Thursday, January 23, 2020

Pacific ADA-Healthcare and the ADA Webinar

Pacific ADA Center

>> Lewis Kraus. Welcome to the healthcare, and the ADA Inclusion of Persons 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 10 regional centers that are federally funded to provide training, technical assistance, and other information, as needed; on the Americans with Disabilities Act.

Your regional ADA center by dialing 1-800-949-4232.

Real cam captioning, the captioning screen can be accessed by the CC icon, in the meeting control toolbar in the screen, to toggle the toolbar permanently on, press your altkey once and then press it again a second time.

As always in our session, only the speakers will have audio.

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Also, I want to note that this webinar is being recorded, and will be able to be accessed on the ADA presentations Web site, next week.

In the archived section of the healthcare. Area.

This webinar series is intended to share issues and promising practices, in healthcare accessibility for people with disabilities.

The series topics cover physical accessibility.

Effective communication.

And reasonable modification of policy issues, under the Americans with Disabilities Act of 1990. The ADA.

Upcoming sessions are available at ADA' presentations.org; under the "schedule" tab in the healthcare section;.

These monthly webinars occur on the fourth Thursday of the month at 2:30 eastern, 1:30 central, 12:30 mountain, and 11:30 a.m., Pacific time.

By being here, you are on the list, to receive notices for future webinars in this series.

Those notices go out two weeks before the next webinar, and open that webinar to registration.

You can follow along on the webinar platform with the slides. If you are

not using the webinar platform, you can download a copy of today's PowerPoint presentation, at the healthcare schedule page at ADA' presentations.org.

At the conclusion of today's presentation, there will be an opportunity, for everyone to ask questions.

You may submit your questions using the chat area, within the webinar platform, 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 your questions type in and submit them in the chat area text box.

Or press altH and enter the text in the chat area if you're listening by phone and not logged into the webinar, you can ask your questions by e-mailing them, to ADAtech,@ADAPacific.org.

>> Lewis Kraus: If you experience any technical difficulties during the webinar, you can send a private chat message to the host, by typing in the chat window, type your comment in the text box, and enter.

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You can also e-mail, any issues to ADAtech,@ADAPacific.org, or you can call us at 510, 285-5600.

Today's ADA national network learning session is titled "effective communication in healthcare."

This webinar, will review the Americans with disabilities, act and other laws, that apply to healthcare with a focus on the rights and responsibilities for effective communication, for people with hearing, vision, and cognitive disabilities, in healthcare settings.

Discussion topics will include common auxiliary aids, services, and strategies, to ensure effective communication as well as ADA resources for training and technical assistance support.

Today's speak is Michael Richardson, Michael is the director of the northwest ADA center and is responsible for coordinating the activities of the technical assistance unit.

He provides technical assistance training, continuing education, and consultation services, related to the Americans with Disabilities Act, and other federal and state disability laws, so Michael, I will now turn it over to you!

Michael Richardson: Thank you, Lewis, I just want to do a quick check and make sure that you are able to hear me now.

>> Lewis Kraus: Yes, we hear you now.

>> Michael Richardson: Perfect, perfect, let me just adjust my slides here. We'll go ahead and move to that first slide, Lewis, if you can give me control.

>> Lewis Kraus: Okay.

>>MICHAEL RICHARDSON: Perfect. There we go, first of all, thank you, all, and thank you, Lewis, for the introduction, and thank you for having me here today and I do want to thank the Pacific ADA Center for hosting me in a partnership we have as part of the ADA national network's efforts to promote

accessible healthcare.

Just FYI: I'm a person who is Deaf and uses a cochlear implant.

I had many friends in the disability and Deaf communities, and unfortunately, I've seen and heard firsthand too many stories of patients, and consumers with disabilities, experiencing communication barriers in healthcare settings.

Including myself.

So this is an important and personal mission of mine, as we address effective communication in healthcare.

(Pause).

>>MICHAEL RICHARDSON: Just trying to click this second slide here. There we go, so today's agenda, we'll talk about relevant federal disability discrimination laws.

We'll also talk about the ADA requirements for effective communication.

We'll sort of touch base on various disabilities categories, such as those with vision loss, who are blind, and how effective communication impacts them.

We'll talk about briefly about cognitive disabilities and effective communication.

And there will be sort of a heavier emphasis on Deaf and hearing loss and access to effective communication, because, that is one of the sort of biggest areas, we see, in our work here at the ADA centers for which individual groups of people with disabilities, often do not get provided access, when it comes to communication in healthcare.

And towards the end, we'll talk about, good ways and ideas and guidance, in establishing effective communication office policy, to address the provision of auxiliary aids and services and all that.

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So there are several federal disability discrimination laws, and we'll start with title II of the Americans with Disabilities Act applies to public, state, and local healthcare providers so quite often you'll see this applied to university-based hospitals at public universities.

Title III of the ADA applies to all private healthcare providers.

Next slide, please:

There's also Section 504, of the rehabilitation act, of 1973.

And this applies to federal healthcare services, and facilities.

And healthcare providers, who are also recipients of federal financial assistance or federal funds.

Such as Medicaid funds.

And then, of course, we have section 1557 of the Affordable Care Act, which applies to pretty much all healthcare providers.

And then, don't forget, we have titles under the Civil Rights Act of 1964, and this federal law mandates that appropriate language access, in the healthcare setting, to individuals, who have limited English proficiency; so this would also apply to individuals who are Deaf, and use American sign language,

as their primary language and we'll talk more about that as we get into the presentation.

And then don't forget: You may have state and local laws that often mirror the above federal laws that we just talked about. So always be aware of what your state laws, may entitle and remember, that if state laws, provide broader and greater protections, then that's all that applies compared to the ADA.

So don't always assume the ADA is a federal law that trumps all state and local laws.

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Slide 12. Just a quick note on the barrier-free healthcare initiative.

This is sort of in my opinion a really cool effort, by the U.S. Attorney's Offices across the nation, and they're partnering with the civil rights division of the Department of Justice, to target enforcement efforts, on accessible healthcare.

And this initiative will make sure people with disabilities, especially those who are Deaf or Hard-of-Hearing, have access to medical information provided to them, in a manner that is understandable to them as well.

And so the barrier-free healthcare initiative is a multiphase plan that also will involve other key issues for people with disabilities, including ensuring physical access to medical buildings.

Currently, on their home page, there's a list of various DOJ Department of Justice, settlement agreements, that go back a few years.

There's a small number that applies, to discrimination-based on HIV, AIDS status; and the rest quite a large majority, have to do with discrimination of people who are Deaf or Hard-of-Hearing, in accessing healthcare services.

Primarily in areas, where the provision of American sign language interpreter, was not followed through, or provided.

Next slide.

