased
Revere HealthCare Center (Broadway)	300 Broadway	Revere	Leased

MGH West - 52 Second Ave	52 Second Avenue	Waltham	Leased
MGH West - PARC Building	40 Second Avenue	Waltham	Leased

Buildings with Non-Licensed MGH Occupancies To Be Included in Survey (Owned and Leased)

Building Name	Address	Location	Status	Comments
Charles River Plaza North	185 Cambridge Street	Boston	Owned	Exclude floors 4 up
Emerson Place #0	0 Emerson Place	Boston	Leased	
Emerson Place #10	10 Emerson Place	Boston	Leased	
Hawthorne Place #01	1 Hawthorne Place	Boston	Leased	
Longfellow Place #02	2 Longfellow Place	Boston	Leased	
Longfellow Place #05	5 Longfellow Place	Boston	Leased	
MGH Downtown	294 Washington Street	Boston	Leased	
North End Health Center	332 Hanover Street	Boston	Leased	
Staniford Street #50	50 Staniford Street	Boston	Leased	

Other Locations

Building Name	Address	Location	Comments
MGH Fresh Pond	185 Alewife Brook Parkway	Cambridge	Leased
Building #114	114 16th Street	Charlestown	Leased
Charlestown Boys & Girls Club	15 Green Street	Charlestown	Leased
Charlestown Health Center	75 West School Street	Charlestown	Leased
Center Parking Lot			
Charlestown Parking Garage	199 13th Street	Charlestown	Owned
Chelsea Imaging Center	80 Everett Avenue	Chelsea	Leased
North Shore MOB	100 B Endicott Street	Danvers	Owned by PHS
Patriot Place	One Patriot Place	Foxboro	Leased
General Med. Assoc.	101 River Street	Weston	Leased

Description of Areas to Be Included and Excluded in the Barrier Removal Survey

Clinical Areas: All useable areas where patient care, diagnosis and treatment takes place, including inpatient and outpatient status, and including areas occupied by clinical and supporting department administration if the public travels to these areas.

Includes:

- Inpatient units of all categories
- Outpatient areas including hospital and physician organization practices, private MD practices in owned buildings
- Ambulatory care practice areas as described above in leased sites except for private hospital-affiliated MD practices where we have no jurisdiction over, or full knowledge of, privately leased sites
- Labs (blood, infusion, pharmacy, etc) open to patients in leased and owned buildings
- Any patient care, research or administrative facilities where “human subjects” (who perceive themselves to be patients) are seen for clinical research or clinical trials purposes
- Any sites where patient care or health information is provided free of charge to the community

Excludes:

- Physically discreet areas room types on a floor that provide clinical and/or operations support, but are clearly closed to patients and visiting public, such as service corridors on inpatient units, support closets accessible to staff only, locker rooms, nurse stations, etc
- OR's and procedure rooms and related support areas where patients are sedated and not ambulatory or in control of their movement in and out of the space.
- Administrative floors in leased space where there are few or no visitors, and no patients or human subjects, and that are not open to the public.
- Vertical shafts, penetrations and wall areas on clinical floors.

Public Areas

Includes:

- In owned buildings, all areas open to patients and visiting public, patients and human subjects, such as corridors, lobbies, lounges, bathrooms, on floors where any clinical or administrative activity takes place. Also, amenity services, whether leased or owned.
- In leased buildings, common areas on the ground floor and leased floors that patients and visiting public would use (to the extent possible under lease).
- Owned parking structures and lots.

Excludes:

- Vertical shafts and penetrations
- Exterior and interior wall area
- Mechanical and building systems infrastructure areas (roof, atrium, etc.)

Research Areas

Includes:

- Areas that human subjects would go for clinical trials.

Excludes:

- Research labs and animal facilities.

Other areas excluded:

Operations and clinical support floors not open to visitors or patients, such as Buildings & Grounds shops, pharmacy and clinical lab processing areas, etc.

