NAD Position Paper on VRI's Table of Contents

Background 1
Controversial Increased Use of VRI in Medical Setting 2
Assessing Communication Needs and VRI as a Last Resort 2
Minimum Requirements for VRI Technology and Equipment 4
Network 4
Equipment 5
Minimum Requirements for Video Interpreters 6
Minimum Requirements for Procedures and Staff Training 8
Minimum Factors to Consider in assessing appropriateness of VRI use 11
Conclusion 12

NAD Position Paper on VRI

Background

The Americans with Disabilities Act (ADA) [1] and Rehabilitation Act of 1973[2] require hospitals and medical providers to ensure effective communication with people who are deaf.[3] For deaf people who communicate primarily in sign language[4], qualified sign language interpreters[5] are often the only effective communication option in medical settings. Failing to obtain qualified interpreters for medical interpreting puts patients' health at risk, increases liability for hospitals and medical providers, 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 to hire 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 an appointment or there may be a need for urgent communication in an emergency situation 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. Interpreting services provided remotely through such technology is known as Video Remote Interpreting (VRI).

Video Remote Interpreting (VRI) is one possible means of providing interpreting services to ensure effective communication with deaf and hard of hearing individuals who communicate using sign language.[6] 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.

Controversial Increased Use of VRI in Medical Setting

However, the most controversial use of VRI has been in the medical setting, where use of **VRI has exploded without input from the deaf and hard of hearing community and without meaningful regulation of how VRI technology is used in this setting.**

Many medical providers[7] are unprepared for this technology and do not have the benefit nor include the direct involvement of the deaf and hard of hearing community in deciding how to best provide this service. In the last few years, too many medical providers have suddenly chosen VRI as the sole auxiliary aid option in the healthcare context, and the limitation to a sole option is completely inappropriate. The deaf and hard of hearing community has become increasingly concerned about the over-reliance on this new technology without a thorough examination and dialogue on the appropriateness of the service. Moreover, because so many deaf and hard of hearing individuals have had adverse experiences in hospitals that rely on VRI technology, there have been numerous lawsuits against hospitals seeking to curtail such overuse of VRI.

As a result, the National Association of the Deaf (NAD) and Deaf Seniors of America (DSA) present this position statement to guide healthcare providers to use in adopting internal VRI policies that best meet the communication needs of deaf and hard of hearing patients and companions.[8] Additionally, the NAD has a Model Policy for Effective Communication in Hospitals[9] that should guide all medical providers in the development of overall effective communication policies in their operations and provision of services to deaf and hard of hearing individuals.

Assessing Communication Needs and VRI as a Last Resort

Because communication methods vary from person to person within the deaf and hard of hearing population, the medical provider must determine which communication method is most effective for the patient being admitted or seen. A deaf or hard of hearing individual knows best which auxiliary aid or service will achieve effective communication with their health care provider. Private medical providers must consult with deaf and hard of hearing persons to determine effective communication needs.[10] Medical providers must give primary consideration to the communication requests of the deaf or hard of hearing individual.[11]

At a minimum, medical providers should present every deaf and hard of hearing patient or companion with a **Deaf or Hard of Hearing Communication Request Form**, whether in paper or electronic form. A model of such a communication request form is provided as Exhibit A of the NAD Model Policy for Effective Communications in Hospitals.

Throughout the entire visit, the medical provider should conduct periodic communication assessments of the deaf or hard of hearing individual(s) involved, including consultation with the deaf or hard of hearing individual(s) about the effectiveness of the communication. The medical provider should make provide the communication request form periodically through the deaf person(s) during their stay or visit and make adjustments based on such assessments to the provision of auxiliary aids and services.

For deaf and hard of hearing people who communicate in sign language, qualified sign language interpreters[12] may be the only effective communication option. The provision of qualified sign language interpreters is critical to ensure that deaf and hard of hearing 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 medical providers to provide qualified interpreters to deaf and hard of hearing 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."[13]*

Although the Department of Justice (DOJ) has developed regulations recognizing Video Remote Interpreting (VRI) as one possible auxiliary aid or service option,[14] medical centers have mistaken this inclusion of VRI as license to use VRI exclusively to the detriment of effective communication, which is the paramount requirement when providing medical services to deaf and hard of hearing patients and companions.[15]There have been numerous instances of medical providers insisting that they are only obligated to provide VRI, and not obligated to provide on-site interpreters at all. This insistence has led to communication failures not only because of a refusal to recognize that VRI is not appropriate for many medical situations but also because the VRI technology has often not worked as promised. As a result, medical providers' insistence on the exclusive use of VRI has led to numerous communication failures and lawsuits.

