PACIFIC ADA CENTER
HEALTHCARE AND THE ADA WEBINAR
INCLUSION OF PERSONS WITH DISABILITIES
NATIONAL NETWORK LEARNING SESSION:
ACCESSIBLE MEDICAL CARE AND LONG-TERM CARE FACILITIES
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>> 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. You can reach your regional ADA Center by dialing 1-800-949-4232.

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Today's ADA National Network Learning Session is entitled "Accessible Medical Care and Long-Term Care Facilities." This session will provide an overview of minimum requirements in the ADA and architectural barriers act, or ADA accessibility standards for medical care and long-term care facilities. The presenters will review the scoping and technical requirements for accessible routes, parking at specialized facilities, patient rooms for both medical and long-term care facilities, alarm systems and toilet rooms in intensive care units. Finally the presenters will provide a brief overview on the requirements for medical diagnostic equipment. Today's speakers are Bill Botten. Bill Botten serves as the training and technical assistance coordinator at the U.S. Access Board. And Bobby Stinnette, Bobby is an accessibility specialist at the U.S. Access Board with focus on medical diagnostic equipment and healthcare. I will now turn it over to both of you, Bill and Bobby.

>> Thank you, Lewis. I would like to thank you for the invitation and opportunity to speak today at this webinar. The issues that we're going to talk about, as Lewis talked about, are going to be the medical care facilities and long-term care facilities and how important it is to make sure that we make them as independent and usable by people with disabilities as possible. Today's agenda is going to cover the facilities that the application applies to, patient sleeping rooms, parking/passenger loading zones. We'll talk about the accessible route requirements, either within the site or within the facility to include employee work areas, service counters, public and common use areas, and, as Lewis said, finally we'll end up with a brief overview of the medical diagnostic equipment voluntary standards issued by the Access Board. If we could move to Slide number 8. Slide number 8 is our title slide and introducing the chapters and sections of where you can find the scoping and technical requirements, and I'll turn it over to Bobby from here.

>> BOBBY STINNETTE: So thanks, Bill. So in today's webinar I'm going to go over the basics and some of the common questions and some of the areas of confusion also related to medical care and long-term care. And you will find those referenced in section 223 and 805 of the ADA standards. Let's move on to the next slide, Slide number 9. All right. So what are we talking about when we look at medical care and long-term care facilities? Now, the type of medical facilities called out in the standards are hospitals, rehabilitation facilities, psychiatric facilities and detoxification facilities and long-term care facilities are specifically addressed. Now, an example of that would be a skilled nursing facility that provides care to its residents, including assistance with activities of daily living. All right, so let's move on to the next slide, Slide number 10. Now, we're also referring to medical units in detention and correctional facilities. I'm not

going to discuss that during this webinar, but we'll talk about in terms of professional offices of healthcare providers, such as those of the general family doctor or dentist, and these for the most part, they're not specifically addressed in the standards except for vertical access requirement. Now, to be clear, those spaces would need to comply with all the other requirements and then many of the typical issues like reception counter, single user toilet rooms, dressing rooms that regularly come up, the requirement for these are no different than it would be for other types of facilities. Okay, so let's move on to the next slide, Slide No 11, talking about patient sleeping rooms. We receive many questions when looking at licensed medical care facilities or license long-term care facilities, medical facilities where the period of stay exceeds 24 hours. If that's the case, more than likely you have sleeping rooms. This is one area where there are some important differences. So Let's go to the next slide, Slide No 12 and talk about those differences. Okay. So patient sleeping rooms provided in hospitals, rehabilitation facilities, psychiatric facilities, and detoxification facilities are covered by the standards in Section 223.2. Now, whether or not the facility specializes in treating conditions affecting mobility is going to be critical in determining the percentage that must provide features for mobility access. So for hospitals, rehabilitation facilities, psychiatric facilities, and detoxification facilities, where they specialize in conditions affecting mobility, then then 100% of the rooms are required to have mobility features. Now, when they do not specialize in treatment affecting mobility, then only 10% are required to have mobility features. Now, additionally, for licensed long-term care facilities, as is referenced in Section 223.3, it requires that 50% of patient sleeping rooms provide mobility features. Okay, so let's move to the next slide, Slide Number 13. We'll talk a little about patient sleeping rooms and dispersion. Now, in the 2004 ADA accessibility guidelines that the board issued there was advisory about dispersion in reference to patient sleeping rooms. But when the 2010 ADA standards were issued by the U.S. Department of Justice, sections were included in the final document requiring that accessible patient rooms be dispersed in a manner that is proportionate by the type of medical specialty in the facility. Now, this applies to those facilities that do not specialize in the treatment of conditions affecting mobility, because those that do will be required to be 100%. So there's no dispersion issue. Okay, so let's move on to the next slide, Slide Number 14. And we'll talk a little bit about patient sleeping rooms and alterations and additions. So when sleeping rooms are altered or added, the requirement of Section 223 only apply to the rooms that you are altering or adding. So, for example, if I had a facility that is not specializing in treatment affected mobility, remember, as I discussed earlier, that 10% of patient sleeping rooms are required to have mobility features, and so let's say, for example, that I had 100 sleeping rooms and that I altered two of the rooms. Then I would be required to provide one accessible room. That is 10% of 10 and not 10% of 100. So that's how that relates to when we talk about patient sleeping rooms and then alterations. All right, so let's move to the next slide, Slide Number 15, and talk a little bit about long-term care facilities. So when we talk about long-term care facilities, because we do get this question on this topic, where people are not clear if this requirement applies to their facility. Now, it's important to keep in mind that this requirement is not concurrent with the International Building Code occupancy classifications. Now, those classifications really are likely to be important when determining the type of facility under, let's say, a state. So as most

states have adopted the IBC, the International Building Code, there are different requirements. And I always tell people, if you're unsure if your facility would fall under the long-term care category, you can contact your state board or you can contact the Department of Justice for that to make sure, to see if your facility would fall under that or not.