ATTACHMENT B

Scope of the Architectural Barriers Assessment

Massachusetts General Hospital

B=Basic
B=Selected
Option
D=Declined
Option
H=Hourly

ADA Surveys Scope Definition

Updated '5-29-09

1 Standards and Laws as Basis for Surveys			
2	Standards to be used in surveys		
3	Current ADA Standards (1994)	B	Yes.
4	Proposed New ADA Standards	B	Yes, for internal informational purposes only
5	UFAS	D	No
6	State Standards	B	Yes
7	Local Standards	D	None
8	Client - specific preferences	D	None
9	Program Access issues for 504 compliance	D	No
10	Question staff to understand programs and access options	D	No
11	Construction and Manufacturing Tolerances	B	
12	Acceptable Measurements	B	
13			
14 Areas/Elements to Survey			
15	Use Codes to survey	B	
16	Site work	B	Yes
17	Exterior routes in Public Right of Way (on or immediately adjacent to facility property or constructed by or controlled by facility)	B	Yes, as necessary to provide accessible routes to the hospital from the nearest subway and bus stops and from the nearest parking garages, and over public ways between hospital controlled facilities on campus, and from accessible passenger loading zones into and connecting each of the primary accessible entrance(s) to the facilities.
18	Site surveys	B	Yes
19	Campus and site accessible routes	B	Yes
20	Entrances	B	Yes
21	Slopes & cross slopes	B	Yes
22	Parking		
23	Accessible areas	B	Survey all public parking areas for circulation path
24	All areas	B	requirements - discuss dispersal of accessible spaces w/
25	On-Street parking	D	Not included
26	Parking requirements	B	Yes
27	Entrances	B	Yes
28	GSF / ADA Healthcare category	B	Yes, what is this?
29	Program access	D	No
30	Transportation		
31	Transportation Vehicles	D	No
32	Fixed routes & Stops (including shuttle services)	D	No
33	Bus stops - Public transportation	B	Yes, when on or immediately adjacent to facility property or constructed by or controlled by facility.
34	Public & Patient vs Employee Areas		
35	Patients	B	Yes, all areas used by ambulatory patients [Does not typically include OR's and recovery areas where all patients are assisted and which exclude family members unless covered below.]
36	General public, visitors & family	B	Survey all Patient, Family, Visitor & Public spaces
37	Activity Rooms	B	Survey all Patient, Family, Visitor & Public spaces
38	Auditoriums	B	Survey all Patient, Family, Visitor & Public spaces
39	Cafeterias & Restaurants	B	Survey all Patient, Family, Visitor & Public spaces
40	Chapels	B	Survey all Patient, Family, Visitor & Public spaces
41	Classrooms	B	Survey all Patient, Family, Visitor & Public spaces
42	Conference Rooms	B	Survey all Patient, Family, Visitor & Public spaces
43	Daycare Centers	B	Survey all Patient, Family, Visitor & Public spaces
44	Diagnostic services areas	B	Survey all Patient, Family, Visitor & Public spaces
45	Gardens, Courtyards, Outdoor Plazas, etc.	B	Survey all Patient, Family, Visitor & Public spaces
46	Gift & Retail Shops	B	Survey all Patient, Family, Visitor & Public spaces
47	Internet Stations	B	Survey all Patient, Family, Visitor & Public spaces
48	Learning Centers	B	Survey all Patient, Family, Visitor & Public spaces
49	Libraries	B	Survey all Patient, Family, Visitor & Public spaces
50	Lounges, Day Rooms, etc.	B	Survey all Patient, Family, Visitor & Public spaces
51	Museum and Exhibit spaces	B	Survey all Patient, Family, Visitor & Public spaces
52	Pharmacies	B	Survey all Patient, Family, Visitor & Public spaces
53	Physical Therapy & Occupational Therapy areas	B	Yes, however, spaces and elements used to teach people with disabilities adaptive approaches to environmental difficulties are not required to comply with any accessibility standards.
54	Playgrounds	B	Survey all Patient, Family, Visitor & Public spaces
55	Transient Lodging	B	Survey all Patient, Family, Visitor & Public spaces
56	Treatment Areas	B	Survey all Patient, Family, Visitor & Public spaces
57	Waiting Rooms	B	Survey all Patient, Family, Visitor & Public spaces

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ADA Surveys Scope Definition