So just kind of stepping back and going to Title III of the ADA, which is sort of, the -- private sector of healthcare -- Title III of the ADA prohibits discrimination against individuals with disabilities by places of public accommodation.

And private healthcare providers are considered places of public accommodation.

Next slide.

So examples of such healthcare providers, could include, of course, hospitals.

Nursing homes.

Psychiatric and psychological services.

Offices of private physicians.

Dentists.

HMOs and health clinics, to name a few.

Next slide, please:

One thing that's important to note is that under Title III for healthcare providers, no matter how small they are, the Title III applies to them, regardless.

And regardless of the size of the number of the employees they have.

And the reason I want to emphasize this, is because, quite often we get calls from small clinics and doctors' offices asking if they had an obligation to provide a sign language interpreter, because they had less than 15 employees.

Now, for those of you who may know about title 1 of the ADA, that applies to employment, and the provision of reasonable accommodations, which applies to employers of 15 or more employees.

But what we talk about services, provided under Title II and Title III, it doesn't matter how many employees there are in an entity, the point is to provide access to the people who are accessing the goods and services.

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And it was also important to note for healthcare providers under Title III, private sector, is that, if a professional office of a doctor, a dentist, or even a psychologist, for example -- is located in a private home, the portion of the home, used for public purposes, including the entrance, is considered a place of public accommodation.

So this is something that people need to think about, if they're operating a private business out of their home, that is related to healthcare.

So what this says in a nutshell is that pretty much, everything from the point of an accessible parking space, to a path of travel to the front entrance, to the area used by the services, including the restrooms and the waiting area, should be accessible.

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So now we get to sort of the core of why we're here today.

To talk about, sort of core tenet of the Americans with Disabilities Act, and the key word is "effective communication." And what the ADA says simply is that disabilities that affect hearing, seeing, speaking, reading, writing, or understanding, may use different ways to communicate.

So we need to think about what potential barriers are out there, for people who have disabilities in which communication is impacted.

And what the ADA mandates is that information, must be as clear, and understandable, to people with disabilities, as it is, for people who do not have disabilities.

Next slide, please.

So for effective communication, healthcare providers have a duty to provide, appropriate auxiliary aids and services, when necessary to ensure that communication, with people with disabilities, is as effective as communication with others.

So, key terms being there:

Auxiliary aids.

And services.

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So the question is, who does effective communication apply to? Often we think it, obviously, applies to the individual with disabilities receiving the services of the healthcare provider.

So it applies to customers, clients, and other individuals with disabilities, who are seeking or receiving services at the center, medical center, and what's important to remember, is it may not always be patients of the healthcare provider.

Auxiliary aids and services, may need to be provided to spouses, partners, and family members, in other words, people who have a right to be involved in the provision of the healthcare services.

So some examples could include a Deaf parent of a child patient, meaning the Deaf parent would have access to a sign language interpreter for example.

There may be some hospital who offer Lamaze classes and so partner participation is often important in that.

So if there is an expectant mother. Her partner spouse or important family member who is involved in that birth process, may also require auxiliary aids and services to participate in the Lamaze classes.

Also thinking about peripheral interviews with family members in psychotherapy situations for example.

Next slide:

So this is sort of some important information to know about when thinking about effective communication.

Means used to provide communication is determined on a case-by-case basis, usually based on the person's need and situation.

Auxiliary aids and services, are devices, or services that enable effective communication for people with disabilities.

And basically, in a nutshell you consult with the individual, to determine, what communication method or technology will be involved for him/her. Now, Title II entities, which are sort of the -- the public-sector often are required to give primary consideration to request of the individual.

And so if an individual requests a sign language interpreter at a university hospital for example, then you can pretty much guarantee you probably need to provide that American sign language interpreter.

Same with -- very similar to Title III entities:

Which are encouraged to consult with a person with a disability, to discuss what aid or service is appropriate, given the circumstances.

The goal is to provide an aid or service that would be effective, given the nature of what is being communicated, in the person's method of communicating.

So generally, the requirement to provide an auxiliary aid or service is triggered, when a person with a disability requests it.

Now, the healthcare provider especially in Title III, has a final say in which aid or service will be appropriate, as long as the result is effective for the individual, given the nature and context of the information being conveyed and we'll talk about some of those examples in a second.

Next slide, please.

So we'll start with the -- the individuals with low-vision or maybe, blind, or on the spectrum of visual impairments.

People with visual impairments often receive important healthcare-related information in standard print.

Which could be problematic and troublesome for individuals who can't read a standard print.

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Here's a common scenario and an actual scenario that did happen.

In this case, a woman with low vision, reported that, only after years, of taking her thyroid medication at dinnertime, that taking the medication, with food weakened the drug's effects, which may have compromised her treatment. In this situation it was understood the woman was given verbal and print instructions in standard print and it's likely she got the gist of the verbal instructions but did not have an accessible document in a large print to refer back to, and, therefore, was confused about how she was supposed to take her medications.

Next slide, please.

Still addressing people with low-vision or who may be blind:

Here are examples of communication needs that are often important, and need to be considered as far as providing alternative formats to print, or ways of communicating.

So think about medical exams, tests and lab results, information explaining diagnoses, or treatment; prescription medication instructions like was just mentioned.

Explanations for informed consent or end-of-life policies and procedures, physical therapy instructions and instructions for the management of chronic conditions and, of course, childbirth preparation resources prenatal materials, just to name a few.

Next slide, please.

So when working with those with vision loss, where information is provided in written form.... especially some of the more complex stuff -- ensure that effective communication for people who cannot read the text -- so consider the context and the information, how critical -- how lengthy, how important it is.

Now, sometimes something brief and very simple, may be able to be given verbally as opposed to having it printed out. But also consider the importance of the information, the safety involved around that. The length and complexity of the materials and be prepared to provide alternative formats to print.

Next slide.

So some examples of auxiliary aids and services, for communication include, Braille.

Large-print text.

Electronic formats, and audio recordings.

If little time to have anything produced in alternative format, you may want to consider reading the information aloud.

So, going back to that first bullet point, it's not expected that every healthcare clinic and facility has everything backed up in Braille, and ready to hand over, but for example, if something needs to be conveyed, without the

opportunity to provide Braille, think about providing a qualified reader.

Now, under the 2008 amendments Act of the ADA, they added the definition of a qualified reader, which is somebody, who's defined as a person, who's able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

So this doesn't mean a person requires, specialized training to perform this; but healthcare providers should think about having somebody designated on staff, or just having the general staff be aware, that at times, they may be called to work -- or provide services, as, what we call, "a qualified reader" and that basically is just reading out information, to help somebody understand.

There was a case, I knew about, a while back -- in which a friend of mine, actually, she was blind.

