nad.org

Position Statement on VRI Services in Hospitals

Overview

The Americans with Disabilities Act (ADA) and Rehabilitation Act of 1973 require hospitals and medical providers to ensure effective communication with people who are deaf.[1] For deaf people who communicate primarily in sign language,[2] qualified sign language interpreters[3] may be the only effective communication option. Failing to obtain qualified interpreters for medical interpreting puts patients' health at risk and drives up medical costs. Miscommunication also increases overall liability among hospitals and medical staff. One way to minimize these risks is to provide a qualified sign language interpreter on-site or sign language fluent medical staff. However, there are situations when this may not be possible. For example, qualified sign language interpreters may not be available for assignment or there may be a need for urgent communication with a medically unstable patient. Technology now provides for an interim solution in the form of off-site or remote interpreting services when in-person, on-site interpreting may not be immediately available. Remote interpreting service is typically called Video Remote Interpreting (VRI).

VRI is a means of providing qualified interpreter services to ensure effective communication with individuals who are deaf and who communicate using sign language. VRI uses videoconferencing technology, equipment, and a high speed Internet connection with sufficient bandwidth to provide the services of an interpreter, usually located at a call center, to people at a different location. VRI is currently being used in a wide variety of settings including hospitals, physicians' offices, mental health care settings, police stations, schools, financial institutions, and workplaces. Entities may contract for VRI services to be provided by appointment or to be available "on demand" 24 hours a day, seven days per week. As such, there are significant possibilities for the use of VRI technology and services.

The guidance provided in this position statement of the National Association of the Deaf (NAD) focuses on the use of VRI services in hospitals, including its use in the emergency department, in-patient hospital settings, and clinics. The growth of VRI services has outpaced research on its use and the development of guidance and best practices for VRI providers, hospitals, and deaf individuals.[4] The NAD views VRI as a service that may "fill the gap" until an on-site interpreter arrives at the hospital. VRI has the potential to provide qualified interpreter services in areas where qualified interpreters are limited or not available. On-site interpreter services are more likely to result in effective communication than VRI services. On-site interpreters have more physical flexibility, have greater access to visual and auditory cues and information present in the environment, do not encounter technology or equipment malfunctions, and can respond immediately to communication events as they arise. In short, on-site interpreter services are not subject to many of the limitations experienced by VRI services. NAD strongly believes that VRI services should be provided only if on-site interpreter services are unavailable. VRI services can

be used effectively in such limited circumstances if certain minimum requirements are met. Those minimum requirements to ensure the effectiveness of VRI services within the hospital setting are set forth below.

Minimum Requirements for VRI Technology and Equipment

The NAD is neutral with respect to the type of VRI technology and equipment used, except to the extent that VRI technology and equipment impacts the delivery of VRI services. The following is a non-exhaustive list of VRI issues specifically related to technology and equipment that impact VRI service delivery:

- Internet connection: the hospital must have a dedicated high-speed (broadband) Internet connection and devote sufficient exclusive bandwidth for the delivery of VRI services to ensure high quality, clear, delay-free, full-motion video and high quality audio.
- Size, proximity, and position of the video screen relative to the deaf individual: the deaf individual must be positioned properly and comfortably to have an unobstructed view of the video screen; the equipment must provide clear, sufficiently large, and sharply delineated pictures of the interpreter's and the deaf individual's head, arms, hands, and fingers.
- Camera angles and focus: hospital staff must be able to adjust the physical position of the camera; and the hospital and/or interpreter must be able to make adjustments in the camera angle (left/right, up/down, wide angle versus close-up view) and focus; and the interpreter must be able to see the deaf individual clearly.
- Audio quality: clear and easily understood transmission of voices; and the interpreter and the hospital staff must communicate consecutively and be able to hear each other clearly, with limited background noise.
- Privacy protocol: deaf patients, whenever possible, should be placed in a private room to minimize visual distractions and to improve quality of VRI communications.
- Portability/size of equipment and its cart: large-sized equipment in small rooms may be problematic; and predicting where a deaf individual will stay or be moved in the hospital is an important factor in determining whether to use VRI services.
- Equipment set up and training: hospital staff must be trained on procedures for setting up VRI equipment and contacting the VRI provider; and hospitals should designate at least one (non-IT) staff position that is staffed 24/7 to resolve equipment set up problems that may arise. Training must include where the equipment is, whether it is stored or in use; where it can be used; how to set it up; and how to access an interpreter. Such training should be incorporated in the required annual hospital staff training and testing, and should include regular hands-on training to be most effective.
- Technical issues: hospitals and VRI providers should designate and have available 24/7 at least one IT staff position capable of troubleshooting and resolving technical issues that may arise.
- Spare VRI equipment: hospitals should have at least two sets of VRI equipment: in case one breaks or when two deaf individuals are in the hospital at the same time.

