Transcript: Fighting for Safe Access in a Masks-Optional Healthcare Environment

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>> EMMA MARTIN: All right. We will get started. As the last people -- folks, join us. This afternoon. Hello, everyone. Welcome to Fighting for Safe Access in a Masks-Optional Healthcare Environment. A workshop on making reasonable accommodation requests under the ADA. This workshop is happily presented by DREDF. The Disability Rights Education & Defense Fund. By Senior Disability Action. And by the Center for Independent Living. We are really happy that you are all here with us today. I would like to introduce our speakers for today's workshop. I will start with myself. Hello, everyone my name is Emma Martin. I use she/hers pronouns. I'm the Community Engagement Program Manager here at the Center for Independent Living. Which is a cross-disability advocacy and direct services organization serving northern Alameda County. I'm a white person with short brown hair. I'm wearing a colorful cheetah print top. And I have a black N-95 mask on as I am in our office today. Next, our next presenter is Beth Kenny. Beth uses they/them pronouns and a member of Senior Disability Action. Senior Disability Action is a member-based organization here in the Bay Area that mobilizes and educates seniors and people with disabilities to fight for individual rights and social justice. And then we also have our final presenter, Claudia Center. Claudia uses she/her pronouns and serves as the legal director at DREDF. Which is a leading civil rights law and policy center directed by people with disabilities and parents who have children with disabilities. As a quick road map for today's workshop, we will begin by discussing COVID mitigation measures in healthcare. Coming from a history to present. We will discuss the impact of the current healthcare environment on patients. We will then move into a discussion about the Americans with Disabilities Act and disability rights and all things reasonable accommodations and how to make a reasonable accommodation and sample language around those accommodations. We will end with touching briefly on some next steps and options if your reasonable accommodation request is denied. And then leave ourselves a good amount of time for questions and answers. As well.

>> CLAUDIA CENTER: Okay. So, yeah, this is Claudia Center. I don't know if my video is visible. Which is fine either way. I'm a white woman over 50 and I sometimes wear glasses. Although I'm not right now. And I'm going to do a short review of COVID mitigation in the context of healthcare where we have been during the pandemic and where we are today. Next slide, please. Okay. So, we have the Federal Public Health Emergency and California's COVID-19 State of Emergency and these two events and different public health orders that went along with them really dictated a lot of the mandates that existed in healthcare facilities statewide. So the Federal Public Health Emergency began January 31, 2020. We had a COVID state of emergency also beginning. And then we have the ending of these emergencies for the federal side May 11th, 2023. For the California side, February 18th, 2023. And then in California, on April 3rd, 2023, the mask mandate for high-risk settings like healthcare, what we are talking about today, ended. Also around the same time on May 11th, 2023, CDC, the Center for the Disease Criminal and Prevention stopped calculating COVID-19 community levels. Which is often the means by which entities decide whether to use COVID mitigation measures. Next slide, please. Okay. So, this is the important -- here on this slide we are talking about the California Department of Public Health March 3, 2023 guidance on masks. And there is a link you will get when we share this slide deck with everyone. The mask mandates ended on April 3, 2023. The statewide mandate for healthcare facilities. It does say in this guidance document that masks are recommended or strongly recommended in high-risk settings like healthcare based on community COVID levels. But as we just noted, CDC is no longer tracking that. Next slide. Okay. So another source for statewide masking requirements comes from Cal OSHA. Occupational Safety Health Administration. We have two links from the Cal OSHA authority. One is the June 2023 California workplace guide covering healthcare. And this workplace guide says that surgical masks, those are masks with ties, or procedure masks, masks with ear loops, should be used for source control. What source control means, it should be used on people who are symptomatic with something that is contagious. And the healthcare facilities must follow the CDC respiratory hygiene rules. And that means that healthcare facilities must offer masks to persons who are coughing and must advise healthcare personnel to wear surgical or procedural masks when examining a patient who has symptoms of a respiratory infection. And so -- this is another authority for masking. Next slide. So even though there is no longer a statewide masking requirement in healthcare for California, local practices do vary. And we have some examples here on the next few slides. This is not a comprehensive review of local exceptions in California. But just to give you a sense. So,­­­­­ San Francisco County as of today which is June 27, 2023, San Francisco County still requires that people who work in healthcare settings wear a mask when around patients. So, for example, San Francisco General which is our large public hospital, masking is required for all patients, staff, and visitors in all areas where patients are present. So that is one example. Another example is Santa Clara County which requires masking in healthcare settings during "designated winter respiratory virus period." So that's another local practice that varies. Next slide. Alameda County and Contra Costa County are still requiring masking at Skilled Nursing Facilities. Los Angeles County is a lot like San Francisco County in that they are still requiring masking in all patient care areas. Cedar-Sinai has the signs up throughout its hospitals that says masking is required in all patient care everywhere and anywhere a patient can be anticipated. Including lobbies, elevators, and waiting rooms. Next slide. So these are takeaways that we want to share. From the history and present of mask mandates from the state of California. The takeaways are most state mask mandates are over, but the existing guidelines show that masking is feasible, that masking is recommended for many settings, and that masking is still required in certain circumstances. For example, Cal OSHA requires masks for source control for an infectious person. And so these principles related to masking really helped to strengthen and underpin the right to request masking, as well as, other COVID mitigation measures as a reasonable accommodation under the ADA. That is why we reviewed these principles. Next slide. Okay. I'm now going to pass to my colleague Beth.

