

RESOURCE GUIDE PART B

ADA Questions and Answers for Health Care Providers

Auxiliary Aids and Services*

Doctors, nurses, dentists, specialists, therapists, and other health care providers must communicate effectively to provide appropriate, effective, quality health care services. Federal disability discrimination laws mandate equal access to and an equal opportunity to participate in and benefit from health care services, and effective communication with individuals who are deaf or hard of hearing. These laws include:

- Section 504 of the Rehabilitation Act of 1973 – applies to federal health care services and facilities; and health care providers who are also recipients of federal financial assistance, usually provided by direct funding (such as federal Medicaid funds) or by grants (such as a federal research grant).
- Title II of the Americans with Disabilities Act – applies to all public (state and local) health care providers.
- Title III of the Americans with Disabilities Act – applies to all private health care providers.

This memorandum focuses on the obligations of private health care providers. However, most of these questions and answers will provide useful guidance for public health care providers (federal, state, and local) as well.

Title III of the Americans with Disabilities Act (ADA) 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 U.S. Department of Justice issued regulations under Title III of the ADA at 28 C.F.R. Part 36. The Department's Analysis to this regulation is at 56 Fed. Reg. 35544 (July 26, 1991).

Which private health care providers are covered under the ADA?

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.

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

Health care providers have a duty to provide appropriate auxiliary aids and services when necessary to ensure that communication with people who are deaf or hard of hearing is as effective as communication with others. 28 C.F.R. § 36.303(c).

Is this obligation limited to deaf or hard of hearing patients?

No. A health care provider must communicate effectively with customers, clients, and other individuals who are deaf or hard of hearing 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 who is deaf or hard of hearing must be provided auxiliary aids or services to ensure that he has 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 communicate effectively with health care providers, 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 also be accessible to deaf and hard of hearing participants.

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

Auxiliary aids and services include equipment or services a person needs to access and understand aural information and to engage in effective communication. For example, the rule includes qualified interpreters, computer-aided transcription services (also called CART), written materials, assistive listening devices, captioning, or other effective methods of making aural information and communication accessible. 28 C.F.R. § 303(b)(1).

How does a health care provider determine which auxiliary aid or service to provide for a patient who is deaf or hard of hearing?

The auxiliary aid and service requirement is flexible, and the health care provider can choose among various alternatives as long as the result is effective communication with the deaf or hard of hearing individual. An individual who is deaf or hard of hearing likely has experience with auxiliary aids and services to know which will achieve effective communication with his or her health care provider. The U.S. Department of Justice 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 auxiliary aid or service. 56 Fed. Reg. at 35566-67.

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

Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these auxiliary 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.

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

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). Making information or communication accessible to an individual who is deaf or hard of hearing is unlikely ever to be a fundamental alteration of a health care service. An individualized assessment is required to determine whether a particular auxiliary aid or service would be an undue burden.

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

An undue burden is something that involves a significant difficulty or expense. For example, it might be a significant difficulty to obtain certain auxiliary aids or services on short notice. Factors to consider in assessing whether an auxiliary aid or service would constitute a significant expense include the nature and cost of the auxiliary aid or service; the overall financial resources of the health care provider; the number of the provider's employees; the effect on expenses and resources; legitimate safety requirements; and the impact upon the operation of the provider. 28 C.F.R. § 36.104. Showing an undue burden may be difficult for most health care providers. When an undue burden can be shown, the health care provider still has the duty to furnish an alternative auxiliary aid or service that would not result in an undue burden and, to the maximum extent possible, would ensure effective communication. 28 C.F.R. § 36.303(f).

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

In some situations, the cost of providing an auxiliary aid or service (e.g., a qualified interpreter) may exceed the charge to the patient for the health care service. A health care provider is expected to treat the costs of providing auxiliary aids and services as part of the 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, the provider is obligated to pay for the auxiliary aid or service.

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?

No. A health care provider cannot charge a patient for the costs of providing auxiliary aids and services. 28 C.F.R. § 36.301(c).

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

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. Interpreters providing services in a medical setting may need to be able to interpret medical terminology.

Do all individuals who are deaf or hard of hearing use the same kind of interpreter?

No. There are various kinds of interpreters. The health care provider should ascertain the particular language needs of the person who is deaf or hard of hearing prior to hiring an interpreter. Some individuals may require interpreters who are fluent in American Sign Language, a language with 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 individual, or cued speech interpreters, who give visual cues to assist in lip reading (also called speech reading).

Can a health care provider require family members or friends to interpret for deaf or hard of hearing patients?

Generally, no. Family members and friends often do not possess sufficient skills to interpret effectively in a medical setting. Family members and friends are also very often too emotionally or personally involved, may have interests that conflict with the patient's, may cause role confusion, and are unable 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.

In what medical situations should a health care provider obtain the services of a qualified interpreter?

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, but are not limited to, 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.

Is lip reading an effective form of communicating with individuals who are deaf or hard of hearing?

Not often. The ability of a deaf or hard of hearing individual to speak clearly does not mean that he or she can hear well enough to understand spoken communication or to lip read effectively. Forty to 60 percent of English sounds look alike when spoken. On average, even the most skilled lip readers understand only 25 percent of what is said to them, and many individuals understand far less. Lip reading is most often used as a supplement to the use of residual hearing, amplification, or other assistive listening technology. Because lip reading requires some guesswork, very few deaf or hard of hearing people rely on lip reading alone for exchanges of important information. Lip reading may be particularly difficult in the medical setting where complex medical terminology is often used. Individuals who are deaf or hard of hearing who rely on lip reading for communication may need an oral interpreter to ensure effective communication.

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

Exchanging written notes may be effective for brief and simple communication. Communication through the exchange of written notes is inherently truncated; information that would otherwise be spoken may not be written. Moreover, written communication can be slow and cumbersome. If a health care provider is communicating less or providing less information in writing than he or she would provide when speaking to a patient, this is an indication that writing to communicate is not effective in that context.

Understanding written material may also depend on the reading level or literacy skills of the individual. The reading level of deaf and hard of hearing individuals is as variable as the reading levels found in the general population. Additionally, for some deaf and hard of hearing people, American Sign Language (ASL) is their first language. Because the grammar and syntax of ASL differs considerably from English, exchanging written notes may not provide effective communication between a deaf or hard of hearing patient and a health care provider. For some deaf or hard of hearing individuals, the services of a qualified sign language interpreter offer the only effective method of communication.

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?

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. Qualified

interpreters, computer-assisted transcription services (also called CART), assistive listening systems/devices, or other auxiliary aids or services may be necessary to ensure equal access to and an equal opportunity to participate for deaf and hard of hearing attendees.

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

Eligible small 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 qualified interpreters, CART services, and other auxiliary aids and services. Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, § 44. Please consult with your financial or tax advisor on this issue.