

ADA Questions and Answers for Health Care Providers

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Title III of the Americans with Disabilities Act prohibits discrimination against individuals with disabilities by places of public accommodation. 42 U.S.C. § 12181 - § 12189. Private health care providers are considered places of public accommodation. The Department of Justice has issued regulations for the obligations of public accommodations under Title III at 28 C.F.R. Part 36. The Department's Analysis to this regulation is at 56 Fed. Reg. 35544 et seq. (July 26, 1991).

This memorandum focuses on the obligations of private health care providers under Title III. Hospitals and other health care facilities that are operated by state or local governments are covered by similar rules under Title II of the ADA. 42 U.S.C. § 12131 et seq. Most of the questions and answers will provide useful guidance for those providers as well.

Q. Which health care providers are covered under the ADA?

A. Title III of the ADA applies to all private health care providers, regardless of the size of the office or the number of employees. 28 C.F.R. § 36.104. It applies to providers of both physical and mental health care. Hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists, health maintenance organizations (HMOs) and health clinics are included among the health care providers covered by the ADA. If a professional office of a doctor, dentist, or psychologist is located in a private home, the portion of the home used for public purposes (including the entrance) is considered a place of public accommodation." 28 C.F.R. § 36.207.

Q. What is the obligation of health care providers under the ADA for individuals who are deaf or hard of hearing?

A. Health care providers have a duty to provide effective communication, using auxiliary aids and services that ensure that communication with people who have a hearing loss is as effective as communication with others. 28 C.F.R. § 36.303(c).

Q. For whom must a health care provider offer effective communication?

A. A health care provider must communicate effectively with customers, clients, and other individuals with hearing loss who are seeking or receiving its services. 56 Fed. Reg. at 35565. Such individuals may not always be "patients" of the health care provider. For example, if prenatal classes are offered as a service to both fathers and mothers, a father with a hearing loss must be given auxiliary aids or services that offer him the same opportunity to benefit from the classes as

would other fathers. Similarly, a deaf parent of a hearing child may require an auxiliary aid or service to participate in the child's health care and to give informed consent for the child's medical treatment. Classes, support groups and other activities that are open to the public must be accessible for deaf participants.

Q. What kinds of auxiliary aids and services are required by the ADA to ensure effective communication with deaf or hard of hearing individuals?

A. Appropriate auxiliary aids and services include equipment or services a person needs to understand aural communication. For example, the rule includes qualified interpreters, assistive listening devices, notetakers, written materials, television decoders, and telecommunications devices for the deaf (TTYs, sometimes called TDDs). 28 C.F.R. § 303(b)(1).

Q. How does a health care provider determine which auxiliary aid or service is best for a patient with a hearing loss?

A. The auxiliary aid requirement is flexible, and the health care provider can choose among various alternatives as long as the result is effective communication for the deaf or hard of hearing individual. A deaf or hard of hearing person knows best which auxiliary aid or service will achieve effective communication with his or her health care provider. The Justice Department expects that the health care provider will consult with the person and consider carefully his or her self-assessed communication needs before acquiring a particular aid or service. 56 Fed. Reg. at 35566-67.

Q. Why are auxiliary aids and services so important in medical settings?

A. Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these aids and services, medical staff run the grave risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem, and prescribing inadequate or even harmful treatment. Similarly, patients may not understand medical instructions and warnings or prescription guidelines.

Q. Are there any limitations on the ADA's auxiliary aids and services requirements?

A. Yes. The ADA does not require the provision of any auxiliary aid or service that would result in an undue burden or in a fundamental alteration in the nature of the goods or services provided by a health care provider. 28 C.F.R. § 36.303(a). However, the health care provider still has the duty to furnish an alternative auxiliary aid or service that would not result in a fundamental alteration or undue burden. 28 C.F.R. §36.303.

Q. When would providing an auxiliary aid or service be an undue burden?

A. An undue burden is something that involves a significant difficulty or expense. Factors to consider include the cost of the aid or service, the overall financial resources of the health care provider, the number of the provider's employees, legitimate necessary safety requirements, the effect on the resources and operation of the provider, and the difficulty of locating or providing the aid or service. 28 C.F.R. § 36.104.

Q. Must a health care provider pay for an auxiliary aid or service for a medical appointment if the cost of that aid or service exceeds the provider's charge for the appointment?