>> BETH KENNY: Thanks, Claudia. So I am going to cover the part about impact on current healthcare environment on patients. I am an immunocompromised person so I can speak from personal knowledge and knowledge that I've gained from people who are in similar circumstances. And share with you some of the impacts. Can you give me the next slide, please. So vaccinations do not prevent COVID infections. And they do not prevent all severe outcomes from COVID infections. We know that vaccinations can reduce your chances of a severe infection and can reduce your chances of long COVID, but they do not prevent the initial infection the way we had initially hoped. And there are many people, including myself, who cannot garner protection from a vaccination. As an immunocompromised person, I've been involved in studies where they have seen what sort of auto immune response and antibodies my body produces and it just doesn't produce enough to garner any protection from the vaccines despite having many. And I would also like to add that some of the tools that we -- they say we have, are no longer available. Like Evusheld for people who can't garner the protection from the vaccines. That tool has been removed from the market. So it was found to be ineffective. And one thing I hear often is if you want to be protected, just protect yourself. Well, one-way masking does not prevent all COVID infections. You know. We have several members of NSDA who have experienced becoming infected while wearing an N-95. But being in indoor circumstances where others were unmasked. So when we talk about an N-95 as being the gold standard of masking, it is a great tool to have. And it, ideally, would prevent 95% of the things in the air from getting into your -- from being ingested -- not ingested. But prevent 95% of airborne infectious things coming into your system. But that's if you have N-95 the correct one that has been fit tested. People who work in scientific labs where these are required go through a fit testing process. And that process is only available to those folks. We've talked to California Department of Public Health about trying to make it available to people who are high risk. But currently, it's only available for people who are in the healthcare and scientific or industrial fields that require that level of protection. So when you say you have an N-95 mask, you are hoping you get 95% protection, but you are really -- that's if your mask is fit perfectly and you don't know. And most of the folks that I've talked to who have been through the mask fitting test process, have been surprised at the one that actually fit them. It was not the one that they would have guessed. So that is something to keep in mind. But certainly the mask levels of N-95 is the best mask available to us right now verses the surgical mask that Claudia was discussing under the OSHA standards. N-95 will definitely provide you a higher level of protection. And then there are other folks in our community that cannot wear masks. Whether for sensory issues, if they have a trach, or whatever. They physically were unable to wear a mask. So some people are unable to wear a mask or wear them reliably. And those circumstances have to be taken into account as well. And I know for myself, personally, when I go in for a procedure, they often have to take pre-procedure medicine. Even if an infusion, I have to take medicine that requires me to take my mask off. If I'm going in for any sort of larger procedure that involves sedation, I have to have my mask off then. I'm unable to protect myself. Like many of us, unable to protect myself by simply one-way masking. Next slide, please. Again, Peter Chin-Hong wrote "no face mask provides 100% protection." And that is for people who have been fit tested, as well as, those that haven't. You know, obviously if you have been fit tested, it's a lot higher protection than what you will see without it. Again, the N-95 mask is the best mask out there at this point. How this impacts us is the lack of having to think about all of this makes in all of these circumstances where you could run into people unmasked. One, you are trying to access healthcare safely. Makes it stressful to access healthcare, to be in a healthcare appointment. And it is hard to communicate. And hard to hear what you are being told and harder to get accurate levels. Like I know my blood pressure is very subjective to stress. Like many folks. So it's hard to know. It's hard to get your accurate assessments. And it's harder to participate fully in your appointments. Next slide, please. So one of the things that many patients -- many people who are high risk are dealing with, is trying to figure out whether to delay. What is more risky? Delaying necessary care, or avoiding the care and -- sorry. Delaying or avoiding the care verses accessing care without mandates in place. And knowing that you are going to be exposed to an airborne infectious disease that is currently the third leading cause of death in our country. And that for many of us are at disproportionate risk for. That just doesn't seem like something you should have to assess as a non-medical just patient person. And it's a lot. And many of our conditions, like my own, is impacted by that stress. And impacted by that not knowing of, do I need to get that lab work done? Do I need to have that preventive cancer check that I'm supposed to have. Do I need to do this? And delaying care we know comes with and avoiding care comes with lots of health complications. So it's very isolating. It's very stressful and you are very left on your own to make these decisions. I have not been inside in any places other than healthcare facilities during this pandemic. And now that's the one place that has -- that is gone. And I'm not alone in that situation. I don't -- there is no medical or infectious-based control measure that says removing masks is okay at this point. We know it's going to -- we know it increases infections. We have seen it at Santa Rosa Kaiser. We have seen it going on in Beth Israel Hospital in Boston. Where now they are calling it a "COVID cluster" happening in the hospital. They say we have put everyone on the same floors. But then what happens when the staff leaves that floor and they take off their masks and you are riding in the elevator with that person? We're not making policies based on science. So we are having to fill that in and think of creative ways to keep ourselves safe. And this is part of what this webinar is. To assert our federal rights to access healthcare safely. Next slide, please. So, yeah, there are many folks out there that are experiencing this. And it's not -- it's impacting us as patients, it's impacting the healthcare workers. We have a healthcare worker shortage now. And continuously exposing them to infectious disease. Or infectious virus that is doing such damage is not going to -- is going to make it harder to have healthcare workers. And access healthcare. And it has changed my relationship with my doctors. Knowing that they are willing to -- as part of a system. The system is willing to let me -- let us be exposed and let us become infected and let us become more disabled. And let preventable deaths occur. For unknown reasons, really. And it is a betrayal. Like this article says. It is a betrayal. I think that is the end of my section and I will pass it back to Claudia.