Okay. So let's move to the next slide, Slide Number 16. We'll talk a little bit about doors. So let's talk about latch side clearance when it relates to doors. There is a minimum requirement of 18 inches of clear side space for doors. What people forget is these are always to remain clear. A lot of times staff or people will see this space and think it's a great place to put like a chair or a cart or some type of piece of equipment. However, this space has to remain clear. You never know who needs to be utilizing that space, so it's important to remain clear in that space. Now, on the image on the right, what we show is one hospital what they did is put a sticker on all of their carts to remind people not to leave the cart in that clear space. So let's move to the next slide, Slide Number 17. Now, you also have to pay attention in what direction someone is traveling as they approach the door. For example, if you're coming straight at the door, perpendicular to it, the clear space at the latch side needs to be at least 18 inches. But if you're approaching the door parallel to it as we show on the diagram here on the slide, you need to provide 24 inches of clearance. Now, also, hospitals and nursing homes, they're required to have doors to the sleeping rooms providing a minimum of 41.5 inches of clear open. Now, the ADA allows for larger doors in hospitals only to be exempt from the poolside clearance space. Now, to be clear, this exemption is for hospitals only. And nursing homes still have to provide that 18-inch full side in addition to the larger one. So let's move on to the next slide, Slide Number 18. So let's talk about turning space in our rooms and spaces as relates to long-term facilities and medical facilities. So you can either do a 60-inch diameter turning circle or you could do a T-shape space. Now, to keep in mind, that 60-inch circle, that's really just the minimum piece that you can do. Sometimes, especially when you have -- like when in a nursing home or if you're in a facility, you may need that to add additional space. So for ease of maneuverability for a patient. So let's move on to the next slide and look at Slide Number 19. So on this slide we show a good example of a sleeping room design that shows access to both sides of the bed. And then there's plenty of room at the foot of the bed for turning space. Now, keep in mind that both hospitals and nursing homes, they there are often lifts and other pieces of equipment that are used that can take up a lot of space. And they also need room to maneuver and to maneuver around, right? So designing the sleeping rooms to meet the minimum standards is good, but the more flexibility as it relates to maneuverability the better. So let's move on to the next slide, Slide Number 20. We'll talk a little bit about patient sleeping rooms and toilet and bathing. Now, of course, it should go without saying that toilet and bathing rooms that serve fully accessible sleeping rooms often need to be fully accessible, right? And, again, keep in mind that that little bit of extra maneuvering room can really go a long way. And then also I want to make note that there is a section, and in those instances where the toilet room, like a critical care or intensive care patient room, they do not have to be -- they don't have to be accessible. And I think one of the reasons behind that is that when you're a patient and you're in intensive care or critical care, you're not

independently trying to go into the lavatory or the toilet room by yourself. So let's move to the next slide, Slide Number 21. So this slide it shows new construction, that all toilet and bathing rooms must be accessible for both public and common use there are two exceptions in this rule. One let's say you have portable toilet units that are clustered. Then only 5% of each type are required to be accessible. And then also if you have a single user toilet room that are clustered, then you're required to have a minimum of 50% of each type be accessible as well. You can find the scoping for toilet and bathing in section 213 of the standards. So let's move on to Slide Number 22.

So I want to make note of an ongoing working group that is currently going on right now with the American national standards institute, or ANSI, the A117. So the ANSI A117 on assisted toileting and bathing facilities. The goal of the working group is to establish technical requirements on toilet and bathing facilities designed for assisted use. And I think a part of this is really about maneuverability, making sure -- for example, when you have like assisted living, nursing homes and rehabilitation facilities, resident bathrooms, because this is more about assistant use as opposed to independent use so the goal of the working group is to be able to provide like some technical guidelines behind assisted use, and with the goal of being able to add it to the IBC, the 2021 version of the IBC. Bill, did you want to add a little bit to that as well?

>> BILL BOTTEN: Yeah, thanks, Bobby. One of the issues when looking at assisted toilet and bathing is that additional space may be on the inside wall or next to the water cooler or toilet. We're showing fold-down grab bars that may assist to have on the open side an additional grab bar for somebody or additional space around the toilet so people can help from both sides. And so what they're looking at through the committee is what should the minimum requirements be in some of the unique facilities that are providing assisted living and need additional space unlike when trying to provide an independent toilet room facility for anyone -- whatever type of facility. So I think it's really important and we're going to talk a little bit later about how important it is to make sure that the toilet or bathing facility really meets the needs and encourages the greatest level of access that you possibly can and whether that is for children or for elderly, and especially when you're in your own house. That's the best way of all, right, where you can set it up so that you can be as independent as possible. This could be a dangerous place. The toilet room or bathing room is a dangerous place where things are wet and maybe you've just taken a shower and not feeling well and falls occur. So we want to make sure they're very safe and usable and as independent as possible. We're going to move on to Slide... I believe the next one is 23. It says communication features. If we could move again to Slide 24. I wanted to highlight that if your facility is still providing either a coin operated or a public pay telephone, a coinless public pay telephone or some type of public closed-circuit telephone or public courtesy phone, that you understand there's still a requirement for a TTY, a text telephone. And the graphic that you see is one where you see an individual standing at a counter and actually typing the message to another TTY or through the relay to use a public pay phone. And so the requirement is that within... wherever these public pay phones are provided, that at least one... if there's even one public pay phone provided, serving a hospital emergency room or hospital recovery one or maybe it's in the waiting room, that at least

one public TTY be provided at each location that you provide a public pay phone to deliver that communication access. If we could move on to Slide Number 25.

Slide Number 25 is fire alarms systems and gives you the provision numbers for the technical requirements, which brings you to a reference standard. And we reference the National Fire Protection Association and we've given their website on this slide. We referenced the 1999 and 2000 versions. So fire alarms systems currently installed with audio and visual alarms have to comply with those two versions. It's incorporated by reference. So you won't find it in the 2010 standards. You have to find it in the reference standards. And we give all the information for those reference standards in the -- in Chapter 1 of the 2010 standards. And so you can find notification information besides the website right here where you can get a copy of NFPA72.

They do pro viewed an exception, if we can move to the next slide, Slide 26. This highlights that exception. And if you have an industry practice that maybe controls the use of that fire alarm system, maybe it's an assisted care facility where you don't want everybody trying to get up as fast as they can and run to the door, that you have staff there to notify and help evacuate people, and that's how the industry handles an emergency. It's not through notification in each room but it's through notification by staff. There is an exception here that fire alarm systems in medical care facilities are permitted to comply with that local industry practice or state practice. Moving to Slide 27. Slide 27 is just a title slide again for switching topics to parking and passenger loading zones. We can move to Slide 28.

Slide 28 is talking about new construction and where access is required. Remember you don't have to provide parking. But if you do provide parking, you have to provide accessible parking. There is an exception that excludes commercial vehicle storage or law enforcement vehicles or vehicle impound, but typically in medical care or long-term facility we're not typically talking about vehicle storage or law enforcement vehicles or vehicle impound parking. Okay, we're going to move on to Slide Number -- the next slide, please.

