

**PACIFIC ADA
HEALTHCARE AND THE ADA WEBINAR
MAY 23, 2019
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>> LEWIS KRAUS: Welcome to Healthcare and the ADA: Including people with disabilities webinar series. I'm Lewis Kraus from the Pacific ADA Center, your moderator for this series. This series of webinars is brought to you by the Pacific ADA Center on behalf of the ADA National Network. The ADA National Network is made up of ten regional centers that are Federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act. You can reach your regional ADA Center by dialing 1-800-949-4232. As always in our sessions, only the speakers will have audio. Real-time captioning is provided for the webinar as you now know. The caption screen can be accessed by choosing the CC icon in the audio and video panel as depicted on the screen.

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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 or the ADA.

Upcoming sessions are available at ADAPresentations.org under the schedule tab. Then follow to healthcare.

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 of ADAPresentations.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 and the speakers and I will address them at the end of the session. So feel free to submit them as they come to your mind during the presentation. To submit your questions, enter your text into the chat area or you can press control-M and enter text in the chat area. If you are listening by phone and not logged into the webinar, you may ask questions by emailing them to ADAtech@ADAPacific.org. That's ADAtech@ADAPacific.org.

If you have any technical difficulties during the webinar, send a private message to us by clicking on the Pacific ADA Center in the participant list and a tab with that title will appear in your chat panel and type in your comments there. If you're using a keyboard, you can hit F6 and arrow up or down to locate Pacific ADA Center and select to send the message. You can also email us at ADAtech@ADAPacific.org or call us at 510-285-5600.

>> LEWIS KRAUS: Today's ADA National Network Learning Session is titled the basics of healthcare and ADA.

The Americans With Disabilities Act the ADA is a civil rights law that aims for equal opportunity for people with disabilities to use the services provided in the United States. Presented by four members of the ADA national network's healthcare subcommittee this webinar will lay the groundwork for understanding the responsibilities for healthcare providers under the ADA in the provision of healthcare services.

We will cover the basic three areas. First facility access including physical access to the building and exam rooms and accessible medical equipment.

Second, effective communication for patients with disabilities and third, modifications of programs, policies and procedures. Our speakers today, myself, Lewis Kraus the co-director of the Pacific ADA Center based in Oakland, California. Michael Richardson the director of the Northwest ADA Center based in Seattle, Washington. Dana Barton director of Rocky Mountain ADA Center located in Colorado Springs, Colorado and Pam Williamson the Assistant Director of the Southeast ADA Center located in Atlanta, Georgia and a member of the healthcare subcommittee, as all of us are. I will now turn my attention from being the moderator to presenting.

As a prelude to discussing the ADA and healthcare for people with disabilities, it might be good to start with a brief demographic of understanding of people with disabilities in the United States. Over the past years, the consistency of disability

questions used in national surveys allows us to look at the percentage of people with disabilities over time. The percentage of those with disabilities, as you can see over time for the past several years, has been somewhat constant but continuing to rise, reaching a level of 12.8% in 2016. Now I do want to make a note that other surveys have publicized other rates of disability. All of those survey's rates are affected by the survey question, their method, other factors. Each have strengths and weaknesses and comparing between the different surveys is discouraged by all of the survey organizations.

But this is one that the American Community Survey so that important take-home message from this graph is that we are in an increase, a slight increase in the percentage of people with disabilities in the United States. And part of that reason, if not most of the reason, is because of the fact that disability increases with age.

This slide shows that the increase in age in disability with age, as you can see, it's very, very low, almost minuscule for those under five years in terms of percentage. But it rises to more than a third of those ages 65 and over.

Disability is also highly connected to poverty. In this slide you can see that there's a gap or a difference between those with and without a disability who are in poverty. But also, as you can see from this, over the past many years, people with disabilities are consistently more than 7 to 7.5 percentage points in poverty more than those without a disability.

Given that we now know that the population is higher in older populations and in poverty, now let's look at what's the future.

It's growing in numbers as the population ages, as you are probably well aware and hear quite frequently about the aging of the baby boom population and also with the technological advances in end case. So we're going to -- in care. So we're going to have increasing numbers of people with disabilities due to those two reasons.

And projections look to show that by 2050 almost 20% of the population will be 65 or older and you saw how much that has an influence on the number or the percentage of people with disabilities.

And some future projections look, some of these past projections look at when you break down that 65 and older group even further that the older that group gets, the higher the percentage of disability, as you can see, the 49.8% of those who are over age 75.

So this is actually even reflected in some healthy people data. And writeups. As the older Healthy People 2020 version even refer to the fact that people with disabilities are more likely to experience difficulties or delays in getting the healthcare that they need. They have not had an annual dental visit. They are more likely to not have had a mammogram in the past two years. They are more likely to not have had a Pap test in the past three years. They are more likely to not engage in fitness activities and more likely to have higher blood pressure. All of these being elements of health behaviors that

are -- suggest less health and more need for medical assistance.

So these disparities that I've just pointed out might result from a variety of different items.

There's poverty that we went over. There's prejudice and stereotypes, which is hard to quantify. But it undoubtedly exists. There's lack of provider training and cultural literacy. There's physical and programmatic inaccessibility of healthcare.

And there's inadequate research to show that things have occurred for people with disabilities. And then there might also be ADA monitoring, implementation and enforcement issues that occur.

So now that we understand what the population looks like and how it may grow in the future and thereby necessitating even more health and medical care, let's turn to what the ADA says about this.