Updated '5-29-09

		B=Basic B=Selected Option D=Declined Option H=Hourly	
58	etc.		
59	Student/intern/resident areas (May need to separate students	D	No
60	Auditoriums	D	No
61	Break Rooms	D	No
62	Classrooms	D	No
63	Conference Rooms	D	No
64	Dressing Rooms/Locker Rooms	D	No
65	Libraries	D	No
66	Lounges	D	No
67	Non-public areas	D	No
68	Research Areas	D	No
69	Showers	D	No
70	Sleep Rooms	D	No
71	Work Stations	D	No
72	etc.	D	No
73	Volunteer areas	D	No
74	Break Rooms	D	No
75	Classrooms	D	No
76	Conference Rooms	D	No
77	Dressing Rooms/Locker Rooms	D	No
78	Lounges	D	No
79	Non-public areas	D	No
80	Work Stations	D	No
81	etc.	D	No
82	Areas for physicians' with hospital privileges (All physicians may	D	No
83	Auditoriums	D	No
84	Break Rooms	D	No
85	Classrooms	D	No
86	Conference Rooms	D	No
87	Dressing Rooms/Locker Rooms	D	No
88	Libraries	D	No
89	Lounges	D	No
90	Non-public areas	D	No
91	Research Areas	D	No
92	Showers	D	No
93	Sleep Rooms	D	No
94	Work Stations	D	No
95	etc.	D	No
96	Staff classrooms in MOB's and hospitals	B	Yes, but only if they are ever used by patients or public during or after hours
97	Staff conference rooms in MOB's and hospitals	B	Yes, but only if they are ever used by patients or public during or after hours
98	Non-public areas used by staff only (includes storage & mechanical	D	No - Reasonable accommodations will be made as needed
99	Patient rooms		
100	Accessible rooms & target acc. rms.	B	
101	One of ea. type in ea. location	D	No
102	All	D	No
103	Toilet rooms	B	
104	Accessible patient room toilet rooms	B	
105	Patient common use toilet, shower, and tub rooms	B	
106	Public toilet rooms	B	
107	Selected employee toilet rooms	D	No
108	All employee toilet rooms	D	No
109	Private office toilet rooms	D	No
110	Transient lodging		
111	Public use, in house hotel rooms	B	Yes, including any sleep areas within or adjacent to lounges.
112	Doctors' sleep rooms	D	No
113	Employee only areas		
114	Common Use areas	D	Not when used only by employees
115	Work areas	D	Not when used only by employees
116	Work stations such as employee only areas of nurse stations	D	Not when used only by employees
117	Maintenance & storage	D	Not when used only by employees
118	Landlord-controlled areas (where Client is tenant)	D	No
119	Stop at lease lines	D	No
120	Accessible routes	D	No
121	Elevators	D	No
122	Circulation paths	D	No
123	Parking	D	No

Massachusetts General Hospital

ADA Surveys Scope Definition
 Updated '5-29-09

		B=Basic B=Selected Option D=Declined Option H=Hourly	
124	Toilet rooms	D	No
125	etc.	D	No
126	Tenants (except doctors) (where Client is landlord)	D	No
127	Stop at door	D	No
128	Accessible routes	D	No
129	Circulation paths	D	No
130	Public areas	D	No
131	Other	D	No
132	Doctor's offices in MOB's and Hospitals	B	Yes, in spaces where healthcare services are provided
133	Front door	B	Yes, in spaces where healthcare services are provided
134	Reception / Waiting / Checkin	B	Yes, in spaces where healthcare services are provided
135	Processing station (vitals)	B	Yes, in spaces where healthcare services are provided
136	Toilet rooms		
137	General public toilet rooms	B	
138	Specimen toilet rooms	B	
139	Dressing rooms	B	
140	Exam rooms	B	
141	Special procedure rooms	B	
142	Labwork areas (blood draw)	B	
143	Consultation rooms	B	Yes. Using Consultation Room survey selection guidelines.
144	Doctors' private offices	B	Yes. Using Private Physician's, Practitioner's, and Provider's Offices survey selection guidelines.
145	Other areas	B	Yes, in spaces where healthcare services are provided
146	Employee only areas	D	No - Reasonable accommodations will be made as needed
147	Exam rooms		
148	Typical & new issue room/facility	B	
149	At least one of ea. type in ea. location	B	
150	All	D	No
151	Patient Dressing rooms		
152	One per location	B	
153	Laboratories, Special procedure, and research rooms		
154	Patient testing (blood draw, urine, etc.)	B	
155	Special procedure rooms		
156	Exam, treatment, and special procedure rooms		
157	Active, ambulatory patients and/or guests	B	
158	Passive patients w/out guests or family	D	No
159	Specimen collection toilet rooms	B	
160	Patient Dressing rooms	B	
161	Research	D	No
162	Employee only areas	D	No
163	Doors	B	Yes, where used by at least one covered group of users
164	Stairs		
165	ADA-covered stairs	B	Yes.
166	State-covered stairs	B	Yes
167	All other stairs - key issues	B	Yes, but for circulation path, signage, and alarm issues only
168	All other stairs - full detail	D	No
169	Signage		A detailed signage solution is outside the scope of this survey
170	Required signs		
171	Permanent room or space designator signs	B	
172	Directional or functional space information signs	B	
173	Other required signs	B	Yes
174	Suggested wording for selected signs	D	No
175	Full detail sign survey / specs	D	No
176	Alarms		
177	Survey	B	Work with hospital alarm consultants to coordinate survey approach and verify compliance during normal testing cycles.
178	Test	B	
179	Telephones and Communications systems		
180	TTY's	B	Yes
181	Pay telephones	B	Yes
182	House telephones		
183	Public House Phones	B	Working with Hospital, identify and survey only banks used by patients and the general public.
184	Employee Only Phones	D	No - Reasonable accommodations will be made as needed
185	Signage related to House Phones	B	Yes, at public use House Phones only
186	Patient Telephones and Nurse call units	B	Discuss w/ Hospitals