In its regulations implementing Titles II and Title III of the ADA, the **DOJ issued the following minimum requirements for VRI use by covered entities:**

- *[VRI must provide] real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication.*
- *[VRI must provide a] sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of [their] body position.*
- *[VRI must also provide] a clear, audible transmission of voices.**[16]***

However, given the sheer volume of VRI-related complaints that the NAD and DSA receive, medical providers have often failed to ensure that the VRI technology contracted for satisfy such general regulatory requirements. **The DOJ regulations mandate minimum performance standards but do not specify the exact technological standards necessary to achieve these performance requirements.**

Without comprehensive technical guidance on the use of VRI, medical providers are at significant risk of facing liability because of miscommunication or because of a failure to allow the patient to fully participate in decision making about the health care. A comprehensive VRI policy should implement VRI as a last resort subject to very specific conditions. In particular, medical providers should provide VRI only if on-site qualified interpreters services are not immediately available and with the consent of the patient. On-site interpreter services are more likely to result in effective communication than VRI services. On-site interpreters are

advantageous in that they: have more mobility, have greater access to visual and auditory cues and information present in the environment, are not disconnected due to malfunctions, and are better able to respond immediately to communication events as they arise.

As a matter of model policy, medical providers should only use VRI: (i) while the medical provider is waiting for an on-site interpreter to arrive (which should be no more than two hours from the time of request for unscheduled medical events); (ii) if duration of the patient's stay is expected to be under two (2) hours; (iii) if a need to communicate with a patient and/or companion who has expressed a preference for an on-site interpreter arises outside of a planned schedule for an interpreter to be provided for a patient and/or companion; or (iv) either (a) the patient has not expressed a preference for an on-site interpreter or (b) the patient's and/or companion's expressed preference for an on-site interpreter has been considered and VRI results in effective communication.

Where it is necessary to provide VRI for a deaf patient or companion after these conditions are met, it is imperative that the VRI technology be in excellent working order. At the present time, **medical providers are not being given guidance on what is required for optimal VRI technology to be prepared for medical situations involving deaf and hard of hearing individuals.**

Minimum Requirements for VRI Technology and Equipment

The NAD and DSA provide the following minimum technical requirements for the use of VRI in medical situations involving deaf individuals, but are neutral with respect to the brand of VRI technology and equipment used. The following is a non-exhaustive list of minimum requirements specifically related to VRI technology and equipment:

Network

- The medical provider 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. Due to the importance of ensuring clear communications during critical medical situations, only high definition video transmissions should be allowed for VRI technology in medical situations.
- To support high definition video transmissions on both ends, every endpoint must support at least 1024k video calling and be uninterrupted and continuous, with an IP overhead of 1.2M Ethernet connection.
- There should be a dedicated connection to a WAN circuit with Quality of Service (QoS) settings that take into account the potential number of concurrent video calls over the WAN and the quality settings for each call.
- Firewalls must not impede or impair optimal video transmission yet security requirements, such as those of HIPAA, should not be compromised. The ideal means to achieve this is by connecting the VRI equipment through centralized equipment via a WAN circuit.

- Every endpoint used for VRI, regardless of type (room-based all-inclusive unit or software/computer-based) must support encrypted transmissions, preferably using 256-bit Advanced Encryption Standard (AES-256).
- All endpoints should be able to place and receive video calls using Uniform Resource Identifiers (URIs).
- All connections should require an IPSEC or SSL VPN to comply HIPAA requirements.
- There should be no interference from signals from other medical equipment (e.g. cardiac monitors), wireless equipment, and other networks.
- Connected and wireless broadband must be tested at least once a week to ensure smooth transmission.
- **The VRI provider chosen by the medical provider must ensure their video interpreters meet the same minimum technical standards from their end.**