Okay, so accessible parking, the scoping requirements are based on where you provide visitor patron or employee parking. It's all the above. It's calculated on a facility-by-facility basis. And a facility could be just a single space to a parking lot, a parking structure or just a standalone parking building or structure. So the scoping requirement is based on facility by facility based on one space or parking lot. We're going to move now to Slide 30. And that will show us the scoping requirement that you find in Table 208.2. You'll find it for both federal facilities and state and local government or private hospitals all covered by Title III would have the same requirements. So you see here based on the number you provide. And a lot of times this can be done just by looking at Google Maps. You can hover over a facility and look at the map and determine how many parking spaces serve that facility. You want to make sure you've got the ones that serve each specific entrance, but you come back to this table and based on the number of parking spaces provided, you determine how many spaces need to be accessible.

So if we can move on to the next slide, it's Slide 31. Slide 31 moves into more of the scoping. And one of the things that can be make-or-break for people is whether or not you can find parking close by or parking that meets the need if you're a person that is using a vehicle that has a lift or ramp that comes out of the passenger side, so you need additional space with van accessible parking space. So parking is such an important feature for site arrival. And Bobby is going to go into further about accessible routes for site arrival. But for site arrival parking there's an increase from the table I showed in the last slide. And so if it's a hospital outpatient facility, we give advisory about the term "outpatient." It's not defined in the standards or the document, but it is intended to cover facilities or units that are located in hospitals that provide regular and continuing medical treatment without an overnight stay. Doctor's offices, independent clinics and other facilities not located in hospitals are not considered hospital outpatient facilities for the purpose of the 2010 ADA standards or the architectural barriers act. So the requirement for hospital outpatient is 10% of the spaces need to provide access. If we're talking about a rehab or outpatient physical therapy facility, 20% of the patient visitor parking spaces to serve that rehabilitation facility specializing in the treatment of conditions that affect mobility and outpatient physical therapy facilities, we're looking at minimum scoping of 20% of the overall number need to comply with Section 502 and be accessible parking. So we also provide another advisory about what is physical therapy or conditions that affect mobility, and the advisory states that requiring the use of an assistance brace or a crutch, maybe a cane, a prosthetic device, a wheelchair, whether it's powered or manual, if you have an arthritic or neurological or maybe an orthopedic condition that could severely limit your ability to walk. It could be a respiratory or another condition which may require the use of portable oxygen or cardiac conditions that impose, you know, a significant limitation on your ability to go distance. It's always easy to judge people when you see them getting out of an accessible space that they don't really need it, but just like I was just sharing with you there, don't pre-judge what somebody's issue is and why they would need that accessible parking space, it's so important to understand that there's so many conditions that may not be visible that still need that accommodation of an accessible space. And when we're treating people with that mobility that affects a mobility issue, I mean, the parking spaces need to be close. I'm a person that uses a manual wheelchair, and I am always saying, I like a van that has got a ramp in it to make it so much easier. And I'm looking for the van space, you know, the space that requires the larger access aisle to get the lift or ramp down so that you can then exit the vehicle from the wheelchair or power device. And I actually think that it would be better to design these facilities to where the van spaces are further away from the facility entrance and provide more of those spaces that are, say, the car space or the one that only requires the five-foot access aisle to be closer to the door. Because oftentimes people using the mobility device, it's not necessarily the distance we need to travel, it's more so that we need the extra space. And when they're closest to entrance, what happens is they're taken first by persons that use the vehicle or car that don't need the extra space for the ramp or lift. So I think it makes it more -- it makes it easier to find the van space if they're not the closest one. We're going to move on to Slide 32. Slide 32 is getting you back to the chart in 208.2. And the chart gets you back to 208.2 because you don't have an additional scoping just for a doctor's office

or for a medical equipment rental facility. You still just come back to the one table that would be the same for restaurant or hotel or whatever else. So there's not an additional scoping for a doctor's office specifically. We're going to move to the next slide, Slide 36. Slide 36 is a graphic of kind of an overhead view of a site and it incorporates a building and then a couple of parking lots, and then also a satellite lot. We often get questions about where the accessible parking spaces need to be. And so parking spaces that are the accessible ones that serve a specific or particular building or facility are required to be located on the shortest accessible route from parking to the entrance that they serve. So parking serves more than one accessible entrance. Parking spaces that are accessible need to be dispersed and located on the shortest accessible route to all the accessible entrances. And if parking facilities that don't serve a particular building or facility, the parking spaces that are accessible should be located on the shortest accessible route to the accessible pedestrian entrance to that parking facility. Parking spaces are permitted to be located in different parking facilities as long as and if substantially equivalent or greater accessibility is provided in terms of the distance from the accessible entrance or entrances, the parking fee, or user convenience. So what we're saying there is that you really need to keep the accessible spaces as you see in this graphic highlighted to the accessible entrances but dispersed to each one of them. And that satellite lot you would count individually and put the additional spaces that were required in that satellite lot closer to the building so that you can facilitate being on the shortest accessible route. Moving on to Slide number 34. Slide 34 brings us into the passenger loading zones and gets you straight to the technical requirements, because here is what we wanted to highlight. At a passenger loading zone, it's on the passenger side of a vehicle. It's a 60-inch minimum width. Doesn't have to be demarcated or identified. It needs to be at the same level as the parking space. And if there is a curb, you have to have curb cuts that are cut into the curb itself and not built up into the space. The idea here is that most oftentimes a person with a disability is going to get out of the passenger side and you don't want to change a level like a curb or anything in this way so that ramps or lifts or mobility devices could be brought out from the passenger side of the vehicle. If we can move on to the next slide, Slide 38. I'm sorry, Slide 35. Slide 35 is the scoping requirement for the passenger loading zone. And it says "required where a period of stay exceeds 24 hours, no canopy required per the '91 standard, the earlier provision. But a passenger loading zone would be required, at least one, provided at the accessible entrance to a licensed medical care and a licensed long-term facility with a period of stay exceeds 24 hours. There's also a requirement in 209.4 that requires parking facilities that provide valet parking services. It seems like when I go to the doctor anymore, there's someone who will park your car because it's so hard to find one, right? So if you have valet parking services, you have to provide a passenger loading zone, so there's an opportunity for a person with a disability to get out, but then the valet could take the vehicle. Now, a lot of times adaptive vehicles cannot be driven by persons that don't understand the technology or have a license to drive that certain type of technology. And so it's going to be important that there be an alternative way besides only valet that vehicles with these accessible features have that they can still park their own vehicles. Okay. Moving on to the next slide, Slide 36. Slide 36 says, here's that canopy. If you do decide to provide it, it has to be a minimum of 114 inches that will allow a raised roof vehicle such as a raised roof