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ADA Surveys Scope Definition

Updated '5-29-09

187	ATMs			
188		Full detail	B	Yes
189		Interpretation for people w/visual impairments	B	Yes. Note accommodations provided. If talking ATM's are provided, consider them compliant.
190	Non-Clinical Equipment			
191		Point of sale devices	B	Only where used by patient or general public
192		Vending machines	B	Only where used by patient or general public
193		Kiosks for information and other transactions	B	Only where used by patient or general public
194		Pantry drink & food dispensers	B	Only where used by patient or general public
195		Infection control solution and foam dispensers	B	Only where used by patient or general public
196		Other	B	Only where used by patient or general public
197	Clinical Equipment			
198		Exam tables	D	
199		Exercise equipment	D	
200		Imaging, diagnostic, & testing equipment	D	
201		Other equipment with architectural space requirements that is	D	
202		Other equipment with no architectural space requirements	D	
203		Patient scales to accommodate wheelchair users and bariatric	D	
204		Physical Therapy & OT equipment	D	
205		Other	D	
206	Furniture		B	Yes, Verify required accessible route widths between furniture and required features such as knee clearances at accessible units. Verify that clear floor spaces are available for wheelchair users in waiting rooms. Will survey in patient and public use areas only.
207	Furnishings		B	Yes, verify required accessible route widths between furnishings, protruding object problems, and required features such as knee clearances at accessible units and operable controls within reach. Will survey in patient and public use areas only.
208	"Sinks" by type under 1994 Standards as "G" Severity			
209		Lavatories (associated with toilets)	B	Yes
210		True sinks (under ADA Standards at 9.2.2(7))		
211		Accessible kitchenettes in transient lodging	B	Yes.
212		Accessible housing (>6 mo.stay) kitchenettes	D	
213		Common use "sinks" (dispensers)		
214		Conference room bar "sinks"	B	Only where used by patient or general public
215		Break room "sinks"	B	Only where used by patient or general public
216		Pantry "sinks" on nursing units	B	Only where used by patient or general public
217		Doctors' surgery scrub "sinks"	D	Only where used by patient or general public
218		Other	B	Only where used by patient or general public
219		Program Access "sinks"	B	Only where used by patient or general public
220		"Activities of Daily Living" OT program	D	Only where used by patient or general public
221		Classroom "sinks" for student use	B	Only where used by patient or general public
222		Graduate student reasearch lab. "sinks"	D	Only where used by patient or general public
223		Other	O	Discuss w/ Hospitals
224		Chem/Bio safety "sinks"		
225		Eye wash units	B	Only where used by patients &/or the general public
226		Emergency Showers	B	Only where used by patients &/or the general public
227		Required hand washing "sinks"		
228		Commercial kitchens	D	No
229		Patient rooms - currently designated as "Accessible"	B	
230		Patient rooms - NOT currently designated as "Accessible" but	B	
231		Patient rooms - NOT required to be accessible.	D	No
232		Corridor	D	No
233		Nurse station	D	No
234		Exam rooms		
235		Selected for survey	B	Survey in Pilot, Discuss before full survey.
236		Not selected for survey	D	No
237		Laboratories	D	
238		Research	D	
239		Classroom	D	
240		Employee only	D	
241		Procedure and treatment rooms	B	Survey in Pilot, Discuss before full survey.
242		Other	B	Survey all in Pilot, Discuss before full survey.
243		Soiled utility "sinks"	D	
244		Work station employee only "sinks"	D	
245		Soiled utility clinical "sinks"	D	

