

Pacific ADA Center
Healthcare and the ADA Webinar - COVID-19, Healthcare and the ADA
Thursday, April 23, 2020
2:30-4:00 p.m. ET

>> LEWIS KRAUS: Welcome to the Health Care and the ADA: Including People With Disabilities Webinar Series. I'm Lewis Kraus from the Pacific ADA Center, your moderator for this series. This series of webinars is brought to you by the Pacific ADA Center on behalf of the ADA National Network. The ADA National Network is made up of ten regional centers that are federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act. You can reach your regional ADA Center by dialing 1-800-949-4232.

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opportunity for everyone to ask questions. You may submit your questions using the chat area within the webinar platform and the speakers and I will address them at the end of the session. So feel free to submit them as they come to your mind during the presentation. To submit questions, you can go to the chat area text box or press alt-H and enter text in the chat area. If you are listening by phone and not logged into the webinar, you may also ask questions by emailing them to ADAtech@ADAPacific.org .

If you experience any technical difficulties during the webinar you can send us a private chat message to the host by typing in the chat window and type your comment in the text box and enter. If you're using keyboards using that as your entry method to alt-H to access the chat box via the keyboard keys. You can also email us any problems at ADAtech@ADAPacific.org or call 510-285-5600. Today's ADA National Network learning session is titled "COVID-19, Healthcare and the ADA." Given the unprecedented demands posed by the COVID-19 pandemic for the provision of healthcare, it is critical for healthcare providers to understand how the decisions they need to make for dealing with this crisis connect with the Americans with Disabilities Act or the ADA. In this webinar several ADA National Network staff from across the country will review general healthcare provisions in the ADA and how they apply to new issues such as temporary medical facilities, drive-thru testing sites and other current healthcare issues. Our speakers today are Jan Garrett, a program manager for the Pacific ADA Center. Emily Shuman, who is the deputy director for the Rocky Mountain ADA Center. Michael Richardson, director for the Northwest ADA Center. And Pam Williamson, assistant director for the Southeast ADA Center. So I am now going to turn it over to our speakers. I think Jan, you're going to start. So, I turn it over to you.

>> JAN GARRETT: Great. Good day, everyone. We will be talking today about "COVID-19, Healthcare and the ADA." So during this webinar, we will be talking about general concepts of the ADA and applicability and I will be addressing those. Accessibility of buildings and facilities. Effective communication. Reasonable modification of policies, practices and procedures. And resources on the ADA and COVID-19.

Next slide, please.

So what is the ADA? The Americans with Disabilities Act, or ADA, is a civil rights law designed to protect the rights of persons with disabilities.

Next slide.

So which people does the ADA cover? People with physical, sensory, mental, cognitive, or intellectual limitations, such as difficulty with walking, balancing or climbing. Difficulty seeing, hearing or speaking. Difficulty reading. Or difficulty in understanding or remembering. Next slide.

What does the ADA require? So the delivery of services in a way that ensures that all people have an equal opportunity to achieve the full benefit of the goods, programs, services and activities offered, in the most integrated setting appropriate. And that is for Title II of the ADA or Title III of the ADA. And we'll learn what those titles cover on the next slide. So what does equal access under the ADA include? Equal access to care and services includes: Physical accessibility of buildings and facilities. And we will be addressing that. Accessible equipment. Effective communication. Which we also will be addressing. And modification of policies, practices and procedures that we will be addressing here. Next slide.

Are ADA requirements waived in an emergency? No. And that is a very important answer. The ADA requirement of equal access to healthcare services applies at all times and is particularly important during an emergency. So the concepts I... let's see, next slide.

Okay, let me go back one then. The concepts I presented are the basic non-employment tenants of ADA for healthcare providers, and the remaining speakers now provide you greater detail on the ADA requirements as they apply in particular to the added measures that healthcare providers have put into place to deal with the COVID-19 pandemic in their localities. Lewis...

>> LEWIS KRAUS: We're going to move along here to Emily. Emily Shuman, from Rocky Mountain ADA Center. Go ahead, Emily.

>> EMILY SHUMAN: Thank you, Lewis, and thank you, Jan. My name is Emily Shuman, deputy director of the Rocky Mountain ADA Center, which serves Colorado, Wyoming, Montana, Utah and South Dakota. One of the things we're seeing in response to the COVID-19 crisis is a rise in emergency health practices such as medical facilities and drive-thru testing sites. I'll be addressing some of the physical accessibility considerations and ADA requirements that go along with those practices. Next slide.

Most emergency response programs are coordinated by state and local government entities, which are covered under Title II of the Americans with Disabilities Act. One of the primary responsibilities of state and local

governments is to protect residents and visitors from harm. They do this by helping to prepare for, respond to and recover from emergencies and disasters, including public health emergencies. State and local governments must comply with Title II of the ADA in the emergency and disaster-related programs, services and activities they provide. This applies to program services and activities provided directly by state and local governments as well as those provided through third parties, such as the American Red Cross, private non-profit organizations and religious entities. Next slide.

Under Title II of the ADA, emergency programs, services and facilities must be accessible to people with disabilities. They generally may not use eligibility criteria that screen out or tend to screen out people with disabilities. The ADA also requires making reasonable modifications to policies, practices and procedures when necessary to avoid discrimination against a person with a disability. State and local governments must also take steps to ensure effective communication with people with disabilities. These topics will be discussed in greater detail later by my colleagues. The ADA generally does not require emergency management programs to take actions that would fundamentally alter the nature of a program, service or activity or impose undue financial and administrative burdens. Next slide.

When emergencies arrive involving a public health crisis, communities may need to provide temporary medical facilities to accommodate the high volume of people requiring medical treatment. This is a photo of a row of hospital beds set up in a parking garage at Vanderbilt University Hospital in Nashville, Tennessee. These facilities are sometimes operated by government entities themselves. More often they are operated by a third party. Regardless of who operates a temporary medical facility the ADA generally requires facility operations to be conducted in a way that offers people with disabilities the same benefits provided to people without disabilities. Such benefits include safety, comfort, freedom, medical care, communication and the support of family and friends. Temporary medical facilities may be critical to ensuring the health of people with disabilities in public health emergencies who are often among the most medically vulnerable. Accessibility of these facilities should be a foremost consideration. Next slide.