van to be able to get underneath that canopy. 114, if you decide to put up the canopy. Moving to the next slide, Slide 37. It talks about the signage. It's so difficult to understand where these parking spaces are if they're not signed. The standard doesn't require the international symbol on the ground. It only requires a sign and the access aisle to be identified or marked. So the international symbol is the one to use. If you're thinking about using the speedy wheelie or another type of international symbol of accessibility, we have a good guidance document about that. It's really making sure that people can still understand that it is the ISA or international symbol. Then you would have to claim equivalency, because the standard specifies this actually pictograms be used. The sign must be 60 inches minimum to the bottom edge of sign. Van accessible must be added to those space that is are required to be van accessible. That is one of every six. So if you had one space, it will be van accessible. If you had seven spaces, you would have two van accessible. There's an exception that you don't have to even have a sign if there is four or fewer spaces in the whole parking lot, including the accessible one. Moving on to the next slide...

Slide Number 38. I want to remind people that remember an accessible route is required to any of those parking meters or pay stations, at least one of each type would be required to be accessible, which would mean we're looking at the reach ranges use see identified here in this yellow squared-off area, a minimum 15 from the floor and maximum of 48, all operating mechanisms would need to be within that square. We also have to have a clear floor space for parallel or forward approach to the machine. Oftentimes I find these up on a curb, or in a location that might not be wheelchair accessible. Make sure they're on an accessible route, you have clear floor space and operating mechanisms. I find also if there's a way you can call for help if you have trouble with the machine it's always very helpful. Next slide, please. Slide 39 talks about electric vehicle charging stations. I think maybe we neglected to say at the beginning of the webinar, we're talking about the federal requirements under the Americans with Disabilities Act 2010 ADA standards and the Architectural Barriers Act accessibility standards. But your local or state building codes, as we alluded to earlier in discussion with the IBC may incorporate greater requirements or already requirements for these electric vehicle charging stations. I just wanted to remind people that the standards don't specify specific provisions for them. Here you see me in this photograph actually reaching where the charging device and cord and dispenser is up on a curb and beyond reach. It's advisable to address the access to EV charging stations so they'll be usable by people with disabilities. So the clear space adjacent to it. If you do provide them, the spaces for charging electric vehicles cannot be counted towards the minimum number required for accessible parking and van parking for the facility. We're going to move to the next slide. And I'm going to turn it back over to Bobby with accessible rules.

>> BOBBY STINNETTE: Thanks, Bill. So now we're going to talk a little bit about accessible routes, the requirements overall, and then we're going to talk about as it relates to medical care and long-term care facilities. So let's move to the next slide, I think Slide 41.

So now on this slide we show the requirements for site arrival point. Now, site arrival points include accessible parking spaces passenger loading zones, public transit stops located within sites and public streets and sidewalks are one of the boundaries. This can sometimes with a challenging issue, especially depending on the landscape or terrain. And then also sometimes other entities can control portions of the route. So what we're showing here on the slide is that at least one accessible route to building entrances from site arrival points must be provided. And if you can find the scoping for accessible route requirements in Section 206. Let's move to Slide 42. Also in the slide we show where accessible routes are required. And then we say at least one accessible route must connect to each accessible room and space. And then also one has to be for each story. Now, unless there is like an exception for vertical access, then it wouldn't be required. But also we talk about for accessible for each accessible element as we show here on the slide where we show access to the drinking fountain, that that is an accessible element. And then lastly you have to have at least one accessible route that must connect to each level on a floor required to be accessible as well. Okay. So let's move to the next slide, Slide Number 43, and talk a little about handrails along routes. So let's talk about the handrail piece. Handrails provided along walking surfaces, other than ramps or stairs, they must also comply. Now, there is an exception, but it's not really for this area, but if there was an assembly area, there is an exception for handrails, but in this situation, if the handrails are provided along walking surfaces, like I said, other than ramps and stairs, they must comply with the standards. And you'll find that in Section 403.6, the technical standards. So let's move on to the next slide, Slide Number 44.

Now, what's important to note is the accessible route must coincide or be in the same area as the general circulation path. And then also if the circulation path is interior, then the accessible route needs to be interior as well. And this is really important. You don't want to have inside where you have an interior route and then someone with a disability, you have that in that whole 'nother area. You want to have them in the same... if it's interior, the circulation path is interior, then the accessible route needs to be interior. And also the routes including exterior routes must coincide with or be in the same vicinity as the general circulation path as well.

>> BILL BOTTEN: Bobby, I'll jump in real quickly here. This is new to the 2010 standards. Remember, in the earlier standard -- you may have some older facilities that didn't have this requirement that the accessible route coincide or be interior if that common circulation path is interior. And so it's so important as an integration issue to be able to incorporate that circulation path and accessible route as close to as possible the same. So that the person that is using a mobility device doesn't have to go out and around, or doesn't have to go on some wild goose chase to get to the same place that everybody else can just walk over to

>> BOBBY STINNETTE: That's a great point. So let's move to slide number 45 and talk about vertical access. So now in guidance from the Department of Justice where professional office of healthcare providers is, where the state regulated professional provides physical or mental health services to the public, so if you have a two-story

building and design it to house the professional offices of, say, a healthcare provider, it will require an accessible route between levels. And for all practical purposes, you would need an elevator. Now, however, it is possible that if you have a physician's office where only all the physicians' offices were only on the first floor, then you would not be required to provide an accessible route. Let's say to the second floor of the building or a building with less than 3,000 square feet per floor. Now, remember, if you do that, that means that the building can only provide healthcare offices on the first floor unless you are willing to have an elevator. Now, again, Title II facilities, state and local governments, would not get this elevator exception to begin with. And then also the architectural barriers act, ABA, which covers federal facilities, you would also not get this exception for vertical access as well. So let's move on to the next slide, Slide Number 46. We'll talk a little about multi-story facilities. In multi-story buildings and facilities as noted here on the slide, at least one accessible route shall connect each story and mezzanine. So in a multi-story building, right? Now unless there is an exception. Like an example would be like in a private building or facilities that are less than three stories or it has less than 3,000 square feet per story. So if that is the case, then an accessible route is not required to connect stories. And I'll talk a little bit about this exception more in the next few slides. And you can find that in Section 206.2.3. So let's move to the next slide, Slide Number 47.