>> CLAUDIA CENTER: Thank you, Beth. I want to just acknowledge that this is a painful experience and a painful time for the disability community. And we're going to be talking about things as lawyers now. Beth is a lawyer, I'm a lawyer. How to maybe resolve your personal situation and that may help people in our community and on this webinar. But that doesn't eliminate the hurt and sense of betrayal that people are having. So I just want to acknowledge that. Next slide. So there are a number of disability rights laws in healthcare that cover a disabled person as a patient or a visitor to a healthcare facility. Really you only need to know about the ADA. Because the ADA is going to cover all public and private healthcare facilities. But I'm going to give you a few additional laws just so you can feel like you really know what laws cover what types of healthcare providers. So if it's a state or a local healthcare provider. So like a government healthcare provider, it's going to be covered by Title II of the ADA. And that's the part of the ADA that covers state and local government. It's also going to be -- that facility is also going to be covered by Section 504 of the Rehabilitation Act because they receive financial assistance typically through Medicaid, Medicare and other grants. And covered by Section 1557 of the Affordable Cares Act. And state law it would be Section 1135. Private healthcare providers are covered by Title III of the ADA that covers, essentially, private businesses open to the public. And then also covered by Section 504 of the Rehabilitation Act. Section 1557 of the ACA. And California's Unruh Civil Rights Act. Next slide. Okay. What do these laws require? So this could be an entire law school class. And this is really just a high-level summary. But these laws require equal access to programs and services for people with disabilities. And equal access includes equal safety, equal risk. That kind of quality. The laws require reasonable accommodations. Sometimes called reasonable modifications. They are both legally accepted phrases. Where necessary to achieving nondiscrimination. Unless the covered entity can demonstrate fundamental alteration. Which is a very high level of burden. And it also requires no interference or retaliation. So you're not supposed to be treated badly because you try to assert your rights as a disabled person. Next slide. Okay. So what is a disability under the ADA Amendments Act of 2008. Hold on one second. So we probably know the definition because this definition has been often shared in webinars that members of our community have gone to. But disability under the ADA is a mental and physical impairment that substantially limits one or more life activities. That has been the standard definition since, you know, we first started having disability rights laws in 1973. So under the ADA Amendments Act of 2008, substantially limits was redefined or we got new rules of construction that allowed there to be much broader coverage of disability than what we had before this amendment. So substantially limits is now construed to not be a demanding standard. To no longer consider mitigating measures. And mitigating measures means things like medications or prosthetic devices or adjustments a person makes to mitigate the symptoms of their disability. And so that means, for example, if you have diabetes but you have a lot of devices that help you maintain your blood sugar and insulin, even if you are doing really well on a day-to-day basis, you are still disabled. What the ADA Amendments Act of 2008 says is that you consider the person as though they are not using any of those devices or, you know, measures to maintain blood sugar and insulin at the proper measure levels. So that encompasses a lot of disabilities. You also consider the condition in its active phase. Even if it's a condition that goes in and out of remission or a condition that is episodic, like migraines or MS or all kinds of psychiatric disabilities, you consider the person when their condition is active. For example, seizure disorders. You consider it when the person is having a seizure. So, of course, in that situation the person is substantially limited in major life activities. The major life activities prong of that definition of disability was also amended and expanded in 2008. So there is a long list of functional major life activities. And then there is an expanded concept and list of major bodily functions that are now, sort of, blast and permitted to be used as major life activities. Next slide. Okay. So I'm not going to spend a long time on this slide. This is a list of some of the functional major life activities that count under the ADA as amended. But you will get the slides after this presentation. But just to note that there is a long list of functional activities that count as major life activities all the way from performing manual tasks to eating to thinking to concentrating to interacting with others and so on. Next slide. And here is a slide that lists a long list of major bodily functions that also count as major life activities. And so the immune system is one. So a lot of people who have disabilities that are vulnerable to COVID-19 and other infectious diseases, the immune system major life activity may be of interest. Next slide. There is also the concept after the 2008 amendments that there's predictive assessments for certain types of disabilities. And this is a concept from the EEOC and DOJ regulations. I have the citations there. Actually, the citations I have here are only the DOJ citations. Because we are talking about healthcare. But it's also true in employment. So they are conditions that are virtually always disabilities because of the way the condition inherently limits major life activities. And so this slide lists the conditions that are virtually always disabilities including -- I'm not going to read them all, but things like deafness, blindness, intellectual disability, using a wheelchair, autism, cancer, and so on. And you will have the slide deck that you can read. Next slide. Okay. So here's the takeaway that I want you to have is that disabilities can include a broad range of conditions. So we had a long period before the ADA Amendments of 2008 when every court case was a struggle around who had a disability. But that is no longer our reality. So in our current situation, disabilities can include psychiatric disabilities like PTSD, bipolar disorder, schizophrenia, depression, OCD, traumatic brain injury, intellectual and developmental disabilities, autism neurodiversity, mobility disabilities, being deaf or blind, learning disabilities, ADHD, dementia, Alzheimer's, and chronic illnesses including things like diabetes, and long COVID. So that's the big takeaway is that the definition of disability under the ADA is broad. Next slide. Okay. So when we're talking about making a request for reasonable accommodation, what courts will look at and what covered entities will look at, is what is reasonable? And reasonable is not defined in the statue or the regulations. But the courts will look at when considering what is reasonable, they will look at, is it feasible? Is it ordinary? Is it something that is ordinarily done? And they will also think, well, even if it's not ordinary, is it justified given the circumstances? So here I think that we can make strong arguments around masking of everyone being present at an appointment to be reasonable. The reason I say this, is that we know masking is still required in some jurisdictions. Including not just of healthcare providers, but of all people present. So we know that is true, at least, in San Francisco. We know it's still required statewide in some circumstances under Cal OSHA. We know it's feasible as demonstrated by past and present experience. And we can say that the modifications justify the given the circumstances. Which include for immunocompromised people and people with other disabilities the risk of severe health outcomes. From acquiring COVID-19 or other dangerous infectious diseases. Next slide. Okay. So what are some of the possible, reasonable accommodations for mitigating infection risk in healthcare? So we've been talking about masking of people during the appointment. Which is a very important accommodation and probably the top accommodation that people need and ask for. But it's not the only accommodation that you should keep in mind. So this slide lists video telemedicine, when it's appropriate, as a way of accessing healthcare without infection risk. The masking of staff during time at site. The masking of all people in the environment at time of site. Increase ventilation at the site. For example, air filters are an open window. Separate space for waiting on site. So waiting in a separate room. So you are not near members of the public who are not masked and who may well be infectious. Waiting in a car or outside until the appointment begins. So in other words, having a protocol or a change in policy that they will call or text you to have you come in so you don't have to be around other people. Referral to a different healthcare facility that does have COVID protocols. Healthcare facilities can, themselves, require masks even their state or local government does not. It's also possible for some appointments to happen outside or at the person's home. Obviously, those are less ordinarily. Remember the slide where I talked about ordinary, those are a little bit less ordinary. So you would have to justify those given special circumstances. But they are still feasible. They are things that could happen. Next slide. Okay. So this is still me. I'm going to be talking about how to make a reasonable accommodation request. One moment. Next slide. Okay. So I'm just going to go over some basics about how to make reasonable accommodation requests. So the first thing is, you want it to be in writing. You want it to be in a writing where you end up with a copy. So it's fine to use the telephone if that's part of, you know, how you are going to get information and have some back and forth and do some investigation. The telephone is a great tool. But you want to confirm your request in writing. Either by e-mail or through the healthcare portal. Take a screen shot. Just make sure you have it on your end in writing in some way. If you are using the e-mail -- making a request by e-mail, you want to cast a wide net. It's not always clear, particularly with private healthcare entities, it's not always clear who is the right person to take your request? So private entities are not required to, sort of, have their staff lists online in the same way that a public entity might have to be more transparent. So you are going to have to do some Googling and some investigation and try to include people like the patient coordinator, the ADA coordinator, the appointment coordinator, and also any kind of supervisor, administrator. Just try to get people who you think have some kind of power over policies and procedures. If your healthcare system doesn't really do e-mail but, instead, directs you to a portal, in that portal you want to be specific. To kind of flag for whoever sees your portal message that you are requesting reasonable accommodation for a disability. And in that portal request, ask for instructions. Just say, you know, if this is the right way to do it. Great. Or if you need me to go somewhere else, let me know. Just make it -- put the onus on whoever is reading your message to respond. Next slide. Okay. The core elements of a request for reasonable accommodation is to, first of all, identify yourself and state the conditions that create the vulnerability. And briefly explain why the condition is a disability under the ADA. So really, you know, as you can see from the ADA Amendments Act of 2008, you don't need to focus so much on whether your condition is a disability under the ADA. Really the issue for these modifications is that you need the reasonable accommodation. And the entity should implement the accommodations you need because they are feasible, reasonable, or ordinary. Okay the first element is disability. That you have a disability. The second is that you need reasonable accommodation, that you need reasonable modifications to mitigate the risk of transmission of COVID or another disease. And we are going to get into a little built more detail on this, but here you want to explain the connection between your disability and why you need to mitigate risk. And then to state the particular accommodations you are seeking, you know, identify what you are asking for. And then the last piece. Now this isn't 100% required but it will make your request stronger. Is to make it clear you are willing to communicate. You are willing to talk about your request, consider alternatives. Next slide. So here's some additional helpful elements that might make your request for reasonable accommodation more persuasive. First, if you have a prior experience where you experienced severe effects from COVID-19 or another illness. And suffered harm. For example, if you missed a substantial amount of school or work or had a permanent injury or, you know, anything really harmful. Which those are all very harmful things. You can describe that experience to say, I previously had COVID-19 or some other infectious illness. That would make it more persuasive. Another prior experience you might want to include is if you were forced to be in a risky setting for a necessary appointment and you experience disruptive fear and anxiety. Say you tried to go to a healthcare appointment or another appointment and were unable to complete the appointment because you had a panic attack. Or your blood pressure went off. They were unable to get a clear reading. And then another personal experience that might be relevant and persuasive. Is if you had a prior experience in which you were accommodated for an appointment, you showed up, everything was easy, everyone found the accommodations to be feasible and appropriate and it was no big deal and a success. Those are additional ideas. Next slide. Okay. Here is some sample text for the reasonable accommodation request for pre-scheduled appointment. So this sample introduction of yourself and disability says, dear Patient Coordinator Smith. I'm a patient at, healthcare provider. I have several conditions including diabetes that puts me at risk for severe outcomes of COVID-19. And you can include a link here to the CDC or something that explains the link between risk and your disability. As you might know, diabetes is a disability under the Americans with Disabilities Act. That limits major life activities. Yours doesn't have to look like that but introducing yourself, your risk, your diagnosis. You don't have to necessarily give chapter and verse of your diagnosis, but some name of your condition and why it's a disability under the ADA. Next slide. Okay. Here the next piece is your statement of why you need the accommodation. So here the sample statement that says I wear a mask to healthcare appointments. But no mask is 100% effective in preventing transmission of COVID-19 or other dangerous infectious diseases. Because of my disabilities, acquiring COVID-19 would threaten my health and well-being and potentially cause great harm. Next slide. And this is a sample statement of the requested accommodations. This slide includes the request that the patient be permitted to wait in a separate space by themselves instead of in a waiting room with unmasked people and that providers and staff wear high-quality N-95 masks while near or interacting with the patient. Next slide. Here's a sample statement of a willingness to communicate. This one says, I think that the accommodations that I have identified are the simplest and most feasible ways for the healthcare provider to accommodate my disability. However, I am open to a discussion, basically. So this is just an example of how you might include your willingness to communicate. Next slide. Okay. Now I get to turn it over back to my colleague Beth. Thank you all.