First, some basics about the ADA. And I see many names in the participant window of people who are quite knowledgeable about the ADA and for this I apologize that we are going to talk about basics.

But basically, there are five titles or sections in the ADA. The first one refers to employment. And this refers to employment, and this is an important area, employment of people with disabilities. And in particular there is an issue about employment of people with disabilities in the field of healthcare.

However, this talk and this series are not going to be covering employment.

Today and throughout the Webinar Series we will talk about the next two titles or parts of the ADA that relate to state and local Government programs and services which is Title II, including health programs and services and businesses that provide services to the public and that's Title III. All of you who are in the audience and are healthcare providers, you will fall into one of those two categories.

So the ADA requires the delivery of services in a way that ensures that all people have an equal opportunity to achieve the full benefit of a program or service, whether you're a Title II or a Title III entity.

Equal opportunity is the key phrase here. The ADA is a civil rights law and just as you understand other civil rights laws as a way to provide equal opportunity this is what the ADA does, as well. In this case this means making sure that people with disabilities have an equal opportunity to enjoy the same benefits of a health program or service as someone without a disability.

Please also note that this is true no matter the size of your business or the number of employees.

What specifically do we mean by an equal opportunity? So equitable access to care and service could include physical accessibility of the buildings and the facilities. Accessible medical equipment. Effective communication. And modification and policies, practices and procedures.

Each of our speakers are going to be covering these areas in more depth. But first

you might be wondering when I say people with disabilities what I'm referring to. So under this we're talking about people with physical, mental, cognitive or intellectual limitations. Such as difficulty walking, balancing or climbing, seeing or hearing, reading or understanding and remembering.

And with that I am now going to turn this over to Dana Barton to start us off with physical accessibility of buildings and facilities. Dana.

>> Dana Barton: Great, thanks, Lewis. And thanks to all of our participants, as well. As Lewis mentioned I am going to cover the physical accessibility of buildings and different facilities and I'm also going to include in that accessible medical equipment but I want to pause here before I get into -- I've got some pictures and we're going to look at some things. But I want to give you some background. I know Lewis just gave you a bit of a background. But just want to give a tiny bit of background first and that's the ADA ensures access to the built environment for people with disabilities and it's the Department of Justice that enforces these accessibility standards.

So when the ADA was first passed in 1990, the ADA included Standards for Accessible Design. And these were amended in 2010. The new standards are referred to as the 2010 Standards for Accessible Design. And these standards became enforceable in 2012 for all new construction, any alterations, so program accessibility and for other barrier removal.

So the actual law doesn't outline the specifications for different facilities. Rather, they rely on the U.S. Access Board who have developed an updated design guideline. And these 2010 standards apply to places of public accommodation, commercial facilities, and state and local governments.

And as Lewis mentioned those Titles II and III of the ADA require that medical care providers provide individuals with disabilities full and equal access to their healthcare services and facilities as well as reasonable modifications to policies, practices and procedures when necessary to make healthcare services fully available.

So when you're evaluating the physical accessibility of your facility, you want to begin outside your buildings so basically you're going to first take a look at your parking. The 2010 standards define a parking facility to be both inclusive of parking lots and parking structures. And the number of spaces required to be accessible is calculated separately for each of those facilities whether it's a lot or a parking structure.

Accessible parking spaces need to be designated as reserved with a sign showing the symbol of accessibility. And then accessible spaces also need to have -- van accessible spaces need to have a sign that says van accessible. All of these signs need to be located so they are not obscured by a vehicle parked in the space and it's important to note that you need to have one van accessible space for every six accessible spaces.

And here on the slide you can see a couple of examples of where a facility got the parking situation wrong.

So in the first photo on the left you see the curb cut was actually built into the access aisle and on the second photo on the right you can see this is a problem a person with a mobility device won't have a flat stable service in order to transfer out of their vehicle because of this curb cut that's built out. So these are a couple of examples of what you don't want to do. And now that we're showing you some pictures you're going to start seeing these things everywhere. Hopefully not at your facility.

This next photo on the left is the proper scoping for parking spaces for accessible parking spaces so the ADA standards are an 11 foot wide space for van with standard 5 foot access aisle however the standards also allow a 8 foot wide space and 8 foot access aisle as an alternative additionally the access aisle needs to be marked so it discourages parking within it. I did in the last week see a person who, rather than parking in the accessible spots, just went ahead and parked in the access aisle. Perhaps that person thought that was better than parking in an accessible spot yet it completely negates the access aisle.

Access aisles can be on either side of the vehicle except with angled parking in which case the aisle needs to be on the passenger side. The 2010 standards outline the number of accessible parking spaces that are required so in hospital outpatient facilities, and that includes or is defined as a facility that's within a hospital and provides regular and continuing medical treatment without an overnight stay. So this might be a doctor's office that's within a hospital, you need to have 10% of patient and visitor parking compliant with these standards.

Rehabilitation facilities and outpatient physical therapy facilities must have 20% of their parking compliant when they specialize in treating conditions that affect mobility.

Stand-alone doctor's offices, independent clinics and other facilities that aren't located in the hospitals aren't considered outpatient facilities so these facilities are subject to the standard scoping as outlined in Chapter 2 of the 2010 standards.

And after you evaluate the accessibility of your parking, you're going to consider the accessibility of the buildings, medical office, exam rooms, and restrooms within the building.

So once a person has parked, they need to have maybe one accessible route from the site from the accessible parking spaces or accessible passenger loading zones, from public streets and sidewalks. And public transportation stops to the accessible building for facility entrance.