So for Title III facilities, those are public accommodations in commercial facilities, we have what is called, of course, an elevator exception, which is in Section 206.2.3. The exception is in multi-story buildings. So if the building is less than three stories or there is less than 3,000 square feet per story, which means that it's either a two-story building or kind of a narrow taller building, then you don't have to meet the requirements to provide an accessible route between the levels of the building. Now, you have to meet all the other requirements. But you don't have to have the accessible route. Which typically means you don't have to have an elevator. Thus that's the elevator exception. However, professional offices of healthcare providers, they don't get this exception at all. So let's move on to the next slide, slide Number 48. So now let's talk about exceptions if you have a building that would otherwise qualify for the exception but has, let's say, an excluded occupancy, like a healthcare provider or a shopping center or sales and rental establishment. You must provide vertical access to those occupancies. So if you have a two-story building with a healthcare provider on the second floor and you have sales and rental establishments of five or more scattered to different stories, you will need vertical access in order to serve those particular occupancies. Okay? So let's move on to the next slide, Slide 49 and talk about protruding objects. Now, when looking at protruding objects... so any objects mounted on walls or partitions, columns, and then other elements along the circulation path, it can really pose hazards until the projections are limited, right? Thus when a cane is used and the element is in a detectable range, it gives a person sufficient time to detect the element with the cane before there is body contact. Now, anything along that circulation path, like a water fountain, a wall scones, could create a hazard for someone who is visually impaired. So now objects with leading edges more than 27 inches and not more than 80 inches above the finished floor can only protrude four inches maximum horizontally into the

circulation path. So let's move on to the next slide, Slide Number 50, and talk about signs. And, Bill, I'll turn that over to you.

>> BILL BOTTEN: Yeah, I'm glad to be back. I've been coming in and out a little bit here. So if by chance I lose it again I'll be calling in. Tactile signs and visual signs and signs that are exempt, as the slide we're currently on here, Slide Number...

[no audio]

>> LEWIS KRAUS: Okay, this is Lewis, and we seem to have lost Bill again. So he will call back in. So, Bobby, do you want to move ahead to the other slides that you were going to take or how would you like to proceed?

>> BOBBY STINNETTE: We can go ahead and I'll start and then Bill will come in and finish up with this.

>> LEWIS KRAUS: Okay.

>> BOBBY STINNETTE: So there's requirements in the signs section, Section 216... before we do that, essentially I want to give kind of a brief overview of the requirement...

>> BILL BOTTEN: Hi, Bob.

>> BOBBY STINNETTE: You got it, man?

Did we lose you again?

>> BILL BOTTEN: Hello?

>> LEWIS KRAUS: Bill, we can hear you now.

>> BILL BOTTEN: I am so sorry. If I have this again I will call in directly, but tactile signs are those signs that are identifying permanent rooms and spaces and exit doors. Visual signs are those that are directional and informational, and signs that are exempt are those that are temporary, a building menu, a directory, address, or a company name or a logo. Moving to the next slide. The next slide further talk about those signs required to be tactile, and they are interior and exterior, but I think the real thing to remember is they're either located at a restroom or they're a room number. They're at a floor level. Or they're an exit discharge or an area of rescue assistance. That's where typically you're going to find a tactile or raised sign. Remember, the idea here is that a person that is looking for a tactile sign is going to have the ability to go along the wall or go along the edge of the wall to find the door and to actually find then the tactile sign. Moving on to the next slide.

So these are required signs at a means of egress. At parking, we just went over parking. At entrances if not all are accessible. At elevators. Toilet and bathing rooms that are not all accessible. There's a specific pictograms for TTYs, assistive listening, and if not all check-out aisles are accessible, those require the international symbol. Moving to the next slide. Bobby, back to you.

>> BOBBY STINNETTE: All right, thanks, Bill. Okay, so I'm going to take a little time to talk about employee work areas. And we do receive questions about employee work areas as relates to medical care and then long-term care facilities. So let's move on to the next slide, Slide Number 54. Now, just to review what an employee work area is. And this is in the definition section of the standards, Section 106.5. So it's any or all portions of a space used only by employees and used only for work. Then it goes on to say that corridors, toilet rooms, kitchenettes and break rooms are not employee work areas. Because in essence, they really serve in supporting employees, but not for the purpose of work. Now, under the Americans with Disabilities Act, employee work areas limited access is required at least to the point where you're able to approach, enter and exit the space. Now, as far as the Architectural Barriers Act, employee workspace has to be accessible just like any other public or common use space. So there are distinct differences between the ADA requirement as relates to employee work areas versus the ABA requirements. So let's move on to the next slide, Slide Number 55. So, when we talk about employee work areas, let's look at employee work areas, a sink, for an example. So in healthcare environments, here is an image that we show as part of an exam room with a sink in the corner and an exam table. So some medical care spaces are actually a combination of both public spaces and employee work areas. And a good example in the image is we show here on the slide is a hand wash sink in the work counter. Now, the work counter likely would be an employee workstation. So those would not be required to be accessible. So just because they are in a public space, it does not mean that they have to be accessible. If they truly are work areas used only by employees. Because, remember, our only obligation for employee work areas is approach, enter and exit, if you're using the ADA. Now, the sink here we show on the slide is an example, but it depends. So if the sink provided is for staff, then it's a workstation, and only staff is using it, it is not required to be accessible, even though it is in a public and common use aerospace. But if that sink is necessary for patients to clean up, let's say, after a procedure, then it would need to be accessible. So you do need to evaluate who is using what to determine the accessibility requirements. And then lastly, lastly on this, just because it is possible for a patient to use the sink, that is not the criteria of how you evaluate it. It is the sink -- what's the intentions for the sink? Is the sink intended to be used by the patient? So you have to look at how you evaluate it. Okay, so let's move on to the next slide, Slide Number 56. Okay, we're going to move to the next area and talk a little bit about service counters. This is another important area. I'm going to hand it over to Bill. Bill...

>> BILL BOTTEN: Okay. How about we move on to the next slide. Slide 57. We thought it was important to talk a little bit about sales and service counters. More so service counters. We figure after you have parked and you come in and know your

accessible route requirements, what is the next requirement you hit? You're going to hit somebody at a service counter, right? Whether that's to take insurance information, just information or whatever. These also cover any type. So it's at least one of each type of counter. So if you have food service areas, again, it's one of each time. We'll talk further about that in a minute. Each type of function at the counter also has to be accessible and where there's more than one counter, we're asking that they be dispersed among all the different types. Slide Number 58, next slide, please.