>> BETH KENNY: Thank you, Claudia. So the next section is next steps to take if your request is denied. And this is an important step. Although we have these federally protected rights, many of us are being denied. And it is a process to work through. And so I'm going to talk about some of those. Next slides, please. So one thing that you can do is evaluate and escalate within the healthcare organization. And I can tell you, personally, I've had some success with this. I have had where some initial requests denied and when I went back to the providers and said, hey, these are my federally protected rights. You have an obligation and let's talk about ways that we can make this work, we've been able to find -- with some of them, I have been able to find different accommodations that have worked for all parties involved. For instance, at my dentist and oral surgeons, we have worked it out I come in before the office is open to the public. And that has been working out quite well for all parties involved. So I think having that open -- all of these, each step it's going to be easier to resolve if you can resolve it with the healthcare provider. Because everything takes a long time. Some healthcare providers don't understand what their responsibilities and duties are under the ADA. And they feel they are following the current California department of health guidelines. And the CDC guidelines. So they are meeting their responsibilities. And so for some folks, it could take an extra bit of education and reminding them that, hey, have these rights, I want to work this out with you, let's talk about it. I really like this piece that Claudia talked about in your letter including being open to ongoing communication with how to resolve this. Because this will be your most effective and quickest way to resolve these issues. After a denial. And, you know, if it's a small office, you can probably talk to somebody. But if it's a bigger organization, you want to find out who the highest -- high-level administrator is that you can talk to. Or contact their general counsel for the healthcare provider. And let them know that you feel like your rights are being violated under the ADA. And you would like them to reconsider the denial and that you are, once again, open to figuring out a way to accommodate your needs that is reasonable for all parties involved. So if you are looking to find out who the general counsel is for a healthcare provider, you can use the State Bar of California Advance Search function. If you go to the State Bar of California and look it up. It will ask for their name, all sorts of different information you don't need to have. You can just put in under their firm name the name of the provider. For instance, I did this for Kaiser. And I simply put in the only field I filled was Kaiser. And I was able to get all the counsel for Kaiser in the state of California. So talk those folks first, see if you can make progress there. If you can't, it's time to ask to file a formal grievance. And follow through and file that formal grievance. That gives the healthcare provider time to resolve the issue once again. And before you can escalate it, most of the next steps will require you to have file that formal grievance. Unless it's an emergency circumstance. But for the most part, you will need to file formal grievance with your healthcare provider in order to, hopefully, at that point, you can work with them again. And resolve it. But if you can't, you have to then -- next slide, please. Oh, this is -- sorry. When you are asking -- during this stage of when you are asking, elevating your concern within the healthcare organization, a great tool that we have is to tell the healthcare provider about their duties, that they have a duty under the ADA. And that they can reach out to the Pacific ADA Center to find out more about what their responsibilities are. We have rights, they have responsibilities that have to be honored under that. So the Pacific ADA Center issued a statement for us that healthcare facilities like hospitals and doctors office must follow ADA requirements. Some patients who visit healthcare facilities have disabilities that make them more likely to get diseases that are easily spread. Such as COVID-19 or lung virus like RSV. These patients may also be more likely to get very sick from these illnesses or take longer to get better. So the Pacific ADA center is recognizing that healthcare facilities need to make reasonable accommodations for people who are at high risk. For disabled folks who are at high risk when visiting these facilities. When you are within the healthcare providers and you can say, hey, contact the Pacific ADA Center, they can tell you your responsibilities under the ADA. The ADA has released a statement saying healthcare facilities must provide reasonable accommodations to protect patients with certain types of disabilities. And accommodations can include telehealth. A separate space to wait for payments. Masking by all staff located near the patient. Better ventilation at the site by opening windows and running air filters and other modifications. The Pacific ADA Center is a neutral party that is there to teach people about their rights under the ADA and responsibilities. They are not -- they are not a political organization. So it's a neutral organization that you can send the healthcare provider to so that they are not just feeling like they are hearing it from you. And that can be powerful. Especially because of our ADA center is saying we have a right to reasonable accommodations in healthcare given the right circumstances. Next slide, please. So if you try to work with your healthcare provider and file the formal complaint and you are still getting denied, then you can file a formal complaint with an administrative agency. Like the U.S. Department of Health and Human Services. Their Office of Civil Rights. Or California Civil Rights Department. For those of us in managed care, the California Department of Civil Care healthcare. I believe it's for people who are on Medicare or Medical can escalate their complaints. These procedures can be very slow and not often have the -- often be ineffective. So that is why I'm saying we should try and work with your healthcare provider as much as possible. It may not be as easy as we would like it to be, but if you can get -- like Claudia said, cast a wide net and get a friendly ear within your healthcare provider network, it makes -- get the accommodations that you need, that will be the fastest way to ensure safe access within the healthcare situations. These steps will take longer, but it is your right to do that. Next slide. And I think, Emma, were you going to talk about this or is this my slide?