Minimum Requirements for Hospital Use of VRI Services

Speed of response

The speed of response needs to be appropriate to the level of service required at the hospital. For instance, when Emergency Medical Services (EMS) call the hospital en route to inform the hospital they are bringing a deaf patient who also requests or requires a sign language interpreter, the hospital staff needs to arrange for a qualified and medically trained on-site interpreter immediately. Hospital staff should first contact a sign language interpreter or agency. If an on-site interpreter is not immediately available, the hospital staff should then immediately call the VRI provider and ensure that the VRI equipment is set up to deliver VRI services by the time the ambulance and deaf patient arrive. Being proactive with this step will minimize any delays for the medical providers and for the deaf individual. This will improve the delivery of efficient and quality medical care to the deaf individual.

Communication assessments

Because communication methods vary from person to person within the deaf population, the hospital must determine which communication method is most effective for the patient being admitted or seen. Below are a few guidelines that may assist hospitals to ensure that effective accommodations are provided in an efficient manner.

- Provision of qualified sign language interpreters is critical to ensure that deaf persons who rely on sign language are able to communicate effectively with health care providers. The U.S. Department of Health and Human Services, Office of Civil Rights has consistently required hospitals to provide qualified interpreters to deaf clients, and has stated that "it would be extremely difficult for the health care provider to demonstrate in certain service settings, that effective communication is being provided in the absence of . . . interpreters." (Section 504, Effective Communications, and Health Care Providers, U.S. Department of Health and Human Services, Region III, Regional Technical Assistance Staff (January, 1982), page 5.)
- A deaf individual knows best which auxiliary aid or service will achieve effective communication with his or her health care provider. Hospitals must consult with a deaf individual and consider carefully his or her self-assessed communication needs before acquiring a particular auxiliary aid or service.[5] The health care provider can choose which auxiliary aid or service to provide, as long as it results in effective communication with the deaf individual. If a deaf individual uses sign language, hospitals should provide a qualified sign language interpreter on-site or, when that is not possible, procure VRI services.
- Communication assessments of deaf patients should be conducted periodically throughout the deaf individual's stay at the hospital and should include consultation with the deaf individual about the effectiveness of the communication. These assessments are necessary to determine, on an ongoing basis, whether any changes are needed with respect to the provision of auxiliary aids and services.
- Hospitals should designate a staff position that is staffed 24/7 to conduct or review communication assessments and to ensure provision of effective auxiliary aids and services to deaf individuals. This staff position should be responsible for ensuring the

effective delivery of VRI services when needed. Personnel in this staff position should receive significant training and annual refresher courses.