Massachusetts General Hospital			<input type="checkbox"/> ADA Surveys Scope Definition Updated '5-29-09
246	Laundry "sinks"	D	
247	Doctors' surgery scrub "sinks"	D	
248	Janitors' mop "sinks"	D	
249	Dish & pot washing "sinks"	D	
250	Food preparation "sinks"	D	
251	Laboratory procedure "sinks"	D	
252	Fume hood "sinks"	D	
253	Darkroom "sinks"	D	
254	Teaching demonstration "sinks"	D	
255	Other	D	
256			
257 Facilities, Areas, and Elements to Survey / Review			
258	Landlord-controlled facilities with lease renewals in less than "x"	D	
259	Landlord-controlled facilities with lease renewals in less than "y" months (long term)	B	Will survey only sites where healthcare services are provided. Will survey internal practice spaces only.
260	Facilities to be abandoned in "x" mo. (short term)	D	No
261	Areas undergoing alteration during the survey period	B	
262	Areas scheduled for alteration in "x" mo.	D	Coordinate timing of surveys, alterations, and future barrier removal work in all areas to increase project efficiencies and reduce costs.
263	Areas scheduled for alteration in "y" mo.	D	Coordinate timing of surveys, alterations, and future barrier removal work in the area to increase project efficiencies and reduce costs.
264	Optional elements / spaces by Severity to survey & show in DB		
265	A Severity: Barriers that might be a safety consideration for	B	Yes
266	B Severity: Barriers that block access to a significant number of	B	Yes
267	C Severity: Barriers that are a major inconvenience to a	B	Yes
268	D Severity: "Barriers" rated by ETA as a minor inconvenience to	B	Survey in Pilot, then review
269	E Severity: ADA Compliant, non-compliant w/state stds.	B	Yes
270	F Severity: Compliant w/ both ADA & State stds.	D	No
271	Parking	D	No
272	Entry doors	D	No
273	Drinking fountains	D	No
274	Telephones	D	No
275	Transaction counters	D	No
276	Elevators and related controls	D	No
277	ATM's	D	No
278	All areas, spaces, and elements	D	No
279	G Severity: Compliant w/ 94 ADA stds.,but not all others	B	"Grandfather" clauses in proposed regulations at 36.304(d) & 36.403(a)(1)
280			
281 Type of survey			
282	ETA Modified Standard Barrier Survey	B	Yes
283			
284 Who to do surveys			
285	ETA Team (Architectural Access Consultants)	B	Yes
286	Facility Staff	D	No
287	Client's Consultants (Arch. Access Consultants)	D	No
288	Single or team surveyors	B	Typically teams of surveyors
289	ETA team assistants	B	Yes
290	Facility staff or Facility-assigned assistants	D	No
291	Short term tag-along assistants	B	Yes, for typical space types
292	Quality assurance		
293	Statistical analysis	B	Yes
294	Spot checks	B	Yes
295	% resurveys	B	Yes, if team members have not worked w/ ETA previously, or if other analysis indicates the need to spot check
296	On-site training	B	Yes
297			
298 How to Survey			
299	"Pilot" or "Model" Survey(s)	B	Pilot Survey will include representative facilities, areas, and elements sufficient to show how the process will work, what the databases will include, and how reports and information will be available.
300	Room by room, issue by issue, or floor by floor	B	Combination
301	Location codes		
302	Notation of Location Codes for Barriers	B	
303	Field notations on drawings	B	Yes, when normal room numbers are not available

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ADA Surveys Scope Definition