>> EMMA MARTIN: Yeah, I'm happy to jump in. Thank you so much, Beth. And Claudia. Just as we are thinking about some things that might be next after this workshop, we covered so much and we wanted to have some more offerings after the workshop so we have decided in partnership with senior and disability action to host a peer support office hour. Not lawyers or legal advocates, but peers will be available to discuss potential, reasonable accommodations, workshop or brainstorm together some simple language, share experiences, and generally support one another with parts of the reasonable accommodation process. Because we know it can be tough. Our peer support office hours is currently scheduled for Thursday, July 6th from 12:00 to 1:00. There is a registration link on this slide that will be sent out after, I think it will be easiest for folks to click it when it's sent out afterwards, along with the slides. But, again, if you wanted to place a hold in your calendar, that will be Thursday, July 6thfrom 12:00 to 1:00 for a peer support office hour. Also after our workshop today, we wanted to send out -- we are going to send out a survey to attendees. Just to hear from folks. So many people here have been sharing, you know, in the Q & A or in their registration questions some of their experiences, like, already sharing their experiences requesting reasonable accommodations in healthcare. And we wanted to send a survey out after the workshop to help our organization and communities to better understand what type of conversations are being submitted by our communities. One conversation is then being denied or not met. And then where? Where are those accommodations being met or denied by which healthcare providers? Et cetera. It's a short survey but I think it will be super informative, not only for our organizations, but also the community. To get a better sense of the accommodation and healthcare landscape and some shared experiences from peers. So we will send out the survey after the workshop, as well, alongside the other materials. All right. It's 1:37, that leaves us, yeah, a little over twenty minutes for questions and answers. We've had so many amazing questions submitted in our Q & A function live during today's workshop. We had wonderful questions submitted during registration. And so I will hop in and present some of these questions and Claudia and Beth or if I have anything else to share, we can do that. We can start with a question about N-95's. It's a two-part question. Someone asked if a healthcare provider is denying an N-95 masking accommodation, are they required to give you a reason? This person said they have medical documentation for the need for an N-95 mask and not just the surgical mask. There is accompanying questions also in the chat about, yeah, if healthcare office doesn't have N-95's, could it be an accommodation to ask them to purchase them. Some healthcare facilities don't have those. That is the first question. I'm happy to repeat, if needed.