- In assessing whether to provide on-site sign language interpreter services or to use VRI services, hospitals must consider the reasonably foreseeable heath care activities of the deaf individual (e.g., group therapy sessions, medical tests or procedures, rehabilitation services, meetings or discussions with health care professionals or social workers concerning billing, insurance, self-care, prognoses, history, discharge, or other matters). The hospital is in a unique position to know what patients will experience during their stay or in the course of their treatment. Accordingly, it is incumbent upon the hospital to anticipate and assess such experiences and communication needs and arrange to provide on-site interpreter services during the communication intensive periods. The hospital should discuss the reasonably foreseeable health care activities and manage the logistics of communication access with the deaf individual and his/her health care providers immediately upon admission.
- Hospitals must also consider the following factors when determining whether to provide interpreter services on-site or through alternatives such as VRI services: (1) the number of people who will be actively participating/talking during the procedure or meeting; (2) whether the situation or matter to be discussed can be understood with a two-dimensional interpreting picture and limited view of the interpreter (i.e., if the physician is explaining a complicated adaptive device with many movable parts, consider whether this can be seen and understood by the interpreter to effectively interpret the physician's instructions to the deaf individual); and the number of deaf individuals in the room (with one camera, an interpreter will be able to see only one deaf individual at a time without adjustments to the equipment).

Facilitating participation in non-medical hospital activities

A comfort level with the environment facilitates recovery and treatment in a hospital and is necessary to ensure full communication access. Deaf individuals need and want an equal opportunity to access and benefit from the care provided by nurses and other hospital staff with whom they have contact. Such access and benefit necessarily requires effective communications between deaf individuals and the hospital staff. The provision of qualified sign language interpreters (whether on-site or through VRI) may also be needed to ensure effective communication between deaf individuals and the hospital staff during non-medical events or activities.

Monitoring of VRI effectiveness

In addition to monitoring the needs of a deaf individual at the hospital, hospital staff must monitor the use and effectiveness of VRI technology and services on an ongoing and repeated basis. If problems with VRI services are unresolved or reoccur, hospitals must take steps to address those problems and provide on-site interpreter service as long as the problems persist.

Community Education and Outreach

Hospitals planning to implement VRI services should consult with deaf individuals in their community. Additionally, hospitals should conduct regular outreach and education programs to introduce the system to the community. These education programs should include the hospital's policy and procedures on providing and using VRI services and the provision of on-site interpreters; how deaf individuals should notify hospital staff when VRI services do not result in effective communication; which staff position (staffed 24/7) is responsible for conducting and reviewing communication assessments and the provision of auxiliary aids and services, including VRI services; and how to file complaints and use the grievance system when necessary.

Conclusion

VRI is a technological tool that may be used by hospitals and other medical entities to ensure immediate communication access with deaf individuals who communicate in sign language. It is the position of the NAD that the use of on-site interpreters should always be paramount, and when VRI is used in the absence of any available on-site interpreter, it must be used properly in terms of policy, procedure, and technology. Failure to conform to these standards is not only a failure to ensure effective communication under federal law but also creates unnecessary risks to the medical welfare and health care of deaf individuals.

1. The term "deaf" is to be interpreted to include individuals who are hard of hearing, late deafened, and deaf-blind.
2. For purposes of word economy, the term "sign language" means American Sign Language (ASL) and other means of visual communication, such as signed English systems or contact sign (a combination of ASL signs and English word order, formerly called Pidgin Sign English).
3. A "qualified interpreter" means an interpreter who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. See 28 C.F.R. § 35.104 and 28 C.F.R. § 36.104.
4. In the context of a hospital setting, the term "deaf individual" includes, but is not limited to patients, family members, companions, or other individuals entitled to an equal opportunity to participate in and benefit from the services, programs, and activities of the hospital. For more information about the scope of coverage, see the ADA and Section 504 and their implementing regulations and technical guidance. See also the Consent Decree in Gillespie v. Dimensions Health Corporation, No. 05-73 (D. Md. July 12, 2006), available at http://www.ada.gov/laurelco.htm.
5. Private hospitals must consult with deaf persons to determine effective communication needs. Dep't of Justice, Title III Technical Assistance Manual, Section III-4.3200. Public hospitals must give primary consideration to the requests of the deaf individual. 28 C.F.R. § 35.160(b)(2).