At least 60% of all public entrances must be in compliance. So if there's only one public entrance to your facility, that must be compliant. Let's say there's four public entrances, three of those would need to be in compliance.

So you can see in this first photo a person who uses a wheelchair would not be able to access the door because of these stairs. And so that would mean that there's no accessible route from the parking spaces or the street, sidewalk, et cetera, to the facility.

You need to make sure that at least one accessible route connects each story or mezzanine if you have a multi-level facility and you'll want to also make sure that entrance doors, doorways and gates have a clear width of at least 32 inches and a clear opening of a full 90 degrees. You can see in the third paragraph the person using the wheelchair would not be able to access the restroom because the door opening is too narrow.

Moving on to these photos in the first you can see an accessible route to this building. There's a flat, stable surface. It looks as if these doors are well within the 32 inch minimum and that they would have the 90 degree clear opening. Of course I'm not there to measure it but that's what you're going to want to look for.

You may also consider using a ramp to access a building. And in the instance of the photograph that I showed in the previous slide, where there are stairs, you might decide to use a ramp but you need to make sure that those ramps -- that they meet the sloping requirements, that they have clear maneuvering space, clear landing space. If you have handrails there would be appropriate clear width and all of this is outlined in the 2010 standards. Once you get into the building and you're within the exam room you need to make sure that you have features that make it possible for patients with mobility disabilities to receive their appropriate medical care so this is going to mean an accessible route to and through the room, an entry door with adequate clear width, maneuvering clearance and accessible hardware so you'll want to look at the doorknobs and door pulls that you have. And make sure that all of those things have operable parts that can be used with a loosely closed fist, that's something important to remember. You need to make sure you have appropriate models and placements of accessible exam equipment. You can see in the second photo here it looks as if everything in this exam room is on wheels so it could be moved out of the way for clear floor space. Also it looks as if all of these items are adjustable for height.

And then just to reiterate you want to make sure you have adequate clear floor space inside the room so you have room for side transfers or if you have a lift that you have room for that lift equipment.

The number of accessible exam rooms with accessible equipment is going to vary based on the size of your practice, what your patient population looks like, and some other factors.

And you also want to ensure that along your accessible route there is an accessible restroom. Chapter 6 of the 2010 standards outlines accessible restroom requirements. And you want to be mindful that the maneuvering space, the height of the title, the height of grab bars as well as knee and toe clearance at the sink are all in compliance. And those are just a few of the requirements.

I think it's also important to note here that if you add furniture to the restroom such as shelving for urine specimen containers or a trash can that can be moved, these need to stay out of the clear maneuvering space. My father recently was in the hospital in the

ICU for several days. And on that floor all of the public restrooms were single user and they were all marked accessible but I found that each time I used the restroom the housekeeping staff had moved the trash can so it was right next to the toilet making a side transfer for a person who uses a wheelchair impossible.

So I went ahead and just moved the trash can every time I was in there so it was out of the clear floor space. But every time I went back in and the janitorial staff had been in there, they moved -- they had moved it back. So this is just to remind you that even though a restroom can be constructed properly, human error can cause the restroom to be inaccessible.

And also, this is where training for your staff comes in. So if the environmental services or janitorial staff had been trained properly they would know not to move those items where they would be in the way. So training is really important as you look at all of this, as well.

So now I'm going to transition into accessible healthcare equipment.

So earlier we talked about the requirement to provide individuals with disabilities full and equal access to healthcare services and facilities. And this is where accessible medical equipment comes in.

Not every exam room has to have fully accessible equipment. But you need to make sure that you're noting the accessibility needs of your patients to ensure that they are accommodated at their visit.

Many exam tables are just too high for patients with mobility disabilities. In the photo on the left you see a non-adjustable table which makes it extremely difficult for a patient to transfer. This patient is trying to use crutches to get up on to the exam table. It's unsteady it's dangerous, it's risky. So you don't want this.

You need to make sure that your medical staff is trained to ask the patient if he or she needs assistance. And if so what is the best way to help them.

You may have items like a transfer board or just provide a steady hand for transfer I'll show some other things for transfer here in a minute.

Another area where it's important to make sure you have accessible medical equipment is when it comes to the accurate measurement of a patient's weight. That weight is essential for diagnostic treatment such as knowing the proper dosage of pharmaceutical drugs.

Oftentimes patients who use wheelchairs are never weighed in their doctors offices because they don't have equipment. They only have a standing scale like you see here on the right. And I've heard this over and over again from individuals who use wheelchairs that they are simply just asked, what do you weigh?

And that's not giving them fair and equal treatment.

So understanding and using accessible equipment is going to minimize the risk of injury to patients but it's also going to minimize the risk of injury to your staff.

Here on the left you can see adjustable height exam table. So when you're using

these exam tables, you want to make sure that they meet the following requirements, that they have the ability to lower to the height of a wheelchair seat which is typically 17 to 19 inches or lower to the floor. And you're going to want to make sure that you also have elements to stabilize and support a person during transfer. And while they are on the table.

So this might be rails, straps, cushions, wedges. You may also consider the use of a lift. As you can see on the top right here we've got a picture of a lift.

And this may be used to transfer a patient safely onto an exam table. This might provide better security for the patient and again minimizes the risk of injury to your staff.