>> CLAUDIA CENTER: This is Claudia. Emma, if you want to stop screen sharing, we'll have all the architecture available. Thank you. So I don't think there is a hard and fast answer to exactly how to go about this other than that the science is really clear that N-95 is the most effective mask. And there is many studies, easily available out there online that demonstrate that N-95 is the most protective. So if you establish a need for accommodation and the hospital grants your accommodation, then it would, logically, follow that they should wear an N-95. We know that logic does not govern our lives here. But, Beth, if you have any or, Emma, in any further?

>> BETH KENNY: I would reiterate what you said, Claudia. And I see somebody saying that their provider is telling them that the latest study says masks don't work. And I know that there was a study out there saying masks don't work. But that study has been very much debunked. The Cochrane Study. And not only has it been debunked by the scientific community, it has been debunked by the Cochrane -- the people who wrote the study. So, N-95's.

>> EMMA MARTIN: And I would think that any healthcare providers just by definition should have N-95s on site. But if they don't, I don't know if you can afford to bring them. That might be easier. But what have you done, Beth?

>> BETH KENNY: I have brought them because I can afford to and I don't always trust that they are going to be there. Even if we have agreed to it. So I like to bring it just to ensure that it's going to be available.

>> EMMA MARTIN: This is Emma. I don't have a full list of resources gathered on this, but I imagine there is community project like project N-95 and other community organizations that are still distributing N-95 masks and, perhaps, could gather up a couple resources to send out, as well. Just in case that is a burden for folks to bring their own masks to places. Another kind of question I saw in the Q & A and I wanted to bring up to address with our presenters. We had a question about the disclosure of disability as part of requesting an ADA accommodation. And some folks were under the understanding they didn't have to disclose their disability when requesting an accommodation. I thought that was important to request.