This is showing the accessible portion needs to be at least as deep as the part that every other customer gets. So here we're identifying the lower portion of the counter that is at least the same depth as the higher portion that somebody in a standing position would be using as well. Moving to the next slide, Slide Number 59.

So the requirements for that sales counter would be that you have either a side or forward approach. Again, preferably would be a forward as you see here where the rolls of paper are, where somebody could pull up underneath. Especially if you're there for a length of time, it's so important to be able to wheel up and be able to use as a surface to fill out a form or whatever. A parallel approach really gives you the opportunity to use just the arm on that side closest to the counter. Moving on to the next slide... public and common use areas is the identifier. We're going to move to the next slide again. Slide Number 61 slows an overhead layout of some public and common use areas that I thought I would just identify that could be found in a medical care facility like a medical suite. And if you had a dressing room or a locker room, even if it's employee-only locker room, access to at least 5% of each type of locker, and remember that dressing, fitting and locker rooms also require a dressing or fitting room bench. That bench so that somebody could get on it and maneuver back and forth to change clothing. So if you're providing dressing rooms or locker rooms, at least 5% of the lockers of each type and addressing fitting and locker room bench would be required. Exam rooms and doctors' offices, 100% scoping for public access. If you had toilet rooms... Bobby went through the minimum requirements before, but if they're all single users and they all serve the same area, same population of people, and they're clustered in the same location, toilet room is only 50% of sing user all in one section need to comply. Now, a men's, women's and single user or family restroom are not permitted to use that exception of 50%. It would be, remember, all the same type. And waiting rooms, public areas would all be accessible. If we could move on to Slide 62. Slide 62 is a graphic of a public common use area. You know, a lot here is just all loose furniture, but we still would be looking to make sure that storage facilities or access to any operable parts in public and common use areas those used by anybody there, controls of mechanisms for a fireplace or TV or things like that, you want to make sure your common use spaces, if those operable parts are available and used by the public, visitors, things like that, you would want to make sure the operable parts are compliant. Moving to the next slide. And I just wanted to highlight if you have dining or work surfaces... maybe you have an area where you provide computers or work surfaces, the requirements in 226 gives you access to at least 5% of the surfaces and applies to both standing and seated spaces. And you disperse those spaces in the facility. So if we're looking for fixed dining surfaces or fixed work surfaces, the requirements in 226 get you

5%. Moving on to the next slide. Slide 64 I thought I would throw in the tray slide issue, because seems like every time in the hospital I'm trying to get food at the cafeteria and they have a tray slide. What's the requirements? Maybe we ought to tell people. It's 28 to 34. You don't have to provide tray slides, but where they are provided that should be 28 to 34 inches from the finished floor. Next slide, please. I also wanted to briefly just talk about some of the recreation facilities and rehab facilities that you might find in these facilities and make sure that you do understand there are specific requirements for these type of unique facilities. So if you had a play area, maybe in some waiting room you would be looking for the play area requirement that you find in Chapter 2 and Chapter 10, but an exercise or workout room, whether it is for your staff or the public to go blow some steam off, you would be looking at meeting minimum requirements for access to at least one of each type of piece of equipment. There's no requirement for the equipment itself to meet any specific types of standards, but there are equipment that do provide upper body exercise cardiovascular, or there are machines that do audio and visual output so that anyone could use, say, the treadmill or things like that, so you have a better access. The ASTM has been working with providing inclusive exercise equipment standards, and that might be a place to look if you're looking to increase the access in your exercise equipment facility. We already kind of talked about locker rooms. Locker rooms would be required even if only for employees, still required to be accessible. 5% of those lockers of each type would be required. And that dressing, fitting or locker room bench. If you had a therapy pool or swimming pool or you had saunas or spas, you look at the minimum requirements in Chapter 10 for those types of facilities. You would be looking at a means of... [no audio]

>> LEWIS KRAUS: Bill, we lost you again. Bobby, you want to take over until he comes back?

>> BOBBY STINNETTE: Sure. And Bill will definitely need this as his -- definitely his area and recreation is definitely his area. So we can go ahead and in terms of swimming pools and spas. I think he went over that piece already. So we can go ahead and move to the next slide, I believe. If we can go to slide 66. This is really in terms -- is Bill back?

>> BILL BOTTEN: I am.

>> BOBBY STINNETTE: Okay. Next slide.

>> BILL BOTTEN: Bobby, you there?

>> BOBBY STINNETTE: I'm here.

>> BILL BOTTEN: Go ahead.

>> BOBBY STINNETTE: So now what we're going to do is wrap up this webinar and talk a little bit about medical diagnostic equipment. So the U.S. Access Board issues standards for medical diagnostic equipment or MDE as we call it. So I'm going to give you a brief overview of the medical diagnostic equipment standard. And before we go -- before I start on this, I just want to go over this brief thing and say that the standards are voluntary. So what we call enforcing agency, like a federal department, like the Department of Justice or Health and Human Services, they would have to adopt these regulations through regulatory actions as a part of their policies to have a mandatory effect. And then likewise what could happen is a state or another purpose for procurement purposes they could actually adopt these as well. These are examples how the standard could be used. So what we have done is we produce add document that is laying the groundwork for future change. And also a resource for people to use. The main thing it does is establish minimum accessible features for the equipment itself. So let's move to the next slide, Slide Number 68.

So the patient protection and Affordable Care Act, the ACA, it added an amendment to Section 510 of the Rehabilitation Act which authorized the U.S. Access Board to develop accessibility standards for medical diagnostic equipment. And they did that in consultation with the Food and Drug Administration. So the standards address independent access to and use of medical diagnostic equipment by people with disabilities to the maximum extent possible. Now, the standards for medical diagnostic equipment apply to equipment that includes examination tables, examination chairs, including chairs used for eye examinations, for procedures, and like if you were going to a dentist, like a dental exam chair procedure, weight scales, mammography equipment, x-ray machines, and then other radiological equipment commonly used for diagnostic purposes by health professionals. Okay, so let's move to the next slide, slide Number 69.