It's understandable that in an emergency, thorough pre-planning may be difficult or impossible when time is of the essence. In these cases accessibility still must be provided to the maximum extent possible. In instances where existing facilities, such as schools, churches and office buildings are repurposed into temporary medical facilities, steps should be taken to find the most accessible locations and to mitigate existing physical access barriers. Facilities built or extensively altered since the ADA went into effect in 1992 may have fewer

barriers to accessibility and could be good choices for temporary medical facilities. Facilities built before 1992 and not altered to provide accessibility may have barriers that prevent access to people with disabilities. Barriers to accessibility and existing facilities must be removed or another nearby accessible facility should be identified. In communities with more than one temporary medical facility, the locations of accessible facilities should be widely publicized, particularly to people with disabilities and organizations that dispatch patients to temporary facilities for treatment. Next slide.

There are many physical access issues that may arise when using an existing facility for a temporary medical facility. The most important accessibility element that should be considered when choosing an existing location to repurpose into a medical facility is the accessible route, which includes accessible entrances. Accessible routes are what permit people with mobility disabilities to participate in the services and programs offered during times of emergency. Everyone must be able to get to each of the various areas where services take place. An accessible route should be provided to all critical areas of the medical facility and should be a continuous route between all areas a person might be expected to go. This includes the check-in area, waiting area, examination areas, bedrooms or private rooms, toilet and bathing rooms and discharge area. Next slide.

Accessible entrances are part of the accessible route and ensure people with disabilities have a way to get into the facility on a surface that is firm, stable, slip-resistant, has no steps or steep slopes and is wide enough for a person using a wheelchair or other mobility aid. Next slide.

Basic characteristics of accessible routes are as follows. Pathways should be 36 inches wide except at doors, and for short distances, when it can be narrower at 32 inches wide. Here is an illustration of ADA standards requirements for accessible pathways. Next slide.

Walking surfaces should have a 5% minimum running slope. Ramps should have a 5 to 8.3% maximum running slope. And cross slopes should never exceed 2%. Here is an example of the running slope and cross slope of a sidewalk. Next slide. Ramps which rise more than 6 inches will need to have both handrails and edge protection. Edge protection is a method which prevents a crutch or wheelchair wheel from running off the side of a ramp. Ramps must also have level lands at the top and bottom of each segment and where the ramp changes direction. Here is an illustration of ADA standards requirements for ramps that rise higher than 6 inches. Next slide.

Walking surfaces should be free from gaps greater than half an inch and vertical changes in level should be no greater than a quarter inch. Vertical changes in

level up to ½ inch should be beveled at a 1:2 ratio. Gaps and changes in level can be caused by broken concrete, potholes an accessible route or threshold at a door. These pictures show illustrations of ADA standards requirements for walking surfaces, walk surface gaps and changes in level. Next slide.

Common barriers to accessible entrances and routes can be as simple as curbs with no ramps, broken concrete walking surfaces, stairs of any number, or grass on an expected walking path. In this picture a wheelchair user is struggling to get into a building at an inaccessible entrance because of a large step at the doorway. Next slide. Mitigation strategies should be implemented if barriers exist. For example, if steps are the barrier to access, a temporary ramp should be installed. A single six-inch tall step will require a six-foot long ramp to act as the accessible route eliminating that barrier. If one entrance is inaccessible but an alternate entrance is accessible, steps should be taken to direct or assist people with disabilities to the accessible entrance. Here are illustrations showing a portable ramp used as an inaccessible building entrance and another building with one inaccessible entrance and an alternate accessible entrance with signs pointing to it. Next slide.

new temporary structures can be constructed to accommodate the needs of the community and should be constructed in accordance with ADA standards. A 36-inch wide circulation path will satisfy accessible route requirements. At least 10% of beds should have a wheelchair space on each side of the bed. And a compliant turning space should be provided within the room. If constructed in a grassy field or otherwise inaccessible surface area, matting such as the Mobi Matt should be utilized to create an accessible route. If the structure is elevated, a compliant ramp or lift should be part of the design. Rest rooms and showers in the design should be compliant with ADA standards as well if portable toilets are provided those should be connect to the accessible route and at least 5% of them accommodate people with disabilities. Next slide. Accessible medical facilities may also contain elements such as public parking, toilets, bathing facilities and other service areas that need to be examined for barriers. Some additional general considerations are as follows. Medical facilities should have an accessible passenger loading zone and accessible parking spaces located in the parking lot nearest the accessible entrance. The image sheer shows ADA requirements for passenger loading zones. A 30-inch by 48-inch clear floor space should be provided wherever possible at procedural check points associated with a medical exam and hospital stay. If not all examination areas can accommodate clear floor space, an inventory should be kept on exam spaces which do account for this feature who do require accessibility. If a space has inaccessible features such as multiple floors but no elevator, the inaccessible upper level spaces should be filled first by those who are physically accessible, physically able to access them and the accessible ground floor spaces should be

utilized last and be available for patients who require ground level access. Next slide.

Now we'll turn to drive-thru medical testing sites. Drive-thru medical sites are one way that hospitals and health departments provide intermittent medical services such as testing for coronavirus with greater ease and safety for patients. Typically consisting of pop-up tents and traffic cones, these temporary sites may be in a parking lot at the hospital, a retail store or a state fairground. In this image a COVID-19 drive-thru testing site in Houston, Texas, is shown. The sites are especially useful for medical testing during times of an outbreak since keeping patients in vehicles can help to minimize exposure to a contagious disease. In these cases the patient's vehicle is approached by a medical provider who is wearing personal protective equipment, including a face mask, gloves and a smock. And the patient is instructed to lower their window to allow a four-inch gap through which the provider communicates with, performs the test on and exchanges written information with the patient. Whether these drive-thru medical sites are funded and operated by state and local governments or a private business, the Americans with Disabilities Act requires that services are accessible to people with disabilities. Next slide. In terms of physical access, the most important consideration is access for wheelchair users. Minimum clearance for wheelchair accessible vans to approach and pass through the site is 8' 2" high as seen in this illustration. Next slide.

For patients who use wheelchairs to exit vehicles at the drive-thru site if instructed to do so, there needs to be an access aisle alongside the vehicle. The access aisle must be at least 60 inches wide if the lane is 132 inches wide. Alternatively the access aisle must be at least 96 inches wide if the lane is 96 inches wide. An illustration of both options is provided here. Next slide. It may be necessary to provide walk-up services for those who cannot drive onsite by vehicle, such as someone who is blind and doesn't have access to a taxi or Uber driver. In these cases there must be an accessible route to access all elements of testing such as check-in, testing, paperwork areas, check-out and so on. Staff should be onhand to help direct those in line for walk-up services and help ensure proper social distancing precautions are observed. Next slide.