And she just told me she had been turned away from her healthcare provider because she could not read the consent forms that she needed to sign, and read upon her arrival for appointment.

And the response she got from the front desk person was, if you cannot read this, we cannot help you so please come back when you can, with somebody who can help you do this, which was, you know, discrimination right there.

So the healthcare provider, cannot require somebody who's blind, for example, to bring someone in -- with them to facilitate communication.

They've got to be prepared to read some information for them; or at least maybe postponing an appointment, to get somebody who is available, during busy times, for example, to sit down with that individual, and read some forms to them.

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The -- at the same time, when doing this, think about confidentiality issues.

So for individuals, who are blind, often report feeling frustrated, and embarrassed after being forced to reveal confidential information, whether it's financial or personal, out loud in public.

So think about the lobby areas, or having other patients, maybe waiting for services.

And whether or not it was appropriate to convey information to that individual, it may require stepping aside to a vacant office or some other part of the facility, where confidentiality can be guaranteed.

Next slide please.

So next, we kind of move to the group of individuals who may have intellectual or cognitive disabilities.

And so basically, just a brief definition, intellectual disability is a disability sort of characterized by significant limitations, both in intellectual functioning, such as reasoning, learning, problem-solving; and adaptive behavior -- which usually covers a range of everyday social and practical skills and often originates before the age of 18, often congenital in nature.

And cognitive impairments, are not caused by any one disease or condition; for example Alzheimer's disease and other dementias, traumatic brain injuries and other conditions such as stroke -- can cause cognitive limitations.

So... when dealing with people who may have some different ways of communicating due to cognitive and intellectual disabilities, just sort of guidelines include:

Allowing plenty of time to teach a new task.

Using repetition, with precise language and simple wording.

Treating adults as adults.

And children as children.

That means including talking directly to the patient, and not their personal care attendant. Or family member, who may be in attendance.

Do not pretend to understand if you do not.

Next slide.

Think about also asking additional questions to clarify any information, a patient may be sharing with you.

May be a need to reduce distraction within the examination area.

Using pictures or objects to convey meaning, if appropriate. There are some great new sort of handy tools out there, available, that provide, diagrams, pain scale levels of images and graphics that are easier to understand for some people with intellectual and cognitive disabilities.

Think about allowing a wait time for the patient to process information, or respond to a question, or make a comment.

So, one thing that's important to note here in these situations is making sure you're taking that extra time, for the patient, appointment to allow for effective communication.

So this may include modifying any policies or procedures, in which an office may have.

For example, say, a doctor has a policy, of limiting his visits to 15 minutes per patient.

Now, if somebody takes longer to communicate in that 15 minutes, then that healthcare provider should consider modifying that policy to allow that appointment to go over time, and allow for full, and equal and effective communication.

And they cannot charge for that extra time as well.

So other tips may include:

Always respecting autonomy and privacy of individuals in this category.

Again, using plain language, when possible.

And even providing questions, in advance of their appointment, might be helpful, to facilitate communication.

Next slide:

And just a brief slide on individuals who may have speech-related disabilities.

Some things to think about as far as allowing them to use and have

auxiliary aids and services.

This could include speech synthesizers communication boards and believe it or not there are some individuals who use sign language to express communication, and it may require bringing in sign language interpreter to orally transliterate what that person is signing.

Maybe even thinking about getting access to a laptop, a keyboard, for typed communication, using tablets or iPads; one thing I want to point out here, is, speech synthesizers and communication boards, are often personal items that individuals bring with them, to appointments, or to engage with in the community.

And the reason I want to mention these, is to allow individuals, to use these devices to the maximum extent feasible, during the nature -- during the course of the healthcare appointment.

And every time I go -- I do this training I bring up a personal story, of having something similar in this situation happen to me.

Years ago.... at the time I was wearing two hearing aids and did not know a whole lot of sign language, and so I relied on my hearing aids, as well as my eyeglasses to effectively communicate with healthcare providers.

I was going in for a minor surgical procedure.

And the policy at the time was to leave all personal items, in the recovery room, and so I did that without thinking that my hearing aids and eyeglasses left behind, and wheeling me to a surgical unit, literally, felt like a half mile down a large hospital corridor, and when they placed me in front of the doors to the operating room, I was immediately surrounded by an anesthesiologist, the surgical team and nurses and what have you and they started talking to me about what was going to happen during the surgery and post recovery and whatnot.

Now, without my glasses I could not take any visual cues through lip-reading.

And without my hearing aids, I couldn't hear anything so it was a frightening experience to be in this healthcare situation and not understanding what was happening, because I did not have what I needed to effectively communicate.

Next slide:

So now we shift into sort of the bigger area, that's -- an area we often see that needs more addressing in when -- when it comes to effective healthcare, effective communication and healthcare.

And this all surrounds individuals with hearing loss, and those who are Deaf or Hard-of-Hearing and one thing I do want to point out before we go further, is always remember, that we do have an aging baby boomer population, and many older individuals are aging, into disability, and aging into hearing loss; so never discount these -- the older population, who may require effective communication auxiliary aids and services to allow for equal, and clear communication.

So for individuals with hearing loss or maybe different, common aids, include qualified ASL interpreters, note-takers might be something to consider for

Lamaze classes for example. Written materials, assistive listening systems or devices such as FM systems or pocket talkers closed caption decoders or making sure any video and media materials is -- either open or closed captioned.

Ensuring there's a possibly access to a relay service, the use of video phones and ensuring that staff know how to answer and respond to a relay call from a Deaf individual, for example.

Communication access, realtime translation, CART, for short, which is captioning, and we'll talk more about that shortly.

And the exchange of written notes, may be okay in some situations. We'll talk more about that as well.

One thing I do want to make clear here:

Is that, sometimes there is stereotypes or even myths about people who are amazing superhuman lip-readers.

And what I want to mention is that lip-reading or speech reading is frequently in reality ineffective, in many factors, lip reading such as lighting facial hair foreign or regional access and many sounds cannot be easily read on the lips, additionally patients who are anxious, scared fatigued, affected by medication, may all hinder the patient's ability to effectively lip-read or speech-read.

In many Deaf individuals, particularly in medical settings, they will pretend to understand and nod their heads in agreement and I tend to see this in our older population who are sometimes often in denial about their hearing loss.

So the point being is lip-reading is not always effective. Think about ways to ensure, there are alternative ways to provide information, and asking sort of open-ended questions to ensure, that individuals, have understood what information you may have provided.

And do not assume that note-writing back and forth on paper is an effective communication tool.

With American sign Language, American Sign Language is not based on written or spoken English, the syntax and grammatical structure are very different from English and English is often the second language for many partially Deaf individuals.