Now, we're talking about medical diagnostic equipment in physicians' offices, clinics, emergency rooms hospitals, and then also dental and optometrist offices as well. Now, accessibility of doctors' offices, clinics and other healthcare providers, it's essential in providing medical care to people with disabilities due to barriers, like individuals that have disabilities, they can be less likely to go seek routine preventive medical care than people without disabilities. So accessibility is not only legally required, it is important medically. Now, to be clear, as I stated before, as issued by the board, the standards are not mandatory on healthcare providers and equipment manufacturers , so the department of add justice they may adopt as mandatory requirements under the Americans with disability act law. Other federal agencies may implement them as well under the Rehabilitation Act which requires access to federally funded programs and services. Let's move to Slide 70.

So I'm using the term "equipment" here as opposed to the term "medical device" because "medical device" is really a very broad term and can include many things. But we are addressing equipment, things such as examination tables and chairs, weight scales and x-ray machines, radiological and mammography equipment. It does not address like personal devices, such as like a glucose monitor or a positioning aid, like a

wedge. Now, if you had that positions edge, that positioning piece, that wedge, you could use that when you transfer on to the exam table and you can use that, however, that's not what the standard addressed. So to note the image here on the slide, that the equipment here requires a good amount of physical access with the equipment, and that is when the standards really come up. So they really are most relevant in those kind of furniture size pieces of equipment that you have to get on or lay down and position on. And then therefore we divided the standards in a certain way. Okay, so let's move on to the next slide, Slide Number 71.

So the standards only address the technical specifications. They are about the features of the equipment that are necessary to ensure a minimum level for the most part of independent access. So it doesn't include scoping, like how many of a particular equipment needs to be accessible or when this happens, how many accessible equipment would need to be dispersed to the facility. That's not addressed in these standards. That is really up to the adopting agency or the enforcement authority that I talked about earlier. Now, for the most part the standards are structured on the patient-physicians, the equipment it supports. So we have four main categories. We have a category for equipment used in the supine or laying on your back position, and then the prone or laying face down on your stomach position. Or sideline position, like you are laying on an examination tables or how you would lay on an MRI machine. And so forth, when laying down in some fashion, right? Then our second category is for equipment that is used in the seated position. And that is seated on the equipment and not seated in a wheelchair. So I'll talk about that a little later. So this is seated on the equipment like you are in a dentist office and you were seated on a dental chair, that would be an example. Now, you will note that these first two categories that I'm talking about is for people in wheelchairs. It's about transfers. And that's what most of those requirements are about, transferring on to these surfaces. But we do also address equipment that you will be transferring but you remain seated in the wheelchair, and that is category number three. Now, this would be things like weight scales or maybe if you have like other equipment that you would pull underneath, like a mammography machine. And then finally our last category is equipment that you use in a standing position. Which is a little different than we normally do in our standards. This is geared towards people who do not stand but have a balance issue but require supports while standing. So supports are the primary reason in this category. So in terms of our four categories, they usually are addressing transfer on to a piece of equipment, how you remain in your wheelchair on a piece of equipment, or if you need to stand on the piece of equipment and how you would maintain stability. So let’s move to Slide Number 72.

So the ADA requires access to medical care services, and the facilities where the services are provided. Now a good companion piece or good companion document to the MDE standards is the guidance issued by the Department of Justice on access to medical care for individuals with mobility disabilities. So this guidance addresses maneuverability situations like exam rooms, and it's important information about lift use. Also this technical assistance publication provides guidance for medical care providers on the requirements of the ADA and medical settings, with respect to people with mobility disabilities, which can include, for example, like those in wheelchairs and

scooters, walkers and crutches, or no mobility device at all. So you can access this document from the Department of Justice. You can access it at ADA.gov. And you can hit the search criteria and in the search criteria you can put in the title of it, which is "Medical Care for Individuals with Mobility Disabilities" and you'll be able to see the document there. Let's move to Slide 73 and talk about the medical diagnostic equipment final rules.

So to access the final standards of the medical diagnostic equipment, you can access in many different ways. But I think one of the easiest ways you can go directly to our home page at access, access-board.gov, and you can click on the menu tab from the drop-down menu. You click on the drop-down menu and you see where it says guidelines and standards. And then from guidelines and standards, then you click on where it says MDE, and then you will find the final rule, you'll find it there under the MDE tab. All right. So let's move to the next slide. And we're going to go over -- Bill is going to go over some of the technical guides and closing states.

>> BILL BOTTEN: Thank you so much, Bobby, and thank you so much for all that detail in diagnostic medical equipment. We also just wanted to highlight briefly that at the Access Board's website we have a series of guides. Some of the recent ones are drinking fountains, bathing rooms and toilet rooms. We are currently working Chapter 6 and hope to finish Chapter 6 real soon. We hope you find these and our animations, and I neglected to say when I was going through signs that we have an animation on signs that goes into greater detail. So please check that if you're looking for additional information on signage. This time we'll move to the next slide.

And Lewis...

>> LEWIS KRAUS: All right. Thank you very much, Bill and Bobby. Appreciate all of that. Already, everyone, please remember to submit your questions in the chat window and we'll get to those in a moment. And while you're doing that, I want to remind you that if you were interested in the accessibility medical equipment, Bobby actually did a webinar for us and it will be in ADApresentations.org in the archives section of healthcare. And you can look at much more detail about that if you have an interest. And also I wanted to let everyone know that we are having technical difficulties at ADApresentations.org that is preventing the slides for this session from being put up today, but the archive hopefully will be ready to go for this as usual next week along with the -- all of the text of this as well as recording. All right. Let's get to a first question. While we're doing that, can you move to their addresses? There's the contact information for the Access Board.

So the first question for you all is where does assistive living device -- sorry -- where does assistive living facilities fall into place with all of this? Are they fair housing units?

>> BILL BOTTEN: Bobby, you want to address that scoping requirement?

>> BOBBY STINNETTE: So they can be really under what we call like the long-term care. So that was what we said 50% of the patient sleeping rooms have to be accessible. But like I said, it depends on what services also are being offered in that specific facility. Because sometimes you have a facility that has multiple different services that they offer. They may have like an independent -- they may have an independent living area and then a memory care area. So I always tell people, it really depends, you know, what really services or what is being offered in that specific, you know, facility as well.

>> LEWIS KRAUS: The next questions refer to the slide where you showed the TTY machine, and there were a couple comments. One was now TDD is outdated for deaf/hard of hearing people but not for people with other form of hearing loss. This needs to be changed and another person said, will there be an update to add caption phones and video phones in addition to TTYs? TTY use has dramatically decreased.