So that's my time for today. Thank you for listening. Before I pass it on to Michael, I want to remind you to contact your local ADA Center about physical access requirements. This can be a complex topic and often requires research. The ADA National Network is here to help with that. Also there will be time for questions at the end of this presentation as you heard before.

>> MICHAEL RICHARDSON: Great. Thank you, Emily. Can you hear me okay?

>> LEWIS KRAUS: We hear you great, Michael. Thank you.

>> MICHAEL RICHARDSON: Thank you for having me, everybody. My name is Michael Richardson, the director of the Northwest ADA Center covering Washington and [audio distortion]

>> LEWIS KRAUS: Michael one second. Can you stop one second? Your audio got distorted. So let's start -- start your -- what you were saying over again and let's see if it improved.

>> MICHAEL RICHARDSON: Sure. This is Michael Richardson, I am the director of the Northwest ADA Center. Is that better, Lewis?

>> LEWIS KRAUS: That works so far. Yes.

>> MICHAEL RICHARDSON: Okay. Great. And as I mentioned before, we cover Oregon, Idaho, Alaska and Washington. I'm a person with hearing loss. I had... [audio distortion]...

So today we'll be covering sort of effective communication in healthcare and the focus here is all about communication access for those who have disabilities in which communication is impacted. We will not be strictly focusing on the common ADA requirements in general scenarios for effective communication but more how COVID-19 has impacted the ability to provide for communication access and some solutions to think about and encourage people to be creative and to think outside the box and provide inclusive communication access. We briefly will cover communication as it pertains to public announcements, whether it's through televised updates, web-based media, and common notices, such as posters and flyers. Then move to hospitals and drive-thru testing sites where we are seeing a lot of issues. Focus today will be on access for those who are deaf or have hearing loss as well as people who are blind or have vision loss. Focus is on awareness to healthcare providers, some of the information we are sharing today are also helpful to consumers. Next slide, please.

So what is effective communication? Under the ADA and Rehabilitation Act, healthcare facilities must provide auxiliary aids and services to ensure that individuals with hearing, vision, speech, and cognitive disabilities can understand what is said or written and can communicate effectively. The goal is to ensure that communication with people with disabilities is as effective as communication

with people without disabilities. So the question is: Which auxiliary aid or service should work? Well, each person's communication method is individualized and they may have a preferred choice. Consider the nature, the length, and the complexity of the communication taking place. However, the issue with COVID-19 is that the emergency crisis have overwhelmed the healthcare system in many areas and common strategies and techniques for obtaining auxiliary aids or services may be impacted. In addition many people don't know tools exist and don't know how to ask for them. I see this in the aging population, especially those with age-onset hearing loss and those with declining vision loss. In recent interactions with the deaf communities as well as the hearing loss community, there's a lot of fear and frustration surrounding communication, and much of it is associated with increased use of face masks. Next slide, please. Turning to public information notices, bulletins and warnings, we have an image -- images here in the upper left, a website image about home testing kits that can be ordered. At the bottom is a public service announcement image. Looks like a healthcare -- public health official with an ASL interpreter on the side providing some updates on COVID-19. And on the right we have a common poster that we see from the Centers for Disease Control regarding a global health alert and some common things to do as far as staying home, washing your hands, cover coughs and sneezes. The image on the right is a poster from the CDC. We'll talk about it more in a minute. It's a very good example of plain language, simple communication and the use of images to convey messages. Next slide, please.

So public information notices, bulletins and warnings, quite often we see today the governors of each state providing daily if not twice weekly announcements regarding an update on COVID-19 issues. Now, we think of this, there's more public service issues but public healthcare information, it's important that that information is conveyed clearly, effectively and equally. So if we're looking at televised public information notices, you probably see now many interpreters, ASL interpreters alongside the governor or public health official and quite often we're seeing now a certified deaf interpreter. Now, a deaf interpreter or CDI, for short, possesses near native fluency in American Sign Language and has specialized training and/or experience in the use of gesture, mime, props, drawings and other tools to enhance communication. They can bring added expertise into both routine and uniquely difficult interpreting situations, which is critical in conveying important information that can impact health. And we also talk about verbal descriptions of charts and diagrams. I have seen some government officials pointing to charts and diagrams and not really clearly explaining what is on the chart or diagram for people who may have vision loss. Always be aware you're doing televised announcements to be descriptive of the charts and diagrams you are using. Of course last but not least, the use of captions, especially open captions is critical in conveying information via televised announcements. And then as we look at print and web media, always

remember to think about large simple font with a lot of contrast. Accessible documents in alternative formats, for example, large print, electronic documents that can be emailed or even Braille documents as well. And also the use of medical graphics and images similar to pain scales or images of people showing fever, nausea, things like that. So it can be used as a plain language alternative to facilitate communication. And, again, I want to emphasize these are just some of the basics. We can cover much more on this, but don't hesitate in reaching out to regional ADA Center for more information or resources on this. Next slide, please.

So we have healthcare facilities: COVID-19 Challenges for Hospitals. This is a brief listing of some of the common things we're seeing today and some of the issues we're hearing about. This increased use of masks that hinder lipreading and facial expressions, the gear on interpreters as well. It can be bulky and very preventive as far as being able to use expressive communication, which is part of American Sign Language. Many hospitals have enacted policies to restrict interpreters and visitors from being on the facilities. And this presents some problems for creating access for patients who may be being treated for COVID-19. There's also a shortage of in-person American Sign Language interpreters that I'm hearing about. Many interpreters are being called to be online to do video remote interpreting. And some interpreters out there that are understandably have a fear for contracting COVID-19 themselves, and would rather not be called for work to attend a hospital situation. So what is happening is we're seeing an increased use of video remote interpreting systems. And this is a system of using software and a screen to have interpreters remotely providing ASL interpretation and translation. Now, historically this was often a very controversial issue within the Deaf community, but it is there. It is technology that can work if used properly. The problem is we continue to see technical issues, including freezing of screens, poor WiFi connections or direct cable connections, and also lack of staff training on the use of equipment. It's very critical that if you plan to use VRI or video remote interpreting systems, you're aware how they work, where to obtain them and that staff are aware on how to basically turn them on and get them functioning. There's some issues with writing back and forth on paper, because that requires kind of close contact and close proximity. So that may not be effective and many healthcare providers may not be willing to use such a way of communication. Next slide, please.