Just as it is for people coming from different or foreign countries. So writing could also be labor intensive for many Deaf people as well as healthcare providers and writing may be found to be cumbersome and inefficient in a medical setting, especially when trying to convey complex and important medical information.

And I have seen cases where even personally, I've had individuals try writing back and forth to me, and cutting out much of the communication, that should be given to me, and trying to abbreviate, which is not effective.

So other considerations in this area is providing visual medical aids. Again, as I mentioned charts, and diagrams. Anything to help, and explain certain concepts and basic anatomy, for example.

Next slide.

So for those who are culturally Deaf, quite often, individuals who are Deaf and use sign language, especially American sign language, most effective auxiliary aids or service with a medical office, can -- which medical office can provide is a qualified, sign language interpreter. And preferably those who are trained in medical terminology, now, questions some people often have, are do all individuals who are Deaf or Hard-of-Hearing, require -- or use the same kind of interpreter.

And the answer is no, so always be prepared to provide potentially different kinds of sign language interpreters.

The healthcare provider should ascertain, the particular language needs of the Deaf or Hard-of-Hearing patient, before hiring an interpreter.

Some individuals may require interpreters who are fluent in ASL, American sign language; others may require interpreters who use, signed exact English or C sign, which is abbreviated. Still there could be others who do not know any sign language, and may require -- require oral interpreters, who take special care to articulate words, for Deaf or Hard-of-Hearing individuals.

And there are people who are trained to kind of help facilitate communication in that method as well.

Next slide.

This is just an image. I want to show a woman, who is laying down or partially upright in a hospital bed, communicating through a sign language interpreter to a healthcare provider and has a look of concern on her face and, obviously, I think talking about a healthcare condition.

Now, I want you to imagine taking out the American sign language interpreter in this situation.

And imagine how frightening, and scary, this experience could be for this woman, to try to explain whether expressively, receptively, to herself. Imagine trying to explain complications through an interpreter. It can be a scary experience, so for a person to be in an anxious state like that. Trying to partially lip read and reading and writing back and forth could be problematic.

Next slide, please.

Here's a common scenario, and this is an actual situation as well, based on some stories we received up here in the Pacific Northwest, as a part of the medical interpreting task force.

In this situation, a Deaf patient, ended up in the hospital, after a heart attack, attributed to medical error and this was because medication was prescribed, without the benefit of a sign language interpreter.

So, obviously, this gentleman misheard and misunderstood, information, and did not take his medication in the way he should have.

And there were some unfortunate consequences, related to safety, and fortunately, he did survive and recovered, but it was something to think about, as far as how providing auxiliary aids and services, also enhances, and almost assures patient safety.

Next slide, please.

So as part of the 2008 amendments Act, the ADA revised the definition of a sign language interpreter, a qualified sign language interpreter, and it's defined as an interpreter who, via a video remote interpreting service, such as VRI, or onsite appearance, is able to interpret effectively, accurately, and impartially, both receptively, and expressively, using any necessary, specialized vocabulary.

And this includes sign language interpreters, oral transliterators; and cued language transliterators, just to name, again, more kinds of sign language, interpreters that are available, out there.

Now, interpreters provided -- interpreters providing services in the medical setting, may need to be able to interpret medical terminology.

So now, one thing I want to point out here, is the ADA definition does not require certification, although some state and local laws, do mandate that interpreters be qualified to provide medical interpreting services.

And there are some up-and-coming new state laws ensuring they have certification in medical terminology as well.

Next slide, please.

Here are some other scenarios that happen far too often and are unfortunate in many situations.

Some healthcare providers may ask sick children to interpret for their Deaf parents. In another situation, there's a case when healthcare providers pressure a Deaf man, to lip-read, and interpret for his Deafblind wife, and this is one I hear often from my friends in the Deaf community. Quite often request for sign language interpreters are often ignored. May show up at an appointment and there are attempts to write back and forth on paper during the course of a complex and important medical procedure.

Or checkup.

Next slide.

And one thing the Department of Justice and ADA makes very clear is that family members should never be used as interpreters.

Family members do not meet the requirements of a qualified interpreter, because they usually cannot remain impartial and often do not have the language skills or training, to effectively and accurately interpret the medical appointment.

And if I can elaborate a bit further on this: Family members and friends, if you think about it, are also often very -- or often too emotionally or personally involved and may have interests that conflict with the patient's.

They may cause role confusion, and are unable to interpret effectively and accurately.

Also, family members, being used as interpreters, or friends -- can cause problems in maintaining patient confidentiality as well.

Now, family members may be used, in an emergency involving imminent threat to the safety or welfare of the individual, or public -- and no interpreter is available, or specific requested by the person with a disability, the accompanying adult agrees and the reliance on that person is appropriate under the circumstances.

So, again, emphasizing, what is a circumstance.

So, obviously, imminent threat to patient safety and all that, makes sense.

But for even general procedures, or general office check-ins and visits:

Using a qualified sign language -- sign language interpreter is often the best way to go.

The ADA also prohibits the use of minor children as interpreters, with, again, the exception of emergencies and situations, where the safety of others are at risk.

But, again, please use caution when I say this, because, again, the general rule is, to not use family members or children, especially -- to facilitate communication.

Next slide please. This is something I've sort of just briefly covered already. Again, for qualified sign language interpreter in medical settings, the recommendation is that interpreters working in settings should have some form of national certification in addition to medical interpreter training.

Because such certification and training serves as an indication of competence.

And, again, this goes back to ensuring patient safety in all methods of communication.

Next slide, please.

Just to review, some -- simple auxiliary aids.

And services, when it comes to communication.

If you think about simple situations, which include brief or simple face-to-face exchanges, sometimes, very basic aids are usually appropriate and effective.

For example, exchanging written notes may be effective when a person -- when a Deaf person asks for a copy of a form to fill out.

Or using a smartphone to write exchange messages, this can be usually accomplished maybe, perhaps at a pharmacy, where a Deaf individual is just picking up medication, and a prescription, and maybe able to get by with just... writing back and forth on paper.

As long as hopefully, that healthcare provider, beforehand has provided instructions in alternative format, whether it's a sign language interpreter to ensure they know exactly how to use that medication.

Next slide, please.

So for more complex situations, again, this is where, lengthy exchanges and information -- this is where we'll be using sign language interpreters.

Or -- or communication access realtime translation, or CART.

And this can be for example in interviews.

Counseling sessions.

Community health events and meetings.

Think about, also, opportunities for too provide written transcripts or closed captions on video for prescripted situations such as speeches or presentations that you may or may not find in programs offered by healthcare

providers such as nutrition programs and things like that, which are open to the public.

Next slide, please.

Now, this is -- we're stepping into sort of an area that has received sort of a lot of attention lately, and has to do with video remote interpreting.

Or VRI.