A. In some situations, the cost of providing an auxiliary aid or service (e.g., an interpreter) may exceed the charge to the patient for that very same service. A health care provider is expected to treat the costs of providing auxiliary aids and services as part of the annual overhead costs of operating a business. Accordingly, so long as the provision of the auxiliary aid or service does not impose an undue burden on the provider's business and does not fundamentally alter the provider's services, the provider may be obligated to pay for the auxiliary aid or service in this situation.

Q. Can a health care provider charge a deaf or hard of hearing patient for part or all of the costs of providing an auxiliary aid or service?

A. No. A health care provider cannot charge a patient for the costs of providing auxiliary aids and services, either directly or through the patient's insurance carrier. 28 C.F.R. § 36.301 (c).

Q. Who is qualified to be an interpreter in a health care setting?

A. A qualified interpreter is an interpreter who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. 28 C.F.R. § 36.104. In the medical setting, this will mean that the interpreter may need to interpret complex medical terminology.

Q. Do all deaf or hard of hearing individuals use the same kind of interpreter?

A. No. There are various kinds of interpreters. The health care provider should ascertain the particular language needs of the deaf or hard of hearing patient before hiring an interpreter. Some individuals may require interpreters who are fluent in American Sign Language, a language that has a grammar and syntax that is different from the English language. Others may require interpreters who use Signed English, a form of signing which uses the same word order as does

English. Still others who do not know any sign language may require oral interpreters, who take special care to articulate words for deaf or hard of hearing individuals, or cued speech interpreters, who give visual cues to assist in lipreading.

Q. Can a health care provider require family members and friends to interpret for deaf patients?

A. Generally, no. Family members often do not possess sufficient sign language skills to effectively interpret in a medical setting. Even if they are skilled enough in sign language to communicate, family members and friends are very often too emotionally or personally involved to interpret "effectively, accurately, and impartially." Finally, using family members and friends as interpreters can cause problems in maintaining patient confidentiality. 56 Fed. Reg. at 35553.

Q. In what medical situations should a health care provider obtain the services of an interpreter?

A. An interpreter should be present in all situations in which the information exchanged is sufficiently lengthy or complex to require an interpreter for effective communication. Examples may include discussing a patient's medical history, obtaining informed consent and permission for treatment, explaining diagnoses, treatment, and prognoses of an illness, conducting psychotherapy, communicating prior to and after major medical procedures, providing complex instructions regarding medication, explaining medical costs and insurance, and explaining patient care upon discharge from a medical facility.

Q. Is lipreading an effective form of communicating with deaf and hard of hearing individuals?

A. Not often. Some deaf and hard of hearing individuals do rely on lipreading for communication. For these individuals, an oral interpreter may be the best means of ensuring effective communication in the medical setting. However, the ability of a deaf or hard of hearing individual to speak clearly does not mean that he or she can lipread effectively. Indeed, because lipreading requires some guesswork, very few deaf people rely on lipreading alone for exchanges of important information. Forty to 60 percent of English sounds look alike when spoken. On the average, even the best lipreaders only understand 25 percent of what is said to them, and many individuals understand far less. Lipreading may be particularly difficult in the medical setting where complex medical terminology is often used.

Q. Do written notes offer an effective means of communicating with deaf and hard of hearing individuals?

A. This will depend on the reading level of the individual. The reading level of many deaf individuals is much lower than that of hearing people. Additionally, many deaf people consider American Sign Language (ASL) to be their first language. Because the grammar and syntax of ASL differ considerably from English, writing back and forth may not provide effective communication between the deaf patient and the health care provider. Moreover, written communications are slow and cumbersome in a health care setting, and information that would otherwise be spoken may not be written. If a health care professional is providing less information in writing than he or she would provide when speaking to a hearing patient, this is an indication that writing is not effective communication in that context. For many deaf individuals, the services of a sign language interpreter offer the only effective method of communication. However, some deaf or hard of hearing individuals who do not use sign language, such as individuals who have lost their hearing later in life, may communicate more effectively in writing with their health care providers.

Q. When do health care providers need to provide accessible telephone services to deaf and hard of hearing individuals?

A. Health care providers that routinely provide telephone services for patients must make these services available to deaf and hard of hearing individuals. See generally 28 C.F.R. § 36.303. Many deaf and hard of hearing individuals use TTYs for telephone communication. A TTY is an inexpensive device with a keyboard, resembling a small typewriter, that is used to send and receive written messages over the telephone lines by individuals with hearing and speech impairments.