So some potential effective communication solutions in hospitals include insuring that individuals who may require VRI or communication apps be in spaces with WiFi or cellular connections to enhance connectivity with electronic devices. We'll talk more about communication apps soon. The use of dry erase whiteboards or large paper pads with large dark markers can be effective instead of doing the close proximity of writing back and forth on small pieces of paper,

they're able to do the six feet or distance communication using whiteboards and large pieces of paper and dark markers. I have been hearing some success stories with the use of FaceTime between a provider and a patient in separate rooms, meaning you have a situation where a patient has worked closely with a nurse and, of course, the nurse is covered in protective gear. Communication is problematic. But in these situations, the nurse or healthcare provider, once their shift is done or their moment is done, they are able to exit the room, clean up somewhere, and from a private other room somewhere is reconnect back with the patient using FaceTime close-up at the person's mouth and slowly repeating some of the information that may have been conveyed in a manner that may help with communication. Also there have been questions about see-through masks. You probably heard of Clear Communicator, which is the primary industry in the country right now that produces medical masks that have a clear window in them to assist with lipreading and in facial expressions. From what I understand right now is they are out of supplies, and more importantly to understand, though, is that those masks are certified at a sort of a level 1 protective situation, so they are not eligible to be used in extreme contagious areas where COVID-19 might be present. So they are an option, but unfortunately supplies of them are limited right now and they are limited to the level of severity in contagious disease interaction. So the bottom line is basically to put forth best efforts, provide communication traditionally through common auxiliary aids and services. Again, if those aids and services are limited or in short supply due to COVID-19, it's a matter of trying to think outside the box and putting together ideas and solutions to best -- and effectively communicate.

Also, what we'll be doing in the next few slides is talking about solutions that will also be applicable to drive-thru testing sites and vice versa as well. Next slide, please.

So drive-thru testing sites present unique communication challenges. By the way, we'll show this again with the resources at the end. There is a new fact sheet and guidance sheet from the national -- the ADA National Network on accessibility guidelines for drive-thru testing sites. And it offers more comprehensive information as well as additional resources to ensure that drive-thru testing sites are as accessible as possible. So we have two images here. We have a left image of a healthcare provider doing a drive-thru testing with more complex technology, such as a portable computer station and keyboard. Whereas on the right we have two providers doing drive-thru testing through a vehicle without any technology but just basically swabs. So there could be some options here for using the technology to enhance communication, whereas on the right side you may need to be more creative to come up with some communication solutions. Next slide, please. Possible solutions for deaf/hearing loss access in drive-thru testing is always be prepared to

communicate in many different ways. The more ways you try to communicate using various kinds of aids or solutions creative ideas the better off you will be. Thinking about printing standard questions on a form such as bold font.

Print out instructions and procedure, such as how a swab is going to work, so people are prepared. Use small dry – race board which can be disinfected for interactive conversation. Consider having small pads of paper and pencils for patients to use and, of course, keep to minimize contamination. Use charts with graphics for visual communicators. This can apply to individuals with intellectual disabilities or cognitive disabilities in which communication is impacted. Try to think about using hands or body motions to be as visual as possible, such as showing a swab and imitating how far back to put your head, for example. Think about offering assisted listening systems and devices if available. And also a mobile device such as a small tablet could be used for communication for typing information to somebody in the vehicle. So next slide, please.

So it is not always going to be possible to have ASL interpreters at testing sites due to availability and demand issues, but it's something to think about, especially in cities and communities that may have larger deaf populations, such as New York City, Washington, D.C., Austin, Texas, Rochester, New York, northern and southern California to name some. So possible solutions for deaf and hearing loss access includes communication systems at the site so that drivers who use ASL or American Sign Language can be connected with the on-site ASL interpreter with little delay. If interpreters Don protective smocks and gloves, give them gloves that provide high color contrast against the smocks. Smocks are white, you want to use black gloves. This is something we heard in the Pacific northwest, issues with interpreters using white smocks and white gloves, which does not provide enough contrast. As I mentioned earlier, video remote interpreting, VRI is an option if an in-person ASL interpreter cannot be scheduled. And information on VRI resources, communication apps and other communication strategies can be found at the link, COVID-19 communication access recommendations in the hospital from the National Association of the Deaf. I'm going to highly recommend this resource from the National Association of the Deaf as it lists a variety of communication apps, such as speech-to-text which may be useful for some people in some situations. Just be aware that such apps may not be effective or accurate given the situation or environment. And this sort of pertains to noise levels and the patients, the behavioral side of patients and coworkers and other medical staff willing to work with this stuff. This resource also mentions VRI resources including free service temporarily offered by a VRI company for drive-thru testing while this time is going on, which can be a nice sort of reprieve for people who may be worried about how are we going to set up billing and payment for the use of VRI services. So something that is available for use. And with this resource, the National Association of the Deaf is

also encouraging the deaf and hard of hearing community to empower themselves with communication tools because the reality is you're dealing with an unprecedented situation, and both sides need to work together to maximize communication. Next slide, please.

For people who are blind or have low vision, some common things to think about is healthcare providers in a drive-thru testing site is state your name and title clearly and repeat this introduction if there are multiple personnel involved so the patient can identify who is talking to them. Verbally describe each step of the procedure using specific directional words like left and right instead of here and there. This will probably apply when talking about preparation for doing a swab test. Provide written materials in high contrast large print, unified English Braille, if necessary. Short pieces of information. And text-only files that can be emailed to a person afterwards. If written materials are laminated or plastic, think about using low-glare coating whenever possible. Offer to read documents aloud and offer to handwrite personal information for people who may not be able to see a form. Next slide, please.

Finally, a big part of effective communication is to be respectful and supportive. Train staff on disability etiquette. So communicate with a patient directly. Use plain language when explaining things to patients, whether spoken or written. Allow extra time and don't rush or interrupt the patient. For people who are blind or have low vision, ask permission to touch the person and let them know when you're reaching in and when you'll be handing them, especially when doing swab testing. If you have additional questions on this, you can reach out to your local Center for Independent Living, your local blind agency, your state deaf and hard of hearing services office, even the Helen Keller National Center would be a good resource to connect with, especially when working with the deafblind population. And, of course, don't hesitate reaching out to your regional ADA Center for resources and technical assistance. And that is it from me. Thank you for your time.

>> LEWIS KRAUS: Okay, Pam, we're going to move to you.