And there was a new definition provided by the ADA Amendments Act in 2008 and it's becoming more popular, in the healthcare provider area.

But it does come with controversy and limitations, which I'll address here, but the definition is, VRI is an interpreting service that uses video conferencing technology over a dedicated line, or wireless technology, offering high-speed, wide-bandwidth video connection that delivers high quality video images.

Next slide, please.

Now, there's two images here, basically people who are receiving healthcare services and in these two situations they are sitting upright and probably either having a general checkup or a general conversation with their healthcare provider and the image shows the use of video remote interpreting, as you see on the monitor screens, there is an interpreter provided, and working alongside the Deaf patient, and the healthcare provider, and even sometimes a family member.

So, what is important tomorrow, though, is that the ADA amendments act requires specific technology requirements in order to provide effective VRI services.

Next slide.

And these requirements include specific performance standards ensuring there's a high quality video and audio. There's a dedicated high-speed connection; and that means usually a direct-connect through the Internet system, and not relying on wi-fi, as we know it, by connecting through the air.

If you can say that. The picture must be clear.

Large.

And sharply-delineated and there must be a good view of the interpreter's head, arms, and fingers.

And voices must be clear, and easily-understood, both ways, and, of course, which is one of the most important things: Making sure that healthcare staff know not only where to find the equipment, but how they can quickly set it up, and know how to turn it on, and know how to connect with a sign language interpreting agency, and making it work.

And this should include regular and ongoing staff training, on how to use this equipment, and making sure, it's working, and functioning appropriately. So consider this, especially in areas that may have high turnover of staff, ensuring that incoming staff, know how to use VRI equipment.

(Pause).

>>MICHAEL RICHARDSON: RICHARDSON: Next slide.

So this is where we find a lot of controversy surrounding VRI.

Some problems that we often encounter with video remote interpreting, include:

A patient being prone.

There's actually one story of a patient who had neck surgery, was prone.

And was forced to use VRI, as part of communication, and in doing so in the process of turning his head to look at the screen, actually detached the stitches and staples in his neck, from surgery, so, again, consider the nature and context and the environment and whether VRI is appropriate.

Often as well as the patient is in pain, or under stress, under the influence of substances -- such as coming out of anesthesia and medications -- that may impair the ability to focus on a screen.

And also, some issues include the size and distance of a device, such as people can't see it well.

Especially here in the Pacific northwest, we have a large Deafblind population, people who are Deaf and have limited vision, and looking at small screens is not going to be an effective way of communication.

Next slide.

Additional problems with VRI, include like I mentioned, a patient has a visual limitation as well. Quite often, in recovery rooms: There is a bunch of other equipment that may be blocking the visual sightlines to the VRI monitor.

There's insufficient signal strength or weak audio, and, again, this goes back to relying on wi-fi, rather than a direct-connect -- connection to the Internet.

And quite often as we see in Deaf culture, quite often you'll have much more Deaf family members involved -- hanging out in the recovery room and being part of the process and providing healthcare.

And not everybody can see, the screen at the same time.

Nor be seen by the camera, so the interpreter can provide effective communication.

Quite often the interpreters cannot see the context identify, who is entering and leaving the room; who is talking; and what they are doing.

And, again, going back to the other issue, as I mentioned before, staff often lack training on how to use the device.

Next slide.

So, the question is, when is VRI effective?

So when the patient is feeling able to sit up and to concentrate, for nonserious -- to the emergency room, or ready for discharge, it may be appropriate to use VRI, again, considering the context and the situation, and the -- cognitive capabilities of the patient, and the clear understanding, VRI can be effective in some situations.

Next slide, please.

So when is VRI most effective? The most effective communication for emergencies and urgent care is a combination of an on-call interpreter and VRI.

So a procedure of asking the Deaf, Hard-of-Hearing patient or Deafblind patient, their most effective means of communication -- what is their preference, I

can guarantee you most people in the Deaf community will require, or want a -- an in-person interpreter.

And I do understand that sometimes this can be limited by location, and the ruralness of an area, where a live person, interpreter may not be available.

And also, if requested, requesting a live, in-person interpreter, calling on the -- first of all, securing VRI and then calling for live interpreter to start communication at least -- so the idea, if you have reliable and functioning VRI equipment, and it's the appropriate situation, it's okay to start using VRI, while somebody is sort of in the background calling the local interpreting agency to ensure hopefully, secure a live in-person interpreter to come over and take over.

So, usually the healthcare provider can make the call on what's going to be effective, as long as it's equally effective, again, given the situation, and the nature and the environment as I've given you several examples.

So, I have seen some hospitals asking me, if it's okay to have a VRI-only policy?

And my answer is always a resounding no.

So entities that rely solely on VRI services, are at risk, of not providing effective communication.

Because like I mentioned: If the equipment or Internet connection fails, the -- or the staff doesn't know where to find the equipment or use it, or the situation is not appropriate for the use of VRI, the entity has not adequately provided access, and this has been well-documented, in several court cases, in settlement agreements.

Next -- next slide.

So when choosing an appropriate VRI provider, one thing to think about -- this is something important -- is I've seen many facilities have foreign-language services.

Agencies, also providing sign-language interpreters.

So many healthcare facilities have arrangements with remote language translation companies, to provide translation for patients who speak other languages.

And some companies add on ASL interpreting as one of their options.

And I do want to bring this up, because this is something you should be aware of and be cautious about.

Because the question you still have to ask is, are these sign language interpreters qualified?

Quite often, people who run foreign-language agencies, do not have the knowledge and expertise, to understand what a qualified sign language interpreter is.

Or who.

And so the question is, are they providing -- do they think they're providing an actual accommodation auxiliary aid or service, or are they providing a language translation service?

So, again, ask yourself, using a foreign language company that provides

translation services, and they say, they do provide sign language -- find out more in detail, and ask probing questions about the nature, and the qualifications of those sign language interpreters.

Next slide...

Now, shifting from sign language, to communication access realtime translation.

Again, we abbreviate this as CART.

And this is for individuals, and, again, this is the definition, that, was redefined in the 2008 amendments act, through the ADA.

So, CART is for individuals, who are Deaf, but do not rely on sign language for communication, and have good levels of reading comprehension, the appropriate auxiliary aid or service is usually the use of transcription services, such as communication access realtime translation.

Next slide.

So the question is, will you be seeing and using CART in all healthcare services? Probably not.

But always be prepared to think about situations where CART may be effective.

I've got two images on the slide. There's an image of an individual receiving captioning services, at a table surrounded by other individuals.

And to the bottom right of that image, is the CART provider using a stenographic machine, to provide captions.

And then the other image -- on the lower right, is somebody providing captioning or CART services to a larger audience that may include more than one individual.