>> CLAUDIA CENTER: Yeah, this is Claudia. I will do a first shot at this. There are situations where there are very quick interactions between a person with a disability and a covered entity where the public policy and the law is that you don't have to provide a lot of detail about your disability. You don't have to provide a medical document. So that would be, for example, someone with a service dog entering a private business that typically doesn't allow pets. Because that is such a quick interaction, it's not considered feasible or appropriate to require that the person demonstrate or disclose their disability. On the other end of the spectrum is when you ask for an accommodation in the workplace. In that context, it's well established that the employer can require, not require, they don't have to require it, but they can require some reasonable medical documentation that generally tells something about your disability and why because that disability you need a particular accommodation in the workplace. So a relationship with a healthcare provider is, sort of, between those two poles. It's not a very brief interaction where you are walking into a store with a service animal. But it's not a day-to-day, you know, day in and day out relationship like you have with your medical provider. So -- and, you know, you are asking for something affirmative that you may have some resistance depending on the healthcare entity. You are asking for masking and other steps. In that situation I think it's best practice and probably much more effective to say something about your disability. To explain what category it is. And why it puts you at higher risk. And then, you know, go ahead and ask for the accommodations. I think saying I have a disability but I'm not going to tell you what it is but I want you to wear a mask, I mean, you can do that and see if it works. But I think you're going to be more persuasive if you give background as to why you need the accommodation.

>> EMMA MARTIN: Thank you. Beth, did you have anything you wanted to --

>> BETH KENNY: I was going to echo what Claudia said and say that, yeah. To establish that nexus of need. And to say you have disability, you know, people are request Ing things right -- people are questioning things right now. And this is something that will not be welcomed in many spots. So you want to say, just establish things as clearly as you can from the outside. I understand it's difficult to disclose. And that's, you know, something you have to decide for yourself. But I would say that stating your case and the why you need it right from the beginning it really helps set the tone. And I have found that there is a lot -- healthcare providers are more receptive to that.

>> EMMA MARTIN: Great. Next, we had several questions submitted during registration and echoed a couple times in our Q&A around the issue of other unmasked patients in different healthcare settings. And if a reasonable accommodation could -- if other patients can be required to wear masks during -- in a healthcare setting alongside the person making the request.

>> CLAUDIA CENTER: So, you know, our point of view and what we are advocating today, is that requiring the other people around the patient wear a mask can be a reasonable accommodation. We think it's feasible. We think it's ordinary given, you know, practices. During the pandemic and also in some settings even pre-pandemic, you know, there are some situations, for example, cancer units or other types of hospital spaces where everybody had to wear a mask even before COVID. So I think that our position is, yes, that should and can be required as a reasonable accommodation in order to make it more likely that you'll get the healthcare you need. We've come up with some other ideas. Such as that you wait in a separate area and that -- so that if it's not feasible for you to -- where it's denied for the other people to be masked, that at least you have maximized the amount of time you are away from those people. Waiting in a separate space. But, yes, we think it's feasible and appropriate to require masks of everyone for your appointment if you are at high risk.

>> BETH KENNY: Yeah. And I would say, again, echoing what Claudia said, it is reasonable, it is following the science. And you might want to include some other ways to make that happen. Whether it be having your own private waiting room or private room if you are staying in for a long time. Where everybody -- all staff coming in has to wear masks. So it is reasonable to us, but you want to provide your healthcare providers with some other ways that maybe you could avoid the situation where you are interacting with people who are unmasked.

>> EMMA MARTIN: I will add in real quick. I don't know if this one made it on to this slide. But one accommodation that we've heard of folks in the SDA, Senior Disability Action group, suggest is requesting the earliest appointment time, or appointment time before the office opens. To the general public. I don't know if you remembered but during the pandemic, grocery stores were doing that where people with disabilities or older people can come in and shop before they open. There is so many amazing questions rolling through. I had one question submitted around requests in writing. And that a lot of healthcare settings -- sorry. Patient saying that, you know, they want to make their ADA, their accommodation request in writing, but they have been unsuccessful because many clinics in healthcare settings are only accepting faxes and often these faxes go ignored. So they were wondering, can I make an accommodation request on the phone? And if so, are there any tips in terms of tracking exactly what happened in the phone call so there is no worry about it later?

>> CLAUDIA CENTER: Beth, any ideas?

>> BETH KENNY: Yeah. For my providers that have not made an e-mail address available or contact them electronically in writing, I have submitted a fax. Called to say I have submitted the fax. And sent what I submitted by fax in the mail. It's a lot. I tell them when I tell them I submitted the facts and also dropping a hard copy in the mail to you guys. Anything you can do to not be ignored.

>> EMMA MARTIN: Sorry, it took me a moment to unmute there. Next, we had several questions also submitted regarding retaliation. We know that's a really big topic that I think could be its own workshop. We had a few questions around folks who have made accommodations and experienced retaliation from their healthcare providers. Like even being discontinued from the practice or from healthcare services. Also other folks who are echoing this question and saying I'm nervous to make an accommodation request because of potential retaliation. And so we know, yeah, what the ADA says and law says but wanting to hear from our presenters if you have any further thoughts about retaliation. Potential retaliation.