>> PAM WILLIAMSON: Thank you. Yes, thank you, Lewis. Hello, everyone. My name is Pam Williamson, and I'm the assistant director of the Southeast ADA Center. We serve the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. Now, today we already have learned a lot about physical and facility access and effective communication but we're going to turn our attention now to some of the issues surrounding reasonable modification under the Americans with Disabilities Act.

In this time of pandemic and COVID-19, reasonable modifications are even more important. So I also want to let you know, I will be referencing several resources during this part of the presentation. They are all available on this slide at the end of the presentation, which you can download at your convenience. Next slide, please.

Let's first talk about what a reasonable modification. It's a term used in Title II of the ADA which applies to state and local government agencies and Title III of the ADA which applies to public accommodations and private businesses. So it's adjustment that any policy practice or procedure, if needed, to provide good services, facilities, privileges, advantages or accommodations to people with disabilities. When we think about this, we may have to make sure that we're looking at this in context. So let's move to the next slide, please.

This slide and the next one actually provide the citations for ADA Title II. Next slide, please. And ADA Title III. Now, a reminder here... so the word is "reasonable modification." And if a healthcare provider can demonstrate that modifying a policy or practice would fundamentally alter the nature of goods and services they provide, then there is no requirement for the modification. And a simple definition for fundamental alteration is any change to an essential nature of the entity's programs or services. Next slide, please.

So today we are going to focus on four specific areas. These are areas that we have noted as we have talked to people over the past several weeks. These are areas of concern that we are hearing from both people with disabilities and healthcare providers. And we're going to touch on issues related to face masks, service animals in a medical facility. Reasonable modifications to visitor restrictions and medical settings, and then bringing personal equipment and supplies to a medical facility. Next slide, please.

One of the things we have heard about a lot during this pandemic are face masks. Should I wear them? Can I get one? Where do I get them? What is the correct way to wear it? Well, in addition to all of that, many states have what are called anti-mask laws. These laws were passed for several reasons. An example is in Georgia we have a law that states a person is guilty of a misdemeanor when he or she wears a mask, hood or device by which any portion of the face is so hidden concealed or covered as to conceal the identity of the wearer and upon any public way public property or on the private property of another without written permission of the owner or occupier of the property to do so. So basically what that means is in the state of Georgia, if you are wearing a medical mask, you are potentially violating this law that is in place and could be charged with a misdemeanor. Thankfully our governor did sign an executive order that suspended the anti-mask law during this pandemic, but what happens

when you have a state where there may not be an executive order that suspends the anti-mask law? Or what happens when the executive order expires? Next slide, please.

This is when reasonable modification under the Americans with Disabilities Act comes into play. Because it would be a reasonable modification to allow a state or state agency or private business to modify its policy to allow a person with a disability to wear a mask to protect him or herself in the current pandemic situation. The New York Department of Health actually developed some interim guidance on this issue and put out a policy that could be used as a sample. And basically it says that if a face covering would inhibit or otherwise impair an individual's health or if they're not able to wear it because of a disability or other health condition, then a person would not be able to -- would not have to -- a person would not be able to either not wear the mask, even if there was a requirement, or there could be a policy in place where there would be a modification so that a person with a disability could wear a mask even if this was an anti-mask law in place. Next slide, please.

Now, as we all know, when we are visiting our healthcare provider or many other places, there may be a policy in place that requiring all patients or customers to wear a mask due to COVID-19. There may be a reason a person cannot wear a mask due to a disability, and particularly a respiratory disability. So must a healthcare provider make a reasonable modification? We have to think about this from the perspective of reasonable modification. So let's go to the next slide.

So there may be a situation where it really is a fundamental alteration of the nature of goods and services provided if a person sun able to wear a mask. However... so it would be a situation that would need to be explored fully to make sure that it's a decision that was made by a head of the public entity and everything has to be considered before that decision could be made. There's a lot that goes into it. It cannot be an off-the-cuff decision made by someone at the front desk. So there's going... so there is the possibility, and the best practice would be to develop a policy that addresses the need for face mask alternatives or other options to serve the person who needs the goods and services either of the healthcare provider or the business or state or local agency.

Next slide, please.

Another issue that we are hearing a lot about are service animals. You know, even before the current pandemic, the CDC had developed guidelines for environmental infection control and healthcare facilities. And they had put together some very concrete information on whether or not to allow the service animals in a healthcare facility. So we really need to go back to the basics on

this one. And what the CDC guidance says is that service animals must be allowed to access medical facilities unless the presence of the animal creates a direct threat to other persons or fundamental alteration in the nature of services. So we have those two pieces again. They must be allowed unless it's a direct threat or a fundamental alteration in the nature of services. So let's go to the next slide and see the second part of this. The second guideline is that if and when a decision must be made regarding a service animal's access to any particular area by healthcare facility, there has to be a process in place to evaluate both the service animal, the patient, and the healthcare situation on a case-by-case basis. There also has to be a determination of whether significant risk of harm exists and whether or not a reasonable modification in the policy, practice and procedure can mitigate or diminish this risk. Next slide, please.

Now, in the case that a person must be separating... so separated from his or her service animal while in the healthcare facility, then two things are very important. One, there must be arrangements made for the supervision and care of the animal during the period of separation. And, two, is that appropriate arrangements need to be made to actually address the patient's needs in absence of the service animal. So what was the service animal trained to do? And what kinds of things need to be put in place in order to make sure the patient's needs are met while in there? Now, having said all this, there's also... this is also a time to remind folks that if a service animal is in a medical care hospital situation, they must be still under the control of their handler. At no time is the healthcare facility responsible for the service animal during the hospitalization. Next slide, please.

Another big issue are visitor restrictions in medical settings due to COVID-19. As we know, because this is a very high-risk situation, most hospitals and healthcare settings have limited the -- have suspended all visitation. But their situation is when a person with a disability may need a family member or support person or some other person be with them to help make decisions or provide support. This is also where it may be that a sign language interpreter may need a reasonable modification in order to come in for a consultation with the patient who is in the hospital. A reasonable modification to the policy would be to allow at least one person chosen by the individual with the disability to accompany him or her in the medical setting. Next slide, please.