Updated '5-29-09

304	Carefully lettered on drawings			Discuss w/ Hospitals
305	CAD overlay layer		O	Discuss w/ Hospitals
306	Responsibility Code use			
307	"Q" list for field determination		O	Discuss w/ Hospitals after Pilot
308	Pre-Survey per Possible Solution type		D	Discuss w/ Hospitals after Pilot
309	Post-Survey per Possible Solution type		O	Discuss w/ Hospitals after Pilot
310	Post survey individual barrier analysis and responsibility		O	Discuss w/ Hospitals after Pilot
311	Photographs			
312	Every barrier		B	
313	Client pref.'s. integrated into process		D	None
314	Survey forms		D	None
315	Possible Solutions		D	None
316	Additional information fields		D	None
317	Level of effort developing solutions			
318	Examples:			
319	Slope problems in parking, entrances		B	Standard surveyor effort
320	Ramp design		B	Standard surveyor effort
321	Phasing for public toilet room barrier removal (by floor)		B	Standard surveyor effort
322	Phasing for patient room barrier removal (by patient room)		B	Standard surveyor effort
323	Facilitate integration with & provide input to FM's coordinating		B	Standard surveyor effort
324	Other		O	Project Specific as documented in Instructions to Surveyors
325	Other		O	Project Specific as documented in Instructions to Surveyors
326	Effort to develop or identify Alternative Methods, Readily Achievable		B	Survey Process for Alternative Methods, Readily Achievable Second Options and Administrative Solutions is still under development.
327	On-site alt. method search			
328	Relocation & directional signs			
329	Using different sites			
330	Coordinating between facilities			
331	Services offered by different doctors			
332	Assignment of members/patients			
333	Cost estimating verification effort			
334	Set cost factors for statewide costs		D	
335	Tailor to local city costs		B	
336	Tailor to specific site/facility		O	
337	Prereview Possible Solutions lists before surveys		D	
338	Review Solutions Used lists post survey		B	
339	Degree of difficulty in gaining access to facilities and spaces			
340	Presurvey meetings/ presentations w/local staff		B	
341	Scheduling		B	
342	Methods / protocol / number of individuals with whom to coord.		B	
343	Off-hour access scheduling		B	Yes, as necessary
344	Surgeries		B	Yes, as necessary
345	Exam rooms		B	Yes, as necessary
346	Procedure rooms		B	Yes, as necessary
347	Other areas		B	Yes, as necessary
348	Interaction with users and staff			
349	Explanation of what we're doing		B	
350	Questions to be answered		B	
351	Tag-along facility staff		D	
352	Security procedures			
353	Notifications		B	
354	Badges		B	
355	Checkin requirements		B	
356	Access to locked rooms/areas		B	
357	Parking availability		B	
358	Availability of survey team work area (room) in each facility			
359	Central location		B	
360	Lockable room w/ team having keys		B	
361	Pagers, cell phone use		B	
362	Availability and usability of plans from FM			
363	Hard copy provided by FM		B	
364	CAD files provided by FM		B	
365	Sketches by surveyors		B	
366	None		D	
367				
368	Report Options			
369	Survey status reports		O	Discuss w/ Hospitals during Pilot
370	Quick reports for selected Responsibility Codes		O	Discuss w/ Hospitals during Pilot
371	Barriers as approved by QA team		O	Discuss w/ Hospitals during Pilot

Massachusetts General Hospital

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ADA Surveys Scope Definition