So, just imagine, for sake of this presentation that upper left picture -- it could be somebody meeting with a surgical team, or recovery team, or whatnot.

And this could be an older American, who is losing a lot of hearing, due to hearing loss.

You want to be sure, that they have effective communication.

Because I can tell you right now: I know so many older Americans with hearing loss who would nod their heads and pretend to understand, when in fact, they have not.

So try using some of these probing questions, again, whether somebody wants to use, some kind of accommodations or they may actually request the use of CART in a situation like this, or especially, with healthcare programs in which large audiences are involved, and people are invited to hear, for example, nutrition improvement programs for aging Americans.

And in this case you might get several individuals who request either FM systems, listening systems, or may require CART.

And my philosophy, is if you can, if you're a large enough healthcare provider, and you are providing healthcare programs to audiences, especially large audiences, that will or may include, aging baby boomers, please consider

using CART as a sort of courtesy, because quite often those audience members will benefit from it, and quite often won't even know that it exists; and it goes a long way, in ensuring, effective communication, and active participation by those in the audience.

Next slide...

So now, we shift gears into sometimes we get questions, on our technical assistance team about costs involved and things like that.

The ADA talks about undue burden and fundamental alteration.

And what this means, is the ADA does not require the provision of an auxiliary aid or service that would result in an undue burden or a fundamental alteration, in the nature of the goods or services provided by the healthcare provider.

Now, if I can further explain that: A fundamental alteration is a change that is so significant, that it alters, the special nature of the goods, services facilities, privileges, advantages, or accommodations offered by a business.

Now, in healthcare settlements, from the DOJ, the Department of Justice has indicated that very rarely, will this be a legitimate defense for failing to provide effective communication in healthcare settings.

So just be aware that a fundamental alteration is often a hard argument, especially with large healthcare facilities.

However -- next slide, please....

We often hear more about undue hardship and the financial burdens of providing auxiliary aids and services, specifically to, when it comes to American sign language interpreters, interpreters, or realtime translation, CART providers what the ADA says is for undue burden and fundamental alteration an individualized assessment is required, to determine whether a particular auxiliary aid or service, would be an undue burden.

Next slide so this is what we got often for our technical assistance line, a small healthcare provider, for example, complaining that it costs too much.

And in a court of law and the DOJ, what they will say is the healthcare provider is expected to treat the cost of providing auxiliary aids and services as part of the overhead cost of operating a business, as long as the provision of the aids or service does not impose an undue burden on the provider's business, the provider is obligated to pay, for that auxiliary aid or service.

So, for example:

A payment may be considered an undue burden, or a fundamental alteration, if it would cause your doctor to go bankrupt or out of business.

So, it could be hard to find such a situation, where providing a sign language interpreter for one appointment, would cause -- and wreak havoc -- on the business and put them in dire financial straits. Now, a loss on a single appointment or even providing ongoing care for a patient, does not establish an undue burden or fundamental alteration.

The overall financial circumstances, of the doctor's practice or office, must be considered.

So -- in many settlement agreements for the DOJ, especially through the barrier-free healthcare initiative list that I mentioned at the beginning of the presentation, settlement agreements negotiated with the Department of Justice, are clear.

Being reimbursed less, than the cost of the services, for sign language interpreter is not considered an undue burden.

Healthcare provider cannot charge a patient, either for the cost of providing auxiliary aids and services.

So this goes back, again, to -- we -- like I mentioned we get calls from doctors saying I can't afford this, this is expensive. I just can't afford it.

And I say, our response typically is in a court of law, you need to be prepared to show, on paper, that providing that one service or multiple services would basically put you in the red or put you into bankruptcy, and that would be, including looking at all potential parent organizations that involve that clinic.

And any connections to the financial resources, and financial assets to make such a decision.

Next slide, please:

Continuing with undue burden and fundamental alteration:

When an undue burden can be shown, for example, the healthcare provider still has the duty, to furnish an alternative auxiliary aid or service that would not result in an undue burden, and to the maximum extent possible, would ensure effective communication.

So -- but, again, this goes back to first, demonstrating, that the provision of a preferred choice, would definitely and actually be an undue burden.

Now, I just want to mention covered entities may require reasonable advanced notice from people requesting aids or services, especially sign language interpreters.

Based on the length of time, needed to acquire the aid or service, so sometimes we see policies, please request an interpreter two weeks in advance, from nine days in advance; however, you may not impose excessive advance notice requirements.

So even with walk-in requests for aids and services, must be honored to the extent possible.

So, whether or not you can find a sign language interpreter on the same day -- of a same- day request, the least you can do is offer alternatives and if the alternatives are not agreeable, then, certainly, requesting an appointment as soon as possible, when, in fact, you can arrange for sign language interpreter or VRI, as an example.

Next slide, please.

So as we get to wrapping this up, I do have a few slides, addressing how to best go about in developing a good policy, and procedures to ensure the provision of auxiliary aids and services, for people with communication disabilities, are best maximized and ensured.

And if not guaranteed.

So, healthcare providers are encouraged to enact internal policies, and procedures that address the specific communication needs of the entity and the patrons they serve.

So drafting policies, and providing training, and the protocols for arranging auxiliary aids and services, keeps staff members, informed, with how to comply, with the ADA.

Next slide please:

When it comes to establishing effective communication, office policy, front-line staff should ask Deaf patients, for example what their preferred communication needs are, and document that in the patient's medical record so it's always there for repeat appointments, and things like that.

And build a database of qualified sign language interpreters and referral agencies, with expertise in medical settings.

So.... sort of in a nutshell, documentation in the -- the chart file should be clear, on how to -- how any language or communication needs will be addressed or were addressed, for the patient at each visit.

And this would also include any reason why accommodations were declined by the patient, so it can be made clear, for example that specific auxiliary aids or services may not work for that individual.

Now, that database, that I mentioned, should be used as a reference for all medical situations, that may come up in the future.

Medical centers for example, including healthcare providers, can -- can contact various organizations, to learn about potential listings, of certified sign language interpreters.

Quite often the Deaf and Hard-of-Hearing state commission, many states do have a commission, or an office for Deaf and Hard-of-Hearing services.

And they will offer -- are often a good connection to connect with, and find out, various lists of agencies and free-lance interpreters available in the area or state. That may be available to provide services.

And quite often they'll link -- there's also a regional link, for regional offices for Registry of interpreters for the Deaf, RID for short, and they're a good resource to go to, to find qualified sign language interpreters in the area.

Next slide....

>>MICHAEL RICHARDSON: Just continuing, an effective communication policy will also include:

A definition of who is entitled to auxiliary aids and services.

And, again, this is -- not only people who require them, because of a disability, but also family members, and spouses partners, who may have a legitimate, right to be involved in that healthcare service.