So the New York Department of Health actually has developed an excellent guidance for hospital operators regarding visitation. And they actually have a policy, and I will read part of it to you now. It says for patients for whom a support person has been determined to be essential to the care of the patient and medically necessary, including patients with intellectual or developmental disability and patients with cognitive impairments, including dementia. The

department considers one support person at a time is essential to patient care in the emergency room or during hospitalization. And then it goes on to say that a family member or care person, they can designate up to two support people but only one person at a time can be allowed at the hospital. And then that way -- so that's a reasonable modification to the restrictions on visitors because of the person's disability. Next slide, please.

The last issue that we're hearing a lot about are people with disabilities who may need to bring their own assistive technology or augmentative communication devices, ventilators, mobility devices to the hospital or healthcare setting with them. And during a pandemic you know, a hospital or other medical facilities may limit the items that a person brings with them to prevent the spread of COVID-19 in this case. However, a reasonable modification would be if a person with a disability needs to bring the personal equipment, then the hospital -- so needs to have a policy in place to make reasonable modifications, but they can also require that the proper steps be taken to clean the equipment and prevent the spread of the virus. An example -- this was prior to COVID-19, but I was in the hospital back in January, and I took in a piece of my own equipment, and the hospital just logged that it was there and we made sure it was clean. Because I was in an isolated room. So that is one of the things that we did in order to be able to facilitate the communication. While I was there. Next slide, please.

Of course, there are always things we can do to make things better. And some of those are things that we really should try to do prior to anything that is emergency-related. But sometimes we have to make decisions on the ground. But hopefully there is already a policy in place for requesting and receiving reasonable modifications. And if you don't know what that policy is, ask. Go ahead and try to find out who is responsible for that at your location. Make sure that all staff are trained to work with people with disabilities and understand the reasonable modification process. This could include disability awareness, customer service, effective communication, as we talked about earlier. And also knowing about the accessibility features in your hospital your medical facility. And last but not least -- and this is even more critical when we're in an emergency situation. Evaluation each case and each person singular. It's a case-by-case basis. Each person is unique and they will have their own needs. The important thing to remember is that modifications to a policy, practice or procedure, allows a person with a disability to receive equal access to care and treatment. And you want to ensure that is what is happening at all times. Lewis, I am now going to turn this back over you. Thank you.

>> LEWIS KRAUS: All right. Thanks so much, Pam, and thank you Jan and Emily and Michael. That was a lot of information. I think everybody really got a lot out of that. This is your time, everyone, to submit your questions in the chat

window if you have not already done so. And we'll get to those in a moment. I do want to mention that we have a lot of questions lined up. And so there is a possibility we may not get to all of them. But remember that you can ask any of these questions of the ten regional centers, ADA Centers, at any time on their confidential phone line at 1-800-949-4232.

The first question was a question about how can I protect my ADA accommodations if I am deployed as a disaster service worker since I work for a county government? Now, I'm going to jump in before any of the panelists here and say one thing. The ADA covers a lot of areas. One area is employment. And these accommodations might be a question about employment. As you heard preparedness the presentation so far, we are not really covering employment-related issues in this webinar, but you can absolutely ask this of your ADA Center by contacting them directly. Anybody, Jan, Michael, Emily, Pam, you want to add on that question?

>> JAN GARRETT: No, I think that was perfect, Lewis. Thank you.

>> LEWIS KRAUS: All right. Let's move on to the next question. And these will be in the order pretty much that you guys presented. So this will probably be an Emily question. Emily, you mentioned about the Mobi Matt. Can you repeat, if you can find it, where you were suggesting people use the Mobi Mattes?

>> EMILY SHUMAN: I was suggesting if you're constructing a new temporary medical facility and happen to be constructing on a patch of grass or gravel, a Mobi Matt is a resource to -- they're these interconnected plastic mats you can construct in all sorts of ways to provide an accessible surface for your accessible route.

>> LEWIS KRAUS: Thank you. The next question... the person says the 5% standard for accessible rest rooms seems so low. That means one accessible restroom if there are 20 rest rooms. But I also assume it means 5% but no fewer than one, because if they are less than 20 rest rooms, 5% is less than one restroom. So I think she's looking for confirmation that that is true. Is that true?

>> EMILY SHUMAN: Yes, I did look at the 2010 ADA standards on this one. It's important to remember that that 5% number is for portable rest rooms. So it would be different if you are in a permanent facility the number of rest rooms required would be different. But even though it doesn't specifically say it in the ADA standards, I believe the interpretation would be that it would be no less than one accessible portable stall.

>> LEWIS KRAUS: Okay. Next question. Are rideshare companies aware of their need to preemptively educate drivers about their non-discrimination obligations, including taking blind or visually impaired passengers to drive-thru testing sites?

>> EMILY SHUMAN: I think that, you know, certainly there have been enough lawsuits against most rideshare companies that they should be aware that their drivers need to be trained on their requirements as they pertain to people with disabilities. I don't know that rideshares have been required to give people free rides to testing facilities. I do think that a rider would still have to pay for that. But hopefully you know, drivers are aware that they have to take their customers wherever the customer would like to go.

>> JAN GARRETT: Yes, I believe that the question is of equal opportunity. So if Uber, Lyft, other rideshare companies are giving anybody without a disability a ride to a drive-thru testing site and charging them a certain amount in order to wait in line at that testing site, etc., that they treat people with disabilities who can use their vehicles in the same way as they treat people without disabilities allowing them to ride if they have a service animal, allowing the service animal there. And also not charging them any more than they would charge any other customer.

>> LEWIS KRAUS: All right. Next question. This is a question about communication and use of clear masks versus N95. We are told that clear masks cannot be used in the COVID-19 unit. I assume maybe this is one for Michael. This is a question of if they have an issue about their clear masks actually could be a Pam question about their modification of policies as well. Maybe we can talk about the clear masks and if they have a policy for not using clear masks in COVID-19 unit.

>> PAM WILLIAMSON: I will go ahead and start with that. I mean, if there is a policy about not using the clear masks because they do not meet CDC guidelines, then, you know, there still needs to be some type of effective communication put into place. And, you know, that is a discussion to be had between the person who needs the communication as well as the medical staff. And this is where reasonable modification may come into play, is there is another type of communication that would work. Then there may need to be a reasonable modification to the policy or practice or procedure in order to, you know... so you can figure out the most effective mode of communication. And then so if a clear mask cannot be worn by medical personnel, then you know, the bottom line is there's got to be that equal access to communication, and it may

have -- and sometimes you have to get created with how that happens. And Michael provided several examples of what that might be.

>> MICHAEL RICHARDSON: Can you hear me okay now?

>> LEWIS KRAUS: Yes.