In many instances, health care providers can receive incoming calls from TTY users through relay systems. 56 Fed. Reg. at 35567. Title IV of the ADA required telephone companies to provide relay services across the nation as of July 26, 1993. 47 U.S.C. § 225 et seq. Relay services enable individuals who use TTYs to communicate by telephone with individuals who use voice telephones. In a relay system, a third person, called a communications assistant, reads what the TTY user types to the voice telephone user and types what the voice telephone user says to the TTY user. Health care providers are not charged for use of the relay center. Rather, the costs of providing relay services are spread among all telephone users.

Individuals who use TTYs may be able to contact their health care providers through relay services for routine appointments and inquiries. Similarly, health care providers can use the relay to call their patients to exchange simple information. However, for the exchange of more complex medical information

over the telephone, direct communication with a TTY is probably more appropriate.

Q. Do health care providers need to provide TTYs for outgoing calls from their facilities?

A. Sometimes. TTYs must be available to deaf patients in hospitals, nursing homes, and other locations where hearing patients are given access to telephones on a more than incidental basis for outgoing calls. 28 C.F.R. § 36.303(d)(1).

Q. Do all individuals with hearing loss need TTYs to communicate by phone?

A. No. Some individuals have enough hearing to enable them to use telephones that are compatible with hearing aids or telephones with amplifiers. Health care providers should make these auxiliary aids available for outgoing calls from their facilities if they offer outgoing telephone services to the general public.

Q. Do newly constructed or altered medical facilities have any obligations to provide TTYs at public pay phones?

A. Yes. If a health care provider is altering or building a new hospital or health care facility, it must ensure that it installs one public TTY pay phone next to a hospital waiting room, recovery room, or emergency room if a public pay phone is available at that location. ADAAG §4.1.3(17)(c)(lii). In addition, if the total number of pay phones at any other location is four or more, and at least one of those phones is located inside a building at the location, a TTY pay phone must be provided inside the building at that location. ADAAG §4.1.3(17)(c)(i).

Q. Do newly constructed or altered medical facilities have other obligations to make their facilities accessible?

A. The ADA Accessibility Guidelines contain precise rules for building or altering medical facilities in a manner that will not create structural communication barriers. The rules contain specific details about installing permanent flashing visual alarm systems, permanent visual doorbells and other notification devices, volume control telephones, and assistive listening systems in assembly areas.

Q. When must medical facilities eliminate structural communication barriers in existing facilities?

A. Medical facilities must remove structural barriers when the removal of those barriers is "readily achievable," i.e. easy to accomplish, without much difficulty or expense. Examples of readily achievable changes include the installation of flashing alarm systems, permanent signage, and adequate sound buffers. 28 C.F.R. § 36.304(a) and (b).

Q. Does the ADA require access to closed captioned television programs for individuals residing in health care facilities on a temporary or permanent basis?

A. Yes. Where patients in hospitals and nursing homes are able to watch television, deaf patients must be able to see the captions on closed-captioned programs. 28 C.F.R. § 36.303(e). All televisions manufactured or imported after July 1, 1993, with screens that are 13 inches or larger, have built-in decoder ability. On older televisions, a separate decoder can be connected to the receiver. 47 U.S.C.A. §§ 303(u), 330(b).

Q. Are there any other times when health care providers may be required to offer captioning to deaf and hard of hearing patients?

A. Yes. At times, health care providers offer information to clients and patients in the form of videotapes. The ADA requires that all public accommodations, including health care providers, make aurally delivered information available to deaf and hard of hearing individuals. 28 C.F.R. § 36.303(b)(1). One very effective way of making videotapes accessible to these individuals is to caption the tapes.

Q. Must health care providers make conferences, health education, and training sessions that are open to the general public accessible to deaf and hard of hearing individuals?

A. Yes. Health care providers that offer training sessions, health education, or conferences to the general public must make these events accessible to deaf and hard of hearing individuals. See generally 28 C.F.R. §§ 36.201 and 36.202. In addition to interpreters and real-time transcribers, there are a variety of assistive listening systems that may be appropriate to eliminate problems with distance and background noise for hard of hearing individuals who use hearing aids.

Q. Can health care providers receive any tax credits for the costs of providing auxiliary aids and services?

A. Yes. Businesses may claim a tax credit of up to 50 percent of eligible access expenditures that are over \$250, but less than \$10,250. The amount credited may be up to \$5,000 per tax year. Eligible access expenditures include the costs of interpreters or TTYs, and providing other auxiliary aids and services. Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, § 44.

For more information, visit www.nad.org/adaq&a.

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