>> BOBBY STINNETTE: I understand that technology has left those devices behind. And there has -- there is an understanding, and I think the requirement for TTYs is fewer and fewer just because facilities are not offering any type of public phone. So they are gone by the way. The rulemaking process for the Access Board to update the 2010ADA standards is very time-consuming and long. I would hope that model building codes, as we discussed earlier, some of the issues with assistive bathing, I would think this would be the first place that we can get additional technology, communications systems, as part of a requirement. I don't know how that is going to be done, but I do know that if it was under the 2010ADA standards to replace the TTYs, we would have to open up the whole standard. And at this time I don't know of that occurring or a timeline to do so. So we're kind of still stuck with the old technology and hopefully it will be addressed as soon as the Access Board can continue do some type of rulemaking to update the 2010 standards. Which the last time we updated from '91 to 2010 it was about a ten-year process. And so you can see that if we haven't started yet, it's -- the Access Board on our end and then the Department of Justice, it's a two-step process, them adopting after we have come up with final guidelines. It's a ways off, I'm sorry to say.

>> LEWIS KRAUS: All right. The next question had to do with when you were talking about pay stations for parking. And the comment is that pay stations usually only have an audio way to get help, so are not accessible to those who are deaf.

>> BILL BOTTEN: I agree there are pay systems that are doing different types of systems. Hopefully there's an app or something you can use on your own personal device that will aid in that, but I do agree that additional requirements need to be made for audible and visual communication on those types of devices. Definitely recommend it.

>> LEWIS KRAUS: All right. The next question... if I have an existing 30-inch leaf double door at an entrance to a medical facility, does adding a low energy powered actuated door connected to standby power allow me to keep the doors?

>> BILL BOTTEN: I'll go, Bobby. Remember the minimum requirement for doorways would be a 32-inch clear opening. You may be able to achieve that with an offset hinge, where it offsets the door clearance further beyond the opening, or the door slab, I should say. That might be a way to get the additional clearance. Typically a 30-inch active leaf is not definitely addressed by or an exception for that reduced clear width bid ag a device that is either power assisted or automatic. The only exception for adding a power assistive automatic door would be maneuvering clearance, not the actual width of the door. So it would still most likely need to alter the door itself to be compliant.

>> LEWIS KRAUS: All right, next question... do you need to identify accessible patient rooms with the ISA symbol, and give some examples of informational signs.

>> BILL BOTTEN: I don't know, Bobby, if you want to address this.

>> BOBBY STINNETTE: No, you don't need to identify the patient room with the ISA symbol. We talked a little bit about you know, the sign sections where the ISA is required. You know, it really depends. But it's not required to have all individual rooms. It wouldn't be required.

>> BILL BOTTEN: You may have to have it tactile or Braille would have to be required, if you're identifying a permanent room or space, if this is, you know, a specific room number, you would be looking for a tactile sign.

>> BOBBY STINNETTE: Correct.

>> BILL BOTTEN: And a sign to be mounted at the specific height and a clear space of 18X18 underneath that sign near the latch side of the door. But the international symbol of accessibility wouldn't be required on those rooms that are providing clearances or mobility features.

>> BOBBY STINNETTE: Correct.

>> LEWIS KRAUS: All right. The next question... does every exam room require a five-foot turnaround?

>> BILL BOTTEN: Bobby, you want to talk about that one?

>> BOBBY STINNETTE: Yes. So you want to have -- I talked about that 60-inch diameter circle. You want to have that turning space. And as said before, one thing that you can do, depending on if you have -- you know, you're in a nursing home or some other area, you know, be able to provide more access is always better. The turning space, that's a minimum requirement.

>> LEWIS KRAUS: Okay. Next question... if the patient resident is required to pay for a phone in their sleeping room, like a rehabilitation center or long-term care facility, what

is the responsibility of the facility to provide a captioned phone, video phone or TTY in the person's room? What if the person declines to pay for phone service in their room, would there have to be a caption phone or video phone or TTY for patient resident use?

>> BILL BOTTEN: Wow. I would probably say on this one it would be better to consult with the Department of Justice on what effective communication is in this specific instance. I've not seen where a captioned phone has been required. But it brings up a really good point that effective communication needs to be provided at some level. I would just feel safer that if that was addressed specifically to those procedures to the DOJ. And I don't know if we give that number here, but they have a technical assistance hotline that is 1-800-514-5301. I would suggest that call go there.

>> LEWIS KRAUS: If you missed that number, you can certainly call any of the ADA Centers at 1-800-949-4232 and get you along to them.

A couple more questions here. The next two have to do with MRI machines. One is are there accessible compliant MRI machines? And the second one is: Can you allow a metal wheelchair within a room with an MRI machine since it's a giant magnet?

>> BOBBY STINNETTE: When I talked about before with MDE, we don't really address that piece. But what we do in terms of being able to have access to the room, the standards for medical diagnostic equipment, just like I said before, it really just looks at the equipment, and it doesn't really, you know, address those other kind of other factors that relate to it as well. But also, before we go on to something else, I want to just make note that if you have any MDE questions, medical diagnostic equipment questions, you can also email me directly on those questions and I can make sure I respond back to you as well, okay?

>> BILL BOTTEN: It does address the platform size which you would transfer, handholds and things like that, and the height of the table you have to get on for an imaging machine based on how you would do it. I personally have brought a wheelchair into an MRI machine room and haven't had any problem with the magnetic issue. I don't know about power, but typically once you're positioned on the table, they remove the chair or anything else from that area. And so I have not seen where there's been any adverse effect or of any that has resulted in that -- being in that vicinity or room.

>> LEWIS KRAUS: Well, there are a lot of questions piled up and I am so sorry that we're not going to have time to answer all of those. We apologize if you didn't get your question asked, but you can contact the Access Board there at that number and that email on the screen right now or you can contact your regional ADA Center at 800-949-4232 and if we can't answer it, we'll certainly get you on to the Access Board as well. You all 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. We want to thank our speakers, Bill and Bobby today for sharing their time and knowledge with us. That was an excellent presentation and we're getting a lot of those excellent messages in the chat. A remainder that today's session was recorded. It will be available for viewing

next week at ADApresentations.org in the archives section of healthcare. And our next webinar on February 25th, Lisa will present research on healthcare disparities for people with disabilities and the potential role of physician bias. We hope you can join us. Watch your email two weeks ahead for the announcement of the opening of that registration. Already, thank you again, Bill and Bobby. Thank you for coming today. And we thank you for attending. And we will see you next time. Have a good rest of your day! Bye-bye!