>> MICHAEL RICHARDSON: I apologize. I was muted somehow. I think Pam is right. It's going back to the clear communicator masks, as I think I mentioned, they're only certified at the basic minimum level of protection. So the question poser is right in that they're probably not allowed in COVID-19 areas or sections, but they can be used in areas that may not be COVID-19 related, but still have some level of protection for you know, staff to use with other fellow staff who may have hearing loss. That's a case-by-case basis and depends on the environment and the situation.

>> LEWIS KRAUS: Okay. Next question. Regarding COVID-19 drive-thru testing, specifically at a hospital, what alternative do you recommend for individuals with no access to vehicles?

>> EMILY SHUMAN: So I believe walk-up testing is becoming more popular. And I know that there are some health clinics that will allow you to make an appointment to come into their facility and take a test. Other than that, I would really recommend contacting your public health department and explaining the situation and finding out what they recommend, or you might contact a testing site itself and see if they have -- if they can make a modification or if they have any ideas as far as people who aren't able to use vehicles getting tested.

>> LEWIS KRAUS: Okay. I wanted to mention, going back to the clear masks, looks like some people had put in some information about that. I'm going to repost that to all attendees, so you can see apparently there's a Facebook group for somebody who makes masks, the clear plastic panel, if you're interested. And then there was a question about whether there's any literature available regarding clinical use of see-through masks. That's going to be beyond the scope of what we're going to be able to talk about. We're going to be able to talk about the ADA issue in using a clear mask but not the clinical issue there. All right. The next question is: Can interpreters be considered as an instrument to meet ADA requirements that would override the hospital and nursing home limited access policy? They would allow a diabetic to wear their insulin pump. Why not an interpreter for the deaf?

>> PAM WILLIAMSON: I will address that. You know, this goes back to what we discussed earlier about a reasonable modification to a no visitor policy. So

because a sign language interpreter is going to be there as a means of effective communication, and a nursing home or hospital both have requirements under the ADA to provide effective communication and reasonable modifications to policy, practice or procedure unless they can show it's a fundamental alteration or an undue burden or expense. So, having said that, there needs to be -- so that's where you need to address this and looking at it from an effective communication standpoint for a person who is deaf and who needs a sign language interpreter in order to communicate about the situation at hand. And also, too, making the hospital and nursing home aware that this is not you know, a run-of-the-mill visitor and this is a time when modification of policy would be the right thing to do under the ADA so that the person can have access to effective communication. Now, again, I want to go back to what Michael said that, you know, there may not be a sign language interpreter available at the time. So always have a backup in place of other types of effective communication that might work too. So given the situation.

>> LEWIS KRAUS: Next question. Would everyone be considered to have, quote, a disability during this period if they have health concerns regarding the mask wearing?

>> PAM WILLIAMSON: Remember, the ADA has a very specific definition of disability. So there are people who are going to meet the ADA definition of disability and then there are going to be other people who have health concerns or may be in high-risk categories but may not necessarily meet the ADA definition of disability. So not everyone is going to meet the ADA definition of disability at this time. Because there are certain criteria that have to be met. And if you've got more questions about that, I would encourage you to call the ADA Center at 1-8 -- 949-4232 so we can talk to you about that in more detail.

>> LEWIS KRAUS: One person asked if the link to the New York policy is available. If that listed in the slides?

>> PAM WILLIAMSON: Yes. The link to the New York policy is available, and the resources. And when you download the information, you can access it there. And I can also put it in the chat.

>> LEWIS KRAUS: And, Gabe, if you can move on to the slides that show the resources so people, while we're answering questions, so people can see all the different things that are available, that would be helpful.

Okay. So there was a question about the Georgia code. How is wearing a face mask a violation of the Georgia code if it doesn't conceal their identity? I don't see how that is an anti-mask law if a COVID mask simply covers the mouth and nose.

>> PAM WILLIAMSON: Well, I am a resident of Georgia, so this has been a hot topic issue that I have become aware of. And so the issue is that there are various types of masks being made. And they're not all your basic medical masks that we're accustomed to. People are making homemade masks and various face coverings, and as such there is the potential that the mask could cover, you know, more than just the nose and the mouth and cover up a person's identity. So, you know, as I said earlier, our governor put an executive order in place in order to address the issue, but there may be other states where that doesn't happen. So that's why it has become an issue.

>> LEWIS KRAUS: Okay. And a couple more questions on masks and maybe then we'll be done with masks. People really have questions about these masks. So in the scenario about face masks, and I think, Michael, this is your question -- what is your suggestion on an alternative? Let's start with that one and then we'll have one more after this.

>> MICHAEL RICHARDSON: Good question. I've been seeing some of the other questions popping up regarding other organizations creating a clear view mask. And I just want to digress briefly. I think we should emphasize clear view masks, they already have been certified to be used. I think obviously they're just being used in low sort of medical infectious areas and not to be used in actual COVID-19 wards or units. I'm seeing more benefits with clear view masks, for example supermarket checkers and being able to use those masks to better communicate with their customers. As far as alternatives go, I think I mentioned, I think it's a matter of depending on a situation in the environment. It's trying a few of the apps that are mentioned in our resources here from the National Association of the Deaf, there is about four or five text-to-speech apps that you can use on a phone. Not to say they work beautifully and splendidly, but it's worth a try to see which might be effective. And looking at ways to use FaceTime or what have you. As I mentioned earlier, it's a situation and crisis right now in which you have to think outside the box and look for alternatives and work with the individual to figure out what is going to work if we can't use a clear view mask. I don't really have clear black-and-white answers for alternatives, but it's a matter of doing the best we can in making a solid effort to communicate in the best way we can, if that helps.

>> LEWIS KRAUS: Thank you. And as those resources are scrolling by there, I hope you're watching that and realizing how much information is available on

these slides after we're done and you can go get that and you can go to these links, when you see it showing up in blue, there's an actual link there as well as the actual link being listed out so you should be able to get to all of these resources. And hopefully one last question about masks. I have a question about making allowances for people who cannot wear a mask due to a disability. Does anyone have examples of a policy that has been developed about this? For example, acceptable alternatives that could be used instead of them wearing no form of mask?