Equipment

- The video cameras should be focused on all stakeholders, but particularly the deaf individual(s) involved and the interpreter(s). The deaf or hard of hearing 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 or hard of hearing individual's head, arms, hands, and fingers.
- The video screen should be a flat-panel, LCD computer monitor, with a minimum screen size of 19.5 inches (measured diagonally from corner to corner) for viewing from no more than 2 feet from the patient, and should be hands-free for the patient. However, the video screen must support high definition video transmissions.
- The video screen must be flexible and stable for the user with adjustable height options, including the capacity to adjust the screen in various directions for optimal viewing by the patient regardless of the patient's position and to place the screen directly overhead, without needing to move the deaf or hard of hearing individual's head.
- All parties' video cameras (at all endpoints) should be capable of a minimum video resolution of 720p (1280 x 720 pixels, progressive, at a speed of at least 30 frames per second) to support high definition video transmissions. At the present time, the ideal resolution is 1080p60 (1920 x 1080 pixels, at 60 frames per second). The cameras should use progressive scan instead of interlaced scan to preserve smoothness and clarity of image and to reduce any possible artifacts or judder.
- Deaf and hard of hearing patients, whenever possible, should be placed in a private room to minimize visual distractions and to improve quality of VRI communications.
- Lighting in the room must be optimal with no backlighting on the signing individual.
- The VRI audio equipment should allow for a clear and easily understood transmission of voices. The video interpreter and the medical provider staff must communicate consecutively and be able to hear each other clearly. Background noise should be kept to a minimum through noise cancelling features, and preferably with use of microphones for the medical staff to speak into for clarity purposes.
- A speakerphone is not recommended unless only one hearing individual is using it and the speakerphone is in that individual's immediate proximity.

- The computer supporting the VRI equipment on all endpoints should have at a minimum the following specifications:
  - 6 GHz processor speed;
  - 8 GB of physical RAM;
  - 500 GB of space available on the hard drive;
  - a dedicated video card;
  - at least one USB 2.0 port.
- The computers supporting the VRI equipment at all endpoints shall have in operation only those programs and features running for the purpose of ensuring the effective and smooth operation of the VRI communications. The medical provider shall ensure that there are no interruptions in communication with the computer or VRI technology during the VRI sessions. Any computer equipment associated with the VRI technology shall have all other programs and screensavers turned off during the VRI session.
- The ability to fit and move around VRI equipment within a given space should be a factor in deciding room assignments.
- VRI equipment and all technology supporting it including the computer must be tested at least once a week.
- Medical providers should have additional VRI equipment beyond the number estimated necessary to serve the local deaf and hard of hearing population. It is recommended that medical providers purchase twice the number of VRI equipment that is deemed necessary by the medical providers. The additional VRI equipment would serve as back up equipment in the event that any of the VRI equipment breaks or there is an unanticipated number of deaf or hard of hearing patients or companions at the medical facility at the same time.

Minimum Requirements for Video Interpreters

- At all times, the video interpreter must be able to accurately, effectively, and impartially interpret all communications between the deaf and hard of hearing patient and/or companion and the medical provider staff/contracting medical personnel. **Moreover, the qualifications of the video interpreter should comport with state licensure laws, if any, that affect sign language interpreters in medical settings in that state.**
- Per the applicability of the Human Resources Standards outlined by The Joint Commission to all **interpreters as contracted personnel engaged in providing services for a healthcare facility, all VRI providers must be able to, upon request, provide the following for each of their interpreters:**
-
  - Education and training that is consistent with applicable legal and regulatory requirements and organization policy, and specifically in medical terminology;
  - Appropriately certified by a national certifying body, and appropriately trained to provide interpreting services in medical settings including familiarity with medical terminology;

    - **Evidence of license or registration, as required by the state in which the site of medical services is located, if the state has any, regardless of where the video interpreter is located;**
    - Evidence that individual's knowledge and experience and competence are appropriate for their assigned responsibilities as required by the contracting organization;
    - Orientation to the contracting organization;
    - Evaluations of performance;
    - Health status as required by job responsibilities, as defined by the organization, and as required by law and regulation;
    - Criminal background check or pre-employment verification of convictions for abuse or neglect, when required by law and regulation; and
    - References, when applicable.[17]
- Video interpreters must act in accordance with any applicable codes of professional conduct, such as a certifying body's Code of Professional Conduct or the statutory requirement of a state's interpreter licensure law.
- Video interpreters must inform the medical provider to terminate the use of VRI technology and obtain the services of an on-site interpreter, when such interpreters determine that VRI is not an appropriate accommodation and is not ensuring effective communication.
- The medical provider may honor but shall not be bound by the personal preferences of a deaf or hard of hearing patient and/or companion for a particular named video interpreter, vendor or agency. However, the medical provider shall honor the preference of the deaf or hard of hearing patient and/or companion with respect to the gender of the video interpreter.
- Prior to rendering interpreting services, the video interpreter should be provided with brief and pertinent background information of the communicative encounter, including but not limited to: patient-specific information and concerns the medical provider will address.
- When it is necessary to transfer an interpreted session, or when an interpreted session is terminated and reestablished with a new interpreter, the previous interpreter will use HIPAA compliant internal communication systems to share pertinent information with the next interpreter. When necessary, the parties should not be placed on hold for more than one minute.
- Patients and companions must be informed if quality assurance monitoring is taking place and they must have the opportunity to decline.
- All video interpreters utilized in the provision of VRI services must be fully versed and trained on the operation and maintenance of the technical video equipment at their location. This includes the ability to do basic troubleshooting to resolve any technical problems as well as the ability to transfer a VRI assignment to another available video interpreter if unable to immediately resolve the technical problems.
- The VRI service needs to ensure that a video interpreter answers the call within 45 seconds on a 24-hour basis every day without exception.