Medical providers should also have an accessible scale with a platform large enough to fit a wheelchair, a high weight capacity for weighing an individual while seated. You want to make sure, as you can see in this lower picture on the right, that the scale has an edge protection, clear maneuvering space to pull on and off the scale and a sloped surface. Aside from exam tables and scales you should also consider other medical equipment such as mammography equipment. The CDC shows -- and Lewis mentioned this earlier, that women with disabilities with disabilities -- women with disabilities receive mammograms at a lower rate than women without disabilities and this lack of equipment means women with disabilities are at higher risk of late stage breast cancer diagnosis and will have a higher mortality rate. And so that's another example of why making sure you have accessible medical equipment is essential to the overall health of your patients with disabilities.

And we just want to go through with you very briefly, you can find a lot of resources where I pulled some of my information. We have these resources outlined for you. So the ADA Standards for Accessible Design. The Department of Justice has put out on access to medical care for individuals with mobility disabilities.

And then on the Pacific ADA Center's healthcare page, they have some of these resources under the healthcare page that include the two I just mentioned, accessible medical examination tables and chairs which was a publication put out by the ADA National Network. A publication on accessible medical diagnostic equipment. The ADA Network has information on accessible parking. The New England ADA Center has put together an ADA Checklist for existing facilities. And then also there's a link to increasing the physical accessibility of healthcare facilities, which was put out by the Centers for Medicare and Medicaid Services.

So with that, I am going to turn this over to Michael for effective communication.

>> Michael Richardson: Thank you, Dana, this is Michael Richardson. I'm just going to do a quick check and ask Lewis if I'm coming through okay.

>> LEWIS KRAUS: Yes you sound great Michael.

>> Michael Richardson: Fantastic thank you for having me. Just a quick reminder as I talk about effective communication this is going to be a very brief overview of the effective communication requirements under the ADA. We will likely have a future

webinar that goes more in depth on a broad spectrum of what's required and what are best practices when it comes to effective communication.

So the next slide for effective communication the purpose of effective communication is to ensure that a person with a vision, hearing, speech or cognitive disability can communicate with, receive information from, and convey information to, a healthcare provider in an equal manner.

Now, when I say an equal manner I mean 100% fully accessible manner in terms of quality and quantity. As an individual with hearing loss, too often I hear from my deaf peers that they had an important medical appointment in which an ASL sign language interpreter was not provided and the doctor conducted the appointment with a pen and paper writing brief notes and messages. So you can assume that this was not a fully accessible appointment in which full information was given in full context and manner.

Healthcare providers must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.

We'll get more into auxiliary aids and services in a moment but I also want to mention that effective communication also includes appropriate signage in a facility, directional signage, signage notifying where the restrooms are and also accessible websites that tend to convey medical information and facility information. So those things will likely be covered in a future webinar, as well.

Going to the next slide.

So the key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal methods of communication.

So usually the person with a disability is their own expert on what works best for them. So it's important to have a conversation on what would be effective again given nature and context of the environment and the communication that is needed.

The rules apply to communicating with a person -- the person who is receiving the services of the healthcare provider as well as with that person's parent, spouse or companion in appropriate circumstances so for example a deaf spouse or partner of a pregnant woman has a right to ASL interpreters for Lamaze classes or the actual childbirth.

The importance of effective communication in healthcare cannot be overstated. There can be and there have been some serious consequences when effective communication did not take place.

In this slide here is a situation in which a woman didn't have access to alternative formats to standard print and she had low vision. And as part of that she learned only after years of taking her thyroid at dinner time that taking medication with food weakened the drugs effects which may have compromised her treatment.

Here is another common scenario.

First of all, the Washington state there's a medical interpreting Task Force which

consists of American Sign Language interpreters and members of the Deaf Community who are currently addressing issues surrounding access to medical care for deaf individuals. And in one case through some conversations on individual mentioned he ended up in the hospital after a heart attack attributed to medical error. And basically in this situation it was medication prescribed without the benefit of a sign language interpreter.

Even if there are clear instructions in print for this individual this may not be effective as English may be a secondary language for individuals in which American Sign Language is a primary language and we'll get to more of that shortly.

On the next slide, here are some examples of auxiliary aids and services for people with vision loss. And this is not an all inclusive list.

But for example, there could be requests for formats in Braille. Now, does this mean that all materials have to be available onsite in Braille? Not necessarily. But depending on the situation, it may be necessary to request some postop recovery instructions for example in Braille for somebody where maybe other formats aren't accessible and a good example here in Washington state where we have a large deaf-blind population some deaf-blind individuals who use ASL may not be able to effectively read English in large print nor use verbally recorded instructions so Braille may be the most appropriate format for them.

Large print could be an option as well and large print can quite easily be done on a copy machine by changing the size of the printouts as well as enlarging the font on a document before printing it out. So think about having some of your handouts and materials available on computers in document formats that can be easily modified to adjust the font.

Digital text. Digital text allows someone to use voice output software at home to listen to print material so in some cases medical providers may email some information to a patient so they can use it at home on their special software to listen to the material.

If it's confidential information and there's some HIPAA rules around sending things over email then sometimes providing the patient with a thumbdrive or a disk with relevant information may be a way to circumvent that situation as well.

Audio is also an alternative. Audio recorded information may be effective, too.

Qualified reader is also something to think about.

Now, a qualified reader under the 2008 Amendments Act is defined as anyone who is able to read effectively, accurately and impartially using any necessary specialized vocabulary.

So this is something you want to think about having somebody on staff, whether it's a receptionist or a nurse to kind of work as a backup qualified reader to help read materials should there not be alternative formats available.