Several examples of various examples that -- if not all, auxiliary aids and services, that the entity has available, processes on how to respond to requests, for an auxiliary aid.

And how long, it should take to respond to those requests.

So, this is very critical, because, once the healthcare provider has been

put on alert, to obtain a sign language interpreter for an appointment, in two weeks, for example, there should be a process in place, to ensure that it's being acted upon, in a quick, and expedient manner from the point it's been requested. Quite unfortunately I've seen too many situations where an interpreter... [interruption in audio].

>> I believe I left off on, continuing a discussion, on developing, an effective communication policy.

Within the healthcare setting.

And, I -- I was mentioning, making sure, that you know where devices, such as VRI equipment, is stored.

The names of subcontractors that provide, auxiliary services.

Such as interpreters.

Captioning of CART.

And Brailling services for example. Hours of when subcontractors are available, to provide services, and also, procedures for obtaining a qualified interpreter, or last-minute or during an emergency.

And this, in my experience working with hospitals that have a good policy in place, they not only have a list of various agencies of free-lance interpreters available, but they also have interpreters who agree to be on call, 24 hours a day, seven days a week, for some of those unique emergency visit that could happen at 2 or 3:00 in the morning.

Next slide.

And, again, developing effective communication policy, also includes the definition of who is entitled to aids and services.

Examples -- I'm not sure if I said this one already, how to respond to a request for auxiliary aids, such as interpreters and, again, how long it should take to respond to requests.

I believe I -- that's a repeat slide.

Next slide.

And then, I should go back one slide. I'm sorry.

We have one more forward.

There we go.

The effective communication policy should also identify when it's appropriate to exchange written notes, and when an interpreter should be called.

Who is considered a qualified interpreter.

Have some language in there, in the policy, about friends, family and children, and impartial parties being unqualified, to interpret.

And appropriate, and inappropriate times, and settings to use VRI video remote interpreting.

Next slide.

>>MICHAEL RICHARDSON: Some resources to think about and have at your disposal, including the ADA.gov Web site:

Which has regulations, and standards, all about the ADA, and effective

communication.

And, of course, don't forget about your local ADA regional center as part of our national network of ADA centers -- they have the 1(800) number, 1(800) 949-2232. We all share that same number so people can call us for confidential, technical assistance on rights and responsibilities.

For not only effective communication, but anything that has to do, with access, and inclusion.

The U.S. Access Board -- and there's a Web site there, WWw.access-board.gov, is also a good resource to look about all the physical requirements for accessible healthcare facilities, but also, effective communication requirements.

Next slide.

>>MICHAEL RICHARDSON: And especially because of the use of sign language interpreters, can often be a confusing and complex situation for many people, new to the field.

These are some good resources to go to as well; and that includes the national association of the Deaf.

Which will often have connections to your local resources for sign language interpreters.

The national federation of the blind, would also be a good resource to go to, to find out local resources for Brailling, for example. Or getting some ideas on how to provide -- how to provide alternative formats to print.

And the registry of interpreters for the Deaf, as I mentioned earlier, (RID) is also a good resource to connect about learning about your local resources for qualified sign language interpreters and not only that, but also those who may be certified as well in medical terminology.

Next slide:

And think about some of your local common state resources that are often common in most states -- such as your disability-related agencies.

This can include the local centers for independent living.

Or your state independent living council.

Also the state office of Deaf and Hard-of-Hearing services; the Department of Services for the Blind as I mentioned before; and also, getting to know your interpreter referral agencies.

Next slide.

So the next -- the next 2 slides, I'm not going to go through, but these are just various sources that I sourced for this presentation.

And we'll going to the very last slide, Lewis, and I just do want to say, I hope, I gave you some good information to start with -- and as I mentioned before, we are here, as the ADA National Network to provide support and resources to you, should you have any questions, to -- don't be afraid to give us a call. Reach out to us by e-mail, and go to our Web sites, whether it's regionally or the Web site Web site at ADATA.org.

At this point, I'm going to turn it over to Lewis, and I'm happy to go

through, and answer any questions.

>> Lewis Kraus: Thank you, so much, Michael, that was great.

And everyone, please, I want to remind you, you can submit your questions, in the chat window.

You choose that down there at the bottom of the screen.

Or you can hit your alt key to bring it up.

And hit it again, to make it stay.

All right. We have quite a few questions here.

Michael so the first question has to do with, a medical office that is leasing space at a hospital.

And is not affiliated with that main hospital.

And the person says, that "hospital claimed that they are not responsible for the provision of accommodation for the office."

And the medical office as a tenant, what if they decline to provide the accommodations.

So -- it's, like, an issue of who's -- who's responsible?

>> Michael Richardson: So the question, right is basically, a for the private business of sorts, involved in healthcare, associated and affiliated with a hospital space.

And your question is who is responsible; is that right?

>> Lewis Kraus: Right.

>>MICHAEL RICHARDSON: Yeah, well, typically it's going to be the private provider of the services is responsible; however, quite often in many settlement cases as we've seen, is that, even overarching entity that owns a property, has some responsibility as well as especially if it's a state-run university hospital, because their responsibility, as well as if they're renting out space to a provider of services and a provider of goods, then they have to ensure that they are being accessible as well.

So in that situation, especially, this -- related with a state hospital, if I'm correct -- it may be up to a point of negotiating cost involved in providing, the auxiliary aid or service.

But still, it does not relieve that small private business of their obligation to provide effective communication, and any appropriate auxiliary aid or service.

>> Lewis Kraus: Okay. Great.

The next question, is --

Q. What can a Deaf person do if a provider refuses to provide an in person, interpreter but instead wants to use VRI, or wants to pass notes?

A. That's a good question.

Now, what I hear a lot sometimes in the Deaf community, is, many individuals feel they have a right to a live, in person, interpreter versus VRI, the reality is, if the entity is providing the VRI service, in the appropriate circumstances, and it is available, and it is working well, in connection.

They are doing their due diligence, in providing the appropriate

interpreting services, even though it may not be the preferred mode of the requester.

Now, if the requester is -- watching a sign language interpreter for a lengthy and complex situation, and VRI is being attempted to be provided and it's not working well -- that is ineffective communication, and usually I encourage the Deaf individual to either reach directly to -- if there is an ADA coordinator within that system, to go through that channel first, to see -- to resolve that issue.

Otherwise, ultimately, filing a complaint, with either human rights commission, or going to the Department of Justice, and filing a claim that way.

I hope that -- I got that right.

>> Lewis Kraus: Okay. Great! The next question is....

Q. What are your suggestions for Medicaid limitations with billing for extra time, needed at times of providing accommodations?

So, many times, providers state that the extra time is not billable.

These policies are not typically driven by a provider, but instead by insurance, including Medicaid.