- The VRI service should ensure that no video interpreter is providing interpreting services longer than sixty minutes without a break, and require transfers to other video interpreters when necessary.
- The use of Certified Deaf Interpreters (CDIs) should be made available upon request of the patient(s) or companion(s), or when assessed as necessary by the video interpreter(s). In many situations, it may be necessary to pair VRI usage with an on-site CDI.

Minimum Requirements for Procedures and Staff Training

- **All employees who deal directly with patients and/or provide medical services, including physicians, nurses, physician's assistants, and admitting personnel, shall receive written instructions regarding which personnel to contact if they encounter a patient or companion who appears to be deaf or hard of hearing. The medical provider shall also provide such written instructions to any new registration or clinical contract staff who deal directly with patients and/or provide medical services upon or prior to the commencement of their first shift.**
- For scheduled appointments for which the patient and/or companion has already agreed to VRI, the VRI equipment must be set up in the designated room and be ready to operate at the time of the appointment.
- For unscheduled visits, the medical provider shall take the following steps at the arrival of a deaf or hard of hearing individual:
  - If a patient is being transported to the medical provider by Emergency Medical Services (EMS), then the EMS must call the medical provider en route to inform the medical provider that a deaf and hard of hearing individual who requests or requires a sign language interpreter will arrive. The medical provider staff will then need to arrange for a qualified on-site interpreter immediately. If an on-site interpreter is not immediately available, the medical provider 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 or hard of hearing individual arrive.
  - In other instances not involving EMS, upon the initial contact[18] with the deaf or hard of hearing individual, the medical provider shall inquire into whether the patient and/or companion is/are deaf or hard of hearing;
  - If it is determined that the patient and/or companion is/are deaf or hard of hearing, the medical provider shall present auxiliary aids and services options to the deaf or hard of hearing individual(s);
  - If the deaf or hard of hearing individual requests an on-site interpreter, the medical provider will contact the appropriate personnel in charge of placing interpreter requests immediately;
  - The medical provider shall provide any available on-site interpreters[19] in a timely manner;
  - The medical provider shall not attempt to discourage or dissuade deaf and hard of hearing patients and companions from requesting an on-site interpreter.

  - In the interim period while waiting for the on-site interpreter(s) to arrive, the medical provider may use VRI as a temporary measure.
  - If the deaf or hard of hearing individual requests VRI or consents to VRI, the medical provider must initiate the VRI protocol immediately.
- The medical provider shall take the following steps when using VRI:
  - VRI equipment must be brought to the room within ten minutes of the arrival of a deaf or hard of hearing individual.
  - Set-up of equipment should be completed and operable within five minutes.
  - A video interpreter must appear on the screen ready to interpret within three minutes after the VRI machine has been set up.
- The medical provider representative who connects to the VRI should provide a brief summary of the discussion about to take place immediately after connecting to the video interpreter to provide context.
- At all times, the medical provider must monitor the effectiveness of the use of VRI based on the factors listed *supra*.
- The medical provider shall take the following corrective actions whenever necessary:
  - If problems arise with the VRI and they are not remedied within ten minutes, the medical provider shall call for technical support.
  - Once the medical provider contacts technical support to fix any VRI problems, the medical provider shall call an on-site interpreter within 30 minutes of when VRI problems are first identified unless such problems are fully resolved within that time frame. If VRI problems recur, the medical provider shall call an on-site interpreter immediately unless the patient or companion explicitly requests otherwise.
- The medical provider shall not impose a time limit for VRI usage. For any conversation involving VRI, the medical provider shall proceed for as long as necessary to ensure that the discussions are as comprehensive as allowed for hearing patients and/or companions.
- The medical provider shall conduct initial and periodic communication assessments of the effectiveness of the use of VRI throughout the deaf or hard of hearing individual's visit.
- The medical provider must consider the reasonably foreseeable health activities of the patient involved (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) and prepare for appropriate provisions of auxiliary aids and services.
- The following personnel must be available on-site 24 hours a day, 7 days a week:
  - One or more designated individual(s) to answer questions from and provide assistance to personnel regarding the use of auxiliary aids and services. Such individuals shall know where the appropriate auxiliary aids are stored and how to operate them. Such individuals shall also know how to procure the appropriate auxiliary services.
  - Appropriate personnel able to conduct analysis regarding the linguistic and medical demands of the conversation before offering VRI. Said personnel must