This could necessitate having a separate appointment a little bit later in the day to spend that time doing that or it could happen on the spot in the lobby in which case for

example the receptionist would read a form for a patient to sign and make sure that he or she understood what was being presented. A note of caution on that though is to think about the confidentiality of the environment. So you don't want to be reading aloud somebody's personal medical information in a lobby full of other individuals.

So it may require going back to a separate room to play the role of the qualified reader.

On the next slide we have effective communication auxiliary aids and services for people who are deaf or hard of hearing or have some level of hearing loss. We look at qualified American Sign Language interpreter. This may also include other forms of interpreters such as tactile interpreters for deaf-blind individuals. There are oral transliterators who are people trained to help with lipreading with doctors and healthcare providers and/or cued speech interpreters which are still out there. Hard to find but you never know what kind of interpreting request will be made. There's also Communication Access Realtime Translation. We call it CART for short. And you can see an image in the far right of somebody looking at a computer screen, a laptop, that has captioning.

And this -- imagine for a second this is a patient meeting with a healthcare team to talk about upcoming surgery, the post operation recovery process. And any necessary physical therapy, medication management and all of that. And the bottom the picture on the right is an individual using a stenography machine which is a common tool used by CART providers so CART can be something to think about providing, especially with our older generation Americans aging with disabilities and having increased issues with hearing loss. CART may be an effective way of providing information, again, depending on the situation and the environment and the circumstance.

Written materials and transcripts and notes may be effective, as well.

And then also Assistive Listening Devices including FM systems and pocket talkers and things like that. And again we will likely go into more details what these devices look like and where you can obtain them in a future webinar.

I'm going to digress a little bit from the area on those with hearing loss and mention that people who have speech disabilities, this may include providing a qualified speech to speak transliterator and this is a person who is trained to recognize unclear speech and repeat it clearly so this can be especially useful maybe for a person with a significant speech disability will be speaking at length to a healthcare provider and some situations keeping a paper and pencil just simple little things on hand that the person can write out words that the staff can't understand or allowing more time simply to communicate with someone who uses a communication board or device may provide effective communication and this is an important area when we talk about modifications and policy procedure some healthcare providers have a limited amount of time to spend with a patient. But if the communication takes a bit more time because of the nature of the disability, then healthcare providers may need to be prepared to go above and beyond their allotted time to ensure that effective communication is taking place.

So the next slide, quite often the Department of Justice cases surround the issue of deaf patients not being provided qualified American Sign Language interpreters so it's important to understand why it is critical to address this.

So for individuals who are deaf and use sign language, the most effective auxiliary aid or service which a medical office can provide is usually the service of a qualified sign language interpreter who are trained in medical terminology.

ASL is a very visual and gestural and rich language that has a different grammatical structure than the English language so reading standard English print or sharing notes may not be effective for some individuals who have been grown -- who have spent all their lives in an environment using sign language as a primary language. So going back to the previous example of trying to provide information in English may not be effective to individuals who are deaf.

One thing I always caution it's very clear in the ADA guidelines is do not use family members as ASL interpreters. Unfortunately and quite often medical providers are trying to encourage family members and even children to interpret in some medical situations. And what the ADA says is do not do this unless it's an extreme health and life and it's immediate and it's emergent and -- but in the meantime at the same time working to secure a qualified sign language interpreter.

Now, one thing I also want to mention is there's also Video Remote Interpreting or VRI in which we have a software and hardware set up to have a remote distance interpreter providing services through a screen and a monitor we can spend hours talking about this.

But it's my opinion and much of the opinion of the Deaf Community, is to use live ASL interpreters, in-person interpreters, wherever possible. Recognizing that there are some facilities out there in more rural areas that may not have access to qualified live person interpreters and may be using Video Remote Interpreting. But the reality is VRI can be effective in some situations. In many situations it's not effective. Such as when patients are lying prone or coming out of surgery and groggy and under medications, things like that.

This is something we'll address more in detail at a future webinar on effective communication.

Just going into some effective communication resources, the ADA National Network has a fact sheet on effective communication. The Department of Justice has several documents, one called Communicating with People who are Deaf or Hard of Hearing in Hospital Settings. And also there's a really good document on web accessibility available through the Pacific ADA Center that Lewis is directing.

Another slide, final slide here, also the National Association of the Deaf has excellent resources on providing auxiliary aids and services to deaf patients. They have questions and answers for healthcare providers and the Department of Health and Human Services has guidance and resources for Electronic Information Technology:

Ensuring equal access to all health services and benefits provided through electronic means. So this would cover not only websites but also the area of telemedicine and distance medicine that's done via computers and the network.

And so I think I'm going to pass it over to Pam Williamson. Pam Williamson to talk about modification and policies, practices and procedures.

>> Pam Williamson: Thank you Michael as Michael said I'm Pam Williamson some and up until this point in today's webinar we've learned about disability statistics, the physical and facility access and the requirements for effective communication.

We're now going to look at the modification of policies, practices and procedures and learn more about what that means.

Under the ADA, it requires that any medical facility, whether that be a hospital, a doctor's office, a public health group make modifications in their policies and practices and procedures, when necessary, so that a person with a disability can access the goods and services.

A couple of examples of what that might mean in real life.

One could be as we mentioned earlier is when it might be helping someone understand some of the more complicated forms, putting it into simple language so a person with a cognitive or learning disability can understand it.

It could be assisting a person with completing a form. If there's a form that they need to complete while they are at the office and they are unable to use a pen or a pencil to do that due to a disability, then they may need someone to help them complete the form. And although that may not be something you do on a regular basis, that would be a modification to the practice in order for the person to be able to complete the form.