Updated '5-29-09

372	Database, Export, & Report		
373	Lotus Notes	O	Discuss options w/ Hospital &/or Corporate IT
374	Excel Version	B	Coordinate w/ Hospital &/or Corporate IT
375	Word Version	B	Coordinate w/ Hospital &/or Corporate IT
376	Adobe Reader Version	B	Coordinate w/ Hospital &/or Corporate IT
377	Internet Browser Software and Version	B	Coordinate w/ Hospital &/or Corporate IT
378	Facility Management Software	B	Coordinate output with Archibus and AutoCAD systems in use
379	Administrative Privileges	B	Coordinate w/ Hospital &/or Corporate IT
380	Report Generation Methods		
381	Online view access with search	B	
382	Pre-generated reports in PDF, Word or Excel formats	B	
383	Executive Level Summary Reports	B	
384	Project Completion Status Reports		
385	Surveys	B	
386	Barrier Removal	B	
387	Report Delivery Methods		
388	Self-Service Reports (pre-defined)	B	
389	Scheduled Reports (user-defined)	B	
390	Pre-Defined Draft and Final Reports	B	
391	Interim & Final report formats to include under Basic Services		
392	ArchData by Location Code	B	
393	Bid version of ArchData by Location Code	B	
394	Phase Code sorted with Location Code subsort	B	
395	Barrier Number sorted	B	
396	Other:	H	
397	Report adjustments requested	H	
398	Number of Hard Copies of Reports (with hard copies of photos)		
399	Interim Report(s)	D	
400	"Final" Reports	D	
401	Database & viewer on CD	D	
402	Web-based database with passworded access	B	Yes
403	Specific detailed analyses & reports	H	
404	Coord.w/prior surveys & barrier removal work	D	No
405	Incorporate prior survey reports in database	D	No
406	Barrier Removal Process		
407	Field verification of reported barriers with client's representative	O	Discuss w/ Hospitals
408	ETA review of solutions over specified dollar amount w/client	O	Discuss w/ Hospitals
409	Responsibility Code Assigned to each Barrier	B	Included. Details to be determined after Pilot
410	Added to the Possible Solution Database (Automated)	B	
411	Added during the Barrier Removal Process (Manual)	B	
412	Maintenance Items	B	
413	Policy and Procedure Items	B	
414	Permitted Items (city)	B	
415	Permitted Items (state)	B	
416	Integrate barriers with existing renovation/capital projects	O	Discuss w/ Hospitals
417	Determine funding source (different budget)	O	Discuss w/ Hospitals
418	Possible removal of maintenance items (different budget)	O	Discuss w/ Hospitals
419	Evaluate major cost items	O	Discuss w/ Hospitals
420	Large dollar items vs alternative solutions	O	Discuss w/ Hospitals
421	Verify claims of technical infeasibility	O	Discuss w/ Hospitals
422	Alternative Methods	O	Discuss w/ Hospitals
423	Explore options when items are not readily achievable	O	Discuss w/ Hospitals
424	Assist w/barrier removal planning post-Action Plan	O	Discuss w/ Hospitals
425	Evaluate priorities of each barrier listed for removal	O	Discuss w/ Hospitals
426	Phase & Severity Code review	O	Discuss w/ Hospitals
427	Room by room vs. element by element	O	Discuss w/ Hospitals
428	Budget development		
429	Based on solution review with client	O	Discuss w/ Hospitals
430	Based on estimated costs with client	O	Discuss w/ Hospitals
431	Contractor and/or Architect review	O	Discuss w/ Hospitals
432	Plan reviews during barrier removal	O	Discuss w/ Hospitals
433	Full set	O	Discuss w/ Hospitals
434	Major rooms & spaces	O	Discuss w/ Hospitals
435	Parking, patient rooms, toilets, tubs & showers, exam rooms, cafeterias, waiting rooms, gift shops, lobbies, etc.	O	Discuss w/ Hospitals
436	Major and repetitive elements	O	Discuss w/ Hospitals
437	Counters, casework, signage, ramps, curb ramps, etc.	O	Discuss w/ Hospitals
438	Review RFI's from design and construction teams	O	Discuss w/ Hospitals
439	Field reviews during barrier removal		

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440		Rooms			
441		Elements		O	Discuss w/ Hospitals
442					
443 Other Facility information					
444	Size			B	Each Hospital will provide Archibus data
445	Age			B	
446	Original construction			B	
447	Last major renovation			B	
448	Local code & enforcement history			B	
449	Location (City, State, Zip)			B	
450					
451 Expenses					
452	Travel time to site/campus			B	
453	Transportation & Parking			B	
454	Per diem allowances or limits			B	
455	Markups			B	
456	Lodging availability & costs			B	
457					
458 Consulting, Training, & Orientation					
459	Develop training videos/brochures for in-house use			O	Discuss w/ Hospitals
460	Design and Construction Teams				
461	Client Design & Construction PM's and others			B	
462	Consulting Arch's. & Eng's.			B	
463	Contractors			B	
464	Administrative & Managerial staff			B	
465	Facility mgt. & maintenance staff - Operations Support			B	
466	"Customer service" staff			B	
467	Housekeeping staff			B	
468					
469 Other Optional or Additional Services					
470	Corporate compliance planning			O	Discuss w/ Hospitals
471	Corp. IT systems integration planning			O	Discuss w/ Hospitals
472	Other corp. systems integration planning			O	Discuss w/ Hospitals
473	Presentations of findings, review project status, discuss work			B	
474	Public review & comment coordination			D	NA
475	Public review & comment presentations			D	NA
476	Consult &/or coord. Surveys & BR work w/ local & state AHJs			H	
477	Lawsuit defense & expert witness			H	
478	Plan reviews for alterations projects				
479	Review plans against survey			H or Lump	
480	Review schematic design drawings			H or Lump	
481	Review design development documents			H or Lump	
482	Review construction documents			H or Lump	
483	Construction observation			H	
484	Review Internal Design Standards for FM's			H	
485	Modify Reports based on Client or FM requested changes			B	
				H	
486	Other			H	
END				END	END