>> CLAUDIA CENTER: I think this is a really hard question to answer. The law is very clear that retaliation is prohibited that interference is prohibited. But what happens when you, in fact, encounter retaliation? That is part of why we are encouraging people to be, sort of, very polite and persistent because it makes it more clear that you are being retaliated against. If something negative happens toward you as a patient following a polite persistent request for accommodations. You can file a complaint with the entities that we listed before on the slide deck. You can go back to your insurance carrier Medicare, Medi-Cal, or your private health network and say I've been dropped by my healthcare provider, I need another healthcare provider. They are supposed to make sure that you have that. I know that's often ignored. We don't have enough providers. Those are some ideas. They are not great ideas because they are not, you know going to fix things on any relevant schedule. Beth, what are your ideas?

>> BETH KENNY: Yeah, I think if I'm being told verbally that I'm going to be dropped as a patient because I've asked for reasonable accommodation, this is the point where I would say I'm worried that you may be violating federal law. And I suggest you check in with the Pacific ADA Center about what your responsibilities are under the ADA. And then let's talk again soon. Because if they are saying retaliation, you can't have much more of a conversation, at that point. You know. But once -- and I feel like they may not be aware. There is a chance they may not be aware of that they are violating the law. So, you know, making a simple statement of I'm afraid you may be violating the law, I suggest you check with Pacific ADA Center to find out what your responsibilities are, could go a long way. But it's not a foolproof method by any means. And also, if you are a person who has experienced retaliation, I don't have a path forward for you, but I would like to know -- SDA would like to know more about how often this is happening and where it's happening. And I really encourage you to fill out that follow up survey that we have. Because we don't have data. Not only is CDC not tracking data, we don't have data on how this is playing out. We hear about different things going on in the news, but the news coverage is unreliable as well. Let's start sharing what we know, where our successes are, and where we are really coming up against bad outcomes.

>> CLAUDIA CENTER: Yeah, and particularly if there is a clear-cut -- if you have a clear-cut case of retaliation, I think this group and others are interested in elevating that, probably, to the United States Health and Human Services Office of Civil Rights. They have been good on related issues and maybe -- we think may be good on this issue. The problem is, it's not going to solve your current need for healthcare. So we can pursue that and we think it's very valuable to pursue that. But in the meantime, you are going to have to figure out where you are going to get your healthcare. So it's not going to be a solution to that.

>> EMMA MARTIN: I also wanted to acknowledge several questions and comments in the question and answer box from folks who have said -- who are expressing that they have tried a lot of different -- making different reasonable accommodations and following these steps and tips that we talked about in the workshop. And that they are still facing, you know, retaliation and denial of accommodations and increase health safety and life risks in healthcare. And urging community advocates and national organizations to expand and lift up advocacy as well. Lift up advocacy. What can national organizations, what can community groups and gross root groups do in addition to self-advocacy as well. I think wanting to lift that up. I don't know if either of you had comments to that.

>> CLAUDIA CENTER: Yeah, I have a comment. This is Claudia. So we went through a little something like this during the pandemic around the way that hospitals shut down all what they called "visitation." And we have patients who were in the hospital who rely on family members for different kinds of communication, supports, and other kinds of supports. Self-care supports. This was, primarily, still is, primarily, people with physical disabilities or significant cognitive and other disabilities. So what we did in that situation, is we worked to get guidance out there through California Department of Public Health through United States HHS, through other means. We did fact sheets. We finally got FDH. Which is now called the California Civil Rights Department to do something. So we eventually got enough out there to have that baseline and then DREDF, my organization, together with Disability Rights California did a limited number letters, where we sent letter to hospitals. And in most cases resolved the situation to get visitation granted or access to support granted. So I think that today's webinar is one of the steps in a similar process for this issue. DREDF is open to, you know, continuing to work on this issue in collaboration with other legal services organizations. In terms of, you know, providing the self-help tools and then doing some limited representation. Particularly, to start with large healthcare providers to try and make this an ordinary, you know, type of accommodation granted. You know, obviously the staff is -- healthcare staff will be easier than the patients. In terms of the affirmative masking. So that's what I can say about the future. It's still a bit of a question mark, but that is the model we have from earlier in the pandemic.

>> BETH KENNY: And I totally understand where people are coming from, as far as, we need to get something going. And we are. I think. It's not as fast as any of us would like it. And that's an unfortunate reality of our time. But we do have DREDF being here today and putting on this webinar. We see national organizations getting involved and wanting to be a part of this fight. And so I understand your frustration and we are trying to do what we can do and as fast as we can get it done. And it's, unfortunately, just a slow process. And, hopefully, we are -- we are considering having another webinar where we can talk about more about what to do when your accommodation is rejected and those next steps. But we really need to find out what is going on and where people are at and where they are getting rejected to be able to formulate those next steps, too.

>> CLAUDIA CENTER: Thank you, all. And Emma's e-mail has been in all of our materials. And so Emma is well connected to the rest of us. And, you know, you can send questions toward Emma and then Emma will share them and will provide answers. To the extent that we can. Some things are not answerable.

>> EMMA MARTIN: Wonderful. I just dropped my contact information back in the chat. But we can make sure everyone can get ahold of me. I have also grabbed some of the questions that came in through the question box that we were not able to answer during our live portion. So we can discuss how we can best address those questions. There are so many incredible questions. Thank you all so much for joining us.

>> CLAUDIA CENTER: Thank you.

>> BETH KENNY: Thanks.