Or it could be scheduling an appointment at a specific time for a patient who has an anxiety disorder and who is unable to wait in a crowded room for his or her appointment.

All of these are examples of reasonable modifications to either a policy, practice or procedure.

Now, there is always that unless piece when it comes to the Americans With Disabilities Act. If a healthcare provider can show that modifying the policy, practice or procedure would fundamentally alter, it would change the nature of the goods or services provided, then there's no requirement for the modification.

Now, while we're talking about reasonable modifications, there are some best practices in place that are very important to consider.

One is actually developing a standard operating procedure around how a person can request a reasonable modification.

Who are they going to ask? What -- do you have a form in place? No, a form is not required under the ADA but it does help to document the request and ensure that you're meeting the needs of the person who is there to receive medical services.

This could be something that's posted in the office or the waiting room or other places. Either an ADA notice. And have a variety of contact methods for the individual. You know either by phone, a relay service, online, via email.

To ensure that individuals can access the information and going back to that effective communication piece.

And also, too, it's important -- and Dana stated this earlier -- that you look at including multiple things in the staff training. Almost every medical office I know of have ongoing staff training. Make it a habit to include elements of disability awareness, customer service, effective communication and the modification request process in these staff trainings just to make sure that you are able to meet the needs of your customers.

And this is one of the things that I think is so very important. And this is important from the top of the line to the frontline staff. Everyone needs to be aware of these policies and the procedures that go with them.

Now, we do have some resources for you. And I always believe that having access to resources is one of the best ways in order for you to be able to have information when you leave here today.

So reasonable modifications are addressed in the Title II regulations for state and local Government groups. And in the Title III regulations for private businesses or public accommodations.

In addition to that, the ADA National Network and the U.S. Department of Justice also have excellent resources that talk more about reasonable modifications and reaching out to customers with disabilities.

If you have already got a training in place and a schedule in place, the online course reaching out to customers with disabilities would be one that I would recommend that you use. And so for your staff, so that they can learn more about the customer service and reasonable modification.

Now, an issue that comes up quite often in many areas but particularly in the healthcare arena are service animals. Under the Americans With Disabilities Act, in Section 504 of the Rehabilitation Act, healthcare facilities must permit the use of a service animal by a person with a disability, including during a public health emergency or disaster.

An excellent document was prepared and it is online from the U.S. Department of Health and Human Services. And it talks about how to accommodate service animals in healthcare facilities.

Many times the question is asked, well if a person is in a hospital why do they need their service animal? Here is a great example, a person has severe diabetes. He has a service animal, service dog, who alerts him to his diabetes. Often low blood sugar. Often before the testing shows that his blood sugar is low that allows he and the medical staff to address the issue before it becomes critical.

Now, a service animal would not be allowed in a place in a hospital such as a burn unit or a very high sterile area, such as a surgical or operating room. Places like that that are off-limits to the public in general would most likely be off-limits to the service animal.

Keeping in mind that the person who has a service animal must still either be in control of the animal and take care of the animal or have a designated person that is not in the medical staff at the hospital to take care of the animal.

Many hospitals have put in policies regarding service animals. A quick search of the Internet brought up a couple. Johns Hopkins has an excellent policy as well as -- such as the Jewish hospital -- I just lost the name. Hold on, folks.

It's a hospital in New York. And I will get the name for you. Before we leave today.

But they also have -- the -- it's the national Jewish health center in New York.

And they have service animal policies in place for both patients and visitors to the hospital.

I would recommend that you look into establishing a service animal policy for your healthcare location. So it will ensure that you are, again, meeting the needs of your customers and also make sure that the rules are clear and that everyone understands what rules are in place when it comes to having a service animal under the Americans With Disabilities Act.

Again we have some more resources. We have a service animals fact sheet from the ADA National Network.

We have a booklet that talks about service animals and emotional support animals.

And then the U.S. Department of Justice has the Frequently Asked Questions about the ADA.

The Center for Disease Control has a guideline for environmental infection control in healthcare facilities and there is a specific section on service animals in this document. And they also have a document for service animals in dental healthcare settings.

And at this time I believe that this goes back to Lewis.

>> LEWIS KRAUS: That is right, thank you very much, Pam. All right. So we have presented to you some basic understandings of the ADA and some specific resources to look at in terms of physical accessibility, effective communication and modifications in policies, practices and procedures we want to share with you. Now, where you can get more information on a broad range of topics, as well.

So the ADA National Network has a series of resources available for you that you can use in implementing the ADA in your area.

There is this series, of course, the healthcare and ADA Webinar Series that you have now signed up for and will receive emails for future webinars on.

There are healthcare and ADA fact sheets available at the national Website which is ADAa.org.

And then you search under that for healthcare.

And you'll find those fact sheets.

All of our regional centers, of which there are ten of us, have our own Websites with links to Federal and state resources. There may be state issues that are also things to consider.

So for example you've heard in terms of the Websites, of regional Websites, you've heard everyone refer back to the Website at the Pacific ADA Center where we have a particular Website on healthcare. You can find it, if you would like at ADA Pacific -- ADAPacific.org/healthcare.

You can also call our 800 line. At 800-949-4232 or send questions by email. That is what we do on -- every day. Any kinds of questions that you may want to ask from any direction to give you an understanding of what the ADA says about the topic can be fielded there.

And if you have more detailed amount of information or you want to deal with an entire group within your setting or an associated setting, we all do trainings, as well. So you can contact your regional ADA Center at that 800 number. And ask if they can come and do trainings for you.