A. That's a good question. That's sort of a topic I'm not fully-versed in, just because it has to do with internal Medicaid, Medicare policies surrounding time.

What I do know is that, again, policies and procedures should be flexible, to ensure, effective communication.

I do know for instance, that some Medicaid, Medicare, situations, do partially I think cover some of the costs of sign language interpreting. That is not my area of expertise at the moment. I will be happy to do that research, and get back to that person who posed the question, I'll get back to this group and if you take down my e-mail, which is MIKE67@uW.edu. And I'm sure you can find my contact information anyways, but I'll be happy to do some research and see if I can find more specifics around that question.

>> Lewis Kraus: And, Michael, if you have an answer you want to write up, if you do find something, you can send it to us and we'll post it with the webinar archive on this.

So, people can come back and look at that later, if they want.

All right. The next QUESTION:

Q. Many doctors' offices are now requesting that people complete forms online, before arriving at an appointment.

This allows a person to complete the paperwork at a time that is convenient for the patient, sometimes these portals are not accessible to a screen reader user.

While having a reader on-site might provide access, that -- doesn't that change the nature of the experience in a way that is not equivalent to nondisabled people?

A. You make a very good point too, yeah, and it's easy for somebody to assume, well, if you can go to the office, and fill out a form, then you can get around that issue with the Web site inaccessibility, but the reality is -- and part of the work we

do -- is to ensure and promote, that everybody has the same and equal opportunity to complete paperwork in the manner that everybody else has an opportunity to do.

So point being is -- that healthcare provider must think about having an accessible Web site, and process online to ensure that people have the same opportunity, as anybody else.

And this is important to think about, because we are seeing more and more settlement cases, and court cases coming out now, with individuals, especially those with vision loss, that file complaints against inaccessible Web sites.

Now, there's nothing right now in the ADA that says Title III or private entity -- fully accessible, but the reality is, court cases are setting precedent, and ruling in favor of the people filing the complaint.

So a very good question, and -- so the point is, think hard and be sure you are providing services, even through the Web site, in accessible format that's usable by all.

>> Lewis Kraus:

Okay.

And the next QUESTION:

Q. Do you have anything that states that communication boards, for charts, diagrams, are allowed in healthcare settings?

A. Say it once more.

Q. Yeah, do you have anything that states, that communication boards, for charts, diagrams, are allowed in healthcare settings?

A. That's a very good question.

Usually it's part of the ADA National network, we usually refrain from recommending specific vendors who sell such equipment. What I can offer as far as advice is, if you look up, you know, on the Internet, and by Googling for example, you know, charts, medical charts for people with disabilities, you might find some resources there. I don't think there should be any limitations a to what somebody can use.

As far as providing visuals when it comes to ensuring effective communication.

Of course, some may be more effective for others, depending on the -- the quality and the nature of the graphs and the charts, and the pictures and diagrams -- whatever you're using.

But there -- again, if it's policies and procedures, around using additional equipment, or diagrams, think about modifying those policies to allow for communication.

One other recommendation, I guess, is to check in with your state or local offices for developmental disabilities on resources on where communication tools can be obtained for the purpose of effective communication in healthcare.

>> Lewis Kraus: Okay.

And another question.

Q. Do you have an available -- a sample policy, that addresses service aids

such as amplified phones, et cetera?

A. I'm just reading that in the captioning.

One second. So basically, an example policy providing either sign language interpreting or other auxiliary aids or services is that right?

>> Lewis Kraus: Correct.

>>MICHAEL RICHARDSON: I probably do have somewhere, I'm going to make a note to myself, to share with Lewis, to share with group as part of the archived webinar.

Again, I want to be very cautious about that, because not all developed policies and procedures are going to be pertinent to the -- to your facility or office.

But I think -- I can probably look up some good examples of some healthcare providers that Lewis and I know of, that are proactive in addressing effective communication, and see if we can put together, and we'll share it with the group.

>> Lewis Kraus: Right. Okay. Great.

Q. Do you suggest having consents, in larger print at a minimum, specifically for registration and/or procedures?

A. Certainly I'm always a proponent of having a set of materials in large font print.

Sometimes it's just as easy as -- if you have a Xerox machine within the office to just basically use legal paper and large size or going back to the document version, and printing something out on the spot.

And enlarging something, definitely it's always being proactive to have stuff available in a large font and it's a great idea, though, I'm all for it.

>> Lewis Kraus: Okay, there was a person earlier who asked if there's a recommended list of CART vendors in Washington state, and I think you listed some resources, for that person.

And also, noted that, you know, we don't really make recommendations on that. But if the person in Washington state wants to call the 800 number, they can -- you'll get the -- Michael's TAs. And they can talk to you a little bit more specifically about that.

So we're going to move on to the next question. The person says...

Q. I noticed that the term medical interpreting task force, regarding VRI, who are they and what do they do?

A. Very good question, basically, the medical interpreting task force, was a -- a group of qualified sign language interpreters, and consumers, and members, from if the Deaf community in Washington state that got together five years ago to address the topic of ineffective procedures and policies, and practices that many people were experiencing in the healthcare industry, of not receiving good-quality interpreting services.

And it was sort of a -- a series of community forums, and working with state legislators, to try to promote state requirements for medical certification in sign

language interpreting.

And sort of, like, an advocacy group, that went about to develop, some common best practices to ensure effective communication, especially with those who are culturally Deaf and using sign language interpreting.

I'm not quite sure about the status of the group at the moment, and whether they have additional materials to share.

But maybe we can receive some of the common scenarios and if not, the horror stories.

Of being denied access in the healthcare settings.

>> Lewis Kraus: All right. Well, everyone, it is pretty much at the top of the hour and I want to respect everyone's time that you committed to this. We realize that many of you still have questions and there are a few, that are still backed up here.

And apologize if you did not get the chance to ask your question.

But you can call your regional ADA Center, at 1(800) 949-4232.

And ask that question, most of these questions are ones that -- TAs at our regional centers will be able to answer for you.

I do want to tell you that you'll receive an e-mail to an online session evaluation, please complete that evaluation, for today's program. We value your input, and want to demonstrate to our funder, the importance of this effort.

We want to thank Michael today, for sharing his time and knowledge with us, it was a great presentation and a reminder to all of you, that the session, was recorded and will be available, for viewing, next week, at ADApresentations.org, in the archives section in the health area.

So, thank you, very much for your attendance today.

Next month, we will -- we'll announce the next webinar, via the e-mail.

And you will be able to register for that two weeks ahead of time.

So thank you, for attending today's session, thank you, again, Michael!

And for everyone, have a good rest of your day!

Bye-bye!

>>MICHAEL RICHARDSON: Bye-bye. My pleasure!