>> PAM WILLIAMSON: One of the pieces I referenced on the New York policy did have some information about what alternatives or other policies that could be put in place about what could be done, you know, if a person was unable to wear a mask due to a disability. I did a lot of research in preparing for this particular webinar. And there may be -- it was very difficult to come up with alternative masks. I will be quite honest. It was almost impossible. However, there were ways to look at other ways to get service. If a person was unable to wear a mask, some of the alternatives were for the -- if a person was going to, like, a doctor's office, that they do telemedicine instead. And have an appointment with the doctor via telemedicine. And most insurance companies and Medicare right now have established telemedicine as an alternative. So that is one thing. The other thing is that you know, there may be -- if it's a business, are there pickup options versus actually going into a store or a business? You know, because so many things have gone to curbside or pickup, is there that option? So it's really thinking beyond just whether a person can wear a mask or can't wear a mask. It's looking at alternatives in order to be able to keep the person with the disability from being exposed to the virus or if they have the virus exposing someone else.

>> LEWIS KRAUS: Thanks. Next question. We have seen visitor restrictions impacting our deafblind community because support service providers are told they can't attend.

>> PAM WILLIAMSON: This is where the ADA and reasonable modification issue comes into play. And the individual with a disability would need to ask for, or if they choose, have someone on their behalf ask for them, for a reasonable modification to the policy for no visitors. Because, you know, the person may need a support person with them for effective communication, for navigation, for other, you know, reasons that we aren't... you know, that we don't even know about. So it would be -- so I would encourage you to look at the information about modifying a policy and asking that a business or a hospital modify a no visitor policy to allow at least one person to accompany them. And I also provided an example, again, from the New York Office of Health on what that might look like. And their focus is particularly on individuals with developmental disabilities and cognitive disabilities, but it could be expanded further.

>> LEWIS KRAUS: Thank you. Next question. I know that emotional support animals are not service animals and not covered under the ADA, but private businesses, including healthcare facilities are increasingly admitting emotional support animals without question.

>> PAM WILLIAMSON: The answer here is emotional support animals are not covered by the ADA. And so if a hospital or other medical facility chooses to allow emotional support animals above and beyond the service animals that are required by the ADA, you may want to check and see if they have a policy regarding that issue. I know of one local hospital in Georgia that has a policy that allows people to bring in their pets. They even have allowed people to bring in a rabbit. When the person was in the hospital. However, there was not a pandemic at the time so that could change things. And I want to caution -- I want to throw caution there because a service dog or a miniature horse are the only two animals allowed under the Americans with Disabilities Act. Anything else is above and beyond and facilities have that option if they choose to go down that road.

>> LEWIS KRAUS: Next question: Is it a reasonable accommodation to have a sign language interpreter or helper in the hospital on the case all the time?

>> PAM WILLIAMSON: I'm assuming when you say "all the time" you mean 24/7. So, you know, again, everything has to be evaluated on a case-by-case basis. And effective communication has to be looked at from many angles. So the best thing to do is to evaluate the person's effective communication needs and then determine what would be reasonable in this situation to allow the person to be able to get the information they need and also to be able to communicate their needs back to staff.

>> MICHAEL RICHARDSON: I'll agree with Pam on that. Say, for example, we have a deaf individual who relies on ASL in a COVID-19 unit spending possibly, you know, two weeks in the unit. I think you know, what would be reasonable is working with that interpreter to determine what are the best times of the day to be on call available to be there to facilitate communication and important complex communication is necessary to allow that interpreter to have breaks and be necessary. Nothing that says somebody should be there 24 hours a day at this point. But case-by-case basis based on the level of communication, whether that person is fully sedated or intubated. Just a lot of scenarios to think about and make a decision from there.

>> LEWIS KRAUS: Thanks. All right, we have -- I think we'll do two last questions here. I think they bring up interesting issues. Do Braille transcription

documents need to be automatically available at drive-thru centers or upon request?

>> MICHAEL RICHARDSON: That's a good question. The issue with Braille is currently, you know, there could be facilities who help produce Braille documents that are not just functioning or opening right now. So it might be extremely difficult, somebody who is very proactive and wants to go out and get some things in Braille. It might be doable. It might not be doable. But it goes back to the situation of if you cannot have a Braille document available and one is requested, determine, again, a situation of what is happening. Is a person coming in and requesting to be tested. If likely going to be in a short time frame. If you can come up with a Braille document, great so, it is. If not then looking at the alternative, which could be getting a person's email address to email some electronic documents, thinking of ways to possibly read documents, spending more time with that individual at the testing site to review documents verbally. So, again, thinking outside the box and looking at alternatives. And more importantly communicating with that individual to say, hey, by the way, if we cannot come up with a Braille document, what is the best way we can get this information to you.

>> LEWIS KRAUS: Great. Thank you. And I think this will have to be our final question. Do ADA regulations apply to healthcare settings owned by religious entities if they are not contracting with Title II entities?

>> MICHAEL RICHARDSON: I'm going to say a majority of religious-based healthcare facilities should... do have obligations under Section 504, the Rehabilitation Act, quite often they're receiving Medicaid, Medicare funding sources and other state funding sources possibly to provide healthcare services. So depending on the funding source and levels and who they're coming from, quite often in my opinion, it's going to be extremely rare to find a healthcare facility that has no obligation whatsoever under ADA nor Section 504 of the Rehab Act.

>> LEWIS KRAUS: All right. There are a slew of messages lined up, and I'm really sorry we're not going to be able to get to them. We want to respect your time. But I will tell you what... you can take that message and call 1-800-949-4232 right after you hang up here and ask them that question and you'll be able to get that answered right away. And even if you don't do it immediately, you can do it at any time. All right, so we... you will receive an email with a link to an online session evaluation. Please complete that evaluation for today's program as we value your input and we want to demonstrate the value of it to our funders. We want to thank our speakers today for sharing their time and knowledge with us. Many chat messages have been

complimenting you all on your presentation. And realize all who are listen, these are people who work at the ADA Centers. That's the number I've been telling you about. We are there to provide information and technical assistance about the Americans with Disabilities Act. This is something that everybody at the centers does every day. I want to remind you today's session was recorded and will be available for viewing next week at ADAPresentations.org in the archive section for healthcare. Our next webinar on May 28th will be joined by Pam Williamson once again for more detail on service animals and healthcare facilities. If you still had questions and want to know more about service animals and healthcare facilities, join us on May 28th and Pam will be going into that in more detail. We hope that you can join us for that. Watch your email two weeks ahead of time for the announcement of the opening of registration for that webinar.

Thank you again, Jan and Pam and Emily and Michael. Really appreciate your efforts today. And for everyone else, have a good day. Be safe out there. And we look forward to seeing you again on May 28th. Bye-bye!