I also want to point out that the U.S. Department of Justice has a website that you may be interested in. Of settlements and agreements that they have. So you can see what has happened before. And this is called the barrier-free healthcare initiative. And it's a partnership of the U.S. Department of Justice's Civil Rights Division and the U.S. Attorney's Offices across the nation.

And it is a resource of court cases.

And they target their enforcement efforts on a critical area for individuals with disabilities which is healthcare.

And it was launched in 2012. And there is the link on the page. I will say it so that it gets into the captioning and that's <https://www.ada.gov/usao-agreements.htm>. And I do want to also mention that the DOJ staff will be with us on this Webinar Series next month to talk about this and other related issues.

Finally, just another reminder just how to contact all of us in the ADA National Network. There you have the 800 number at the top. For free and confidential answers on the ADA and also the links and contact information for myself and Michael and Dana and Pam. And with that we are complete with our presentation and will now take our -- take your questions. So thank you, Dana, Michael and Pam. So all of you remember to submit your questions in the chat window and we'll start working through those right now.

So the first one looks like it's from Michael. Is it okay to use pen and paper with a deaf patient if they are just stopping in for a blood pressure check?

>> Michael Richardson: That's a good question the answer is it depends on the situation as I mentioned earlier in the presentation it's always best to defer to the

individual, the deaf individual, about what their preferred methods of communication are. However what the ADA does say is that the -- ultimately the healthcare provider or the service provider does have the ultimate say, final say, in what is going to be effective, again, given the nature, length, complexity and context of the communication and the person's normal methods of communication.

So let's say in this situation an older gentleman, a deaf gentleman has hypertension. During the course of a lengthy doctors appointment with an interpreter he was instructed to stop by the clinic once a week for two months to get a blood pressure check in a two minute timeframe if that deaf individual says I would like a sign language interpreter for all those times I drop in ultimately you could say I think we'll be okay with pen and paper given again having that conversation ahead of time to determine what kind of communication will take place if it's just the matter of a individual showing up getting the can you have on and getting their check and put it on charts it's likely that writing back and forth on pen and paper may be effective however if the individual calls in one day saying he's experiencing symptoms or increase in hypertension or other things going on and wants to have a more in-depth conversation about that at the drop-in, then that might be a situation in which an interpreter may be required.

So again it all depends on the nature and complexity of the length of the communication being conveyed.

>> LEWIS KRAUS: Great, thanks, Michael. I realized that I failed to read out our contact emails. So let me do that now for a moment.

My email is [Lewisk@ADAPacific.org](mailto:Lewis@ADAPacific.org).

Michael's email is Mike67@uw.edu.

Dana's is dBarton@mtc-inc.com.

And Pam's is prwill01@law.syr.edu.

All right. Also a reminder because we are getting questions about this, if you want the PowerPoint, you can get it at the ADApresentations.org Website under the schedule page. That's today. Next week it will be in the archive as will all of the transcript and the archive of this presentation.

And if you are asking about training, you would want to contact your regional ADA Center. Just call them up or get them on the -- at their Websites. Or you can go to the ADA national Website, ask it there. And they will link you to us and the national Website is at ADAta.org.

All right. Next question. For Dana.

What if I lease my office space. Am I still responsible for the accessibility of the building?

>> Dana Barton: Okay. Thanks for that question, Lewis.

So yes and no. So you and your landlord are both responsible for assuring that the facility, the parking lot, et cetera, are accessible.

So I would suggest, the first thing I would do is check with your landlord and look at your lease to see if the landlord has maybe contracted a survey or done an audit, maybe they have a timeline in which they are going to correct any infractions say restriping the parking lot or fixing the door pressure on a door, et cetera.

And negotiate that with your landlord. Find out when they are going to be making any improvements. And then you're also -- you need to make sure that your interior layout and design of your office space, including those exam rooms, the lobby area where a patient may check in and those restrooms, et cetera, you are going to be responsible for making sure that those areas are accessible and within compliance, as well.

So within your space, that's fully you. On the outside of your space, you're going to want to work through that with your landlord. And of course you know I've heard from several people that have given our center a call and said well our landlord they are not going to do anything about it. Well that might be time to look for a new lease then and site selection is really imperative if you're leasing office space to make sure from the get-go you're looking at accessible office space and buildings, et cetera.

So there you have it.

>> LEWIS KRAUS: Okay. Thank you, Dana.

I want to remind everyone, if you do have questions, the way we're going to deal with questions is if you enter it into the chat room so that we can record it and also get it into the closed captioning. So feel free to enter your questions there.

All right, Dana, another one for you. What is the percentage of accessible parking spaces required for a private physical therapy facility?

>> Dana Barton: Okay so a physical therapy facility since general physical therapy facilities are going to be dealing with mobility, they must have 20% of their parking compliant. So hopefully that answers the question.

>> LEWIS KRAUS: Okay. And one more for you it looks like.

I wondered in a clinic that has a wheelchair scale, how is the weight of the wheelchair deducted from the total weight?

>> Dana Barton: That's a great question.

That I don't know off the top of my head. Give me a second, Lewis, and I'll find the answer.

>> LEWIS KRAUS: Okay we'll go on to some others.

>> Dana Barton: Can we come back to that one?

>> LEWIS KRAUS: Sure. It looks like many of our service dog questions. So Pam, may I ask that a service dog be removed from a healthcare setting?

>> Pam Williamson: Thanks, Lewis that's a very good question. The only time a service dog -- you can ask that a service dog be removed is when the dog is not housebroken, you know, they have having accidents. Is out of control. Or -- and the handler/owner does not take effective action to control the service animal.

Now, on occasion there is -- if there was a fundamental alteration, meaning a significant change to the services because of the service animal or a direct threat, which is a significant risk to the health or safety of others that can't be eliminated in some way, then you could ask for the dog to be removed.

But a service animal typically is allowed to go wherever anyone else is allowed to go. And cannot be asked to be -- and you cannot ask that they be removed unless one of these situations apply.

>> LEWIS KRAUS: Okay. Great. Thank you. And it looks like Dana is telling me that she has the answer for the weighing of the wheelchair.

>> Dana Barton: I do, Lewis. So what is suggested is that you remove any kind of extra weight from the wheelchair, any backpacks or anything that can be removed and you weigh the patient and the wheelchair together. And then once you have the patient in the exam room and you have safely transferred them on to the examination table, you make sure that your medical staff is trained and that you let the patient know I'm going to now weigh this chair without the patient in it. Of course make sure that the patient is safe and secure on the exam table.

And then weigh that wheelchair and then you can note that in the patient's chart and then for subsequent visits, if they are using the same wheelchair and you have removed the equipment, you should not have to reweigh that wheelchair every time.

And that's basically -- there's no standard weight for a wheelchair. So that would be one way to do that so hopefully that answers the question sufficiently.

>> LEWIS KRAUS: Okay. Great.

Next question, and I'm not sure who will answer this so let me just lay it out there and you guys can decide who wants to answer.

Are there accessible methods or recommendations for a patient to obtain and understand their medical records? For example someone who is blind or low vision?

>> Michael Richardson: This is Michael. First of all like I say there should be -- I mean the individual would have a right to obtain and understand the medical records and if they are blind for example and they need it in an alternative format then the healthcare provider does have a responsibility to either provide that in Braille or whatever format is going to work for that individual.

Now, with the understanding that it's not -- may not happen overnight, depending on the kind of alternative format that's requested.

So it's okay to let the patient know you need a little bit of leeway, lead time, to send a request out for Braille, copies of medical records and whatnot.

So again, having that conversation with the patient is -- if somebody doesn't ask for Braille, you can also ask can you use electronic format as well because sometimes individuals who use Braille use electronic formats and one of those formats may be easier than the other.

>> LEWIS KRAUS: All right, great.

Next question, actually it looks like there's a follow-up to the physical therapy question, Dana.

If a physical therapy facility is located within a strip mall, must the accessible spaces be closest to the facility or may it be dispersed?

>> Dana Barton: Also a great question. And you know I think you're going to want it to be as close to the physical therapy office as possible with a clear and safe route. And again, you need 20% of those parking spaces compliant. So I would get them as close to the physical therapy office as possible.

>> LEWIS KRAUS: And let me just ask -- sorry; go ahead. Go ahead.

>> Dana Barton: Okay. That's all I've got.

>> LEWIS KRAUS: I do want to add to people who are asking questions, we are trying to answer the questions here. A lot of times questions, we classify them sometimes as complex as opposed to simple questions.

And they sometimes take time to look up. And if you are not getting your question answered here, the best way to get that complex answer done is by calling the 800 number and talking to the technical assistance at the centers. They will be able to research and get you the answer that you need to get.

So just wanted to mention that.

All right. We have another service animal question.

Pam, can a patient with a service animal in a hospital be put in a room away from other patients?

>> Pam Williamson: Lewis that's an excellent question but I'm going to go back to our physical therapy place located in the shopping center strip mall momentarily and just add a little bit to Dana's answer.

Although you would want to have accessible parking closest to the physical therapy location, remember that many of those other businesses are also probably covered by Title III of the ADA. So there is actually -- it may be one of these situations that you say Lewis where the answer is a little more complicated. So there maybe needs to be a congregate of some accessible places near the physical therapy location. But also dispersed spaces to meet the needs of the other Title III entities.

So having said that, let me go back to our question about the person who has a service dog can they be isolated from other patients.

And the answer is no. So a person who is using a service dog cannot be isolated from other patients, put in a room down the hall away from everyone.

So -- because that person needs to be able mixed with everyone else.

So it's not -- so it would not be acceptable and would be considered discriminatory for them to be put into a room away from everyone else.

>> LEWIS KRAUS: Great, okay. Yes, and I do think that you should always consider your own questions through the context and through the lens of equal opportunity so to think about some of the answers that you have received here to these

questions.

You'll see where the equal opportunity really applies in every one of these cases.

All right at this point we realize that many of you may still have questions for our speakers and I apologize if you didn't get a chance to ask your questions.

But as I've mentioned before, please contact your regional ADA Center at 1-800-949-4232 and they will be able to answer your question for you.

You will be receiving an email with a link to an online session evaluation. Please complete that evaluation for today's program as we really value your input and want to demonstrate the import of it, of the session, to our funder.

We want to thank all of our speakers today for sharing their time and knowledge with us.

And a reminder to all of you that today's session is being recorded. And it will be available for viewing next week at ADApresentations.org in the archive tab.

And as I mentioned before, on our next webinar, on June 27th we will be joined by Stephanie Burger from the Civil Rights Division of the U.S. Department of Justice for an overview of the Department of Justice's barrier-free healthcare initiative we hope you can join us for that watch your email two weeks ahead for the announcement of the opening of registration for that webinar, thank you again for attending today's session and have a great rest of your day. Take care. Bye bye.