consider all the criteria discussed in this document and must be able to identify when VRI is not facilitating effective communication.
    - At least two individuals fully trained on procedures for setting up VRI equipment and contacting the VRI provider.
    - At least one information technology (IT) staff to troubleshoot and resolve technology and equipment problems that may arise.
- **The medical provider shall circulate and post broadly within the facility the telephone numbers and e-mail addresses of the individuals above. The contact information of the individual(s) responsible for communication assessments should be shared with patients and/or companions in order to obtain the assistance of such individuals.**
- Medical providers should conduct staff and contractors training on the use of VRI guidelines as well as the use of medical providers' VRI equipment *before* implementing VRI usage. The medical providers should also conduct periodic annual refresher trainings.
- The medical provider shall distribute a set of training materials to all affiliated physicians. These materials shall contain at least the provider's policy statement and any relevant forms, as well as a description of the medical provider's duty to provide auxiliary aids and services to patients and/or companions and the procedures for arranging interpreter services.
- The training sessions should meet the following objectives: to inform them of the procedures set forth in its VRI policy; to inform them of the procedures that they should follow in order to arrange interpreter services or other auxiliary aids and services; to educate them that the medical provider offers interpreters to patients and/or companions based on the patient's and/or companion's wishes or if circumstances indicate that a patient or companion needs or desires an interpreter; and to educate medical personnel on their obligations. This training shall be given to the following persons:
    - Employees with or likely to have direct patient care responsibility, including, without limitation, the following categories and their equivalents: nurses, nurse's aides, therapists, social workers, case managers, and medical technicians; and
    - Key employees not otherwise trained as provided above, including: all clinical directors and nursing supervisors; all senior-level administrators; inpatient registration personnel, outpatient registration personnel, the General Information desk; all triage nurses and other triage professionals; administrative heads and desk clerks of units or departments where such individuals are likely to have communications with patients or their companions, families and friends
    - All other personnel charged with decision-making involving VRI and the handling of VRI technology and equipment.
- 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 medical provider staff training and testing, and should include regular hands-on training to be most effective.

- If the commencement or reactivation of service of any of the identified personnel above occurs after VRI implementation, the medical provider shall provide the training specified above within sixty (60) days of such date.

Minimum Factors to Consider in assessing appropriateness of VRI use

In assessing the appropriateness of VRI, the medical provider must consider the following factors. If any of these factors are present, the medical provider should refrain from using VRI and employ best efforts to seek an on-site interpreter. Primary consideration should be granted to deaf or hard of hearing individual's express request for a specific version of qualified sign language interpreting services.

- Whether the deaf or hard of hearing individual consents to the use of VRI, with the understanding that the initial consent does not constitute a waiver of right to effective communication via on-site interpreter.
- Whether the VRI provider offers the language that the deaf or hard of hearing individual uses: for example, standard American Sign Language (ASL) or other sign languages /visual communication systems;
- The deaf or hard of hearing individual's fluency in the communication system used;
- Whether the patient's condition is serious and/or unstable;
- Whether the deaf or hard of hearing individual is limited in their ability to view the video interpreter, due to vision limitations, limited head/body mobility, physical obstacles, distance between the individual and the screen, their ability to stay still, or any other reasons;
- The video interpreter's ability to view the deaf or hard of hearing individual, due to limitations on the deaf or hard of hearing individual's ability to move their head, hands, arms; any physical obstacles; the distance between the individual and the screen, the ability of the deaf or hard of hearing individual to stay still; or for any other reasons;
- Whether the deaf or hard of hearing individual's state of mind impacts their ability to communicate;
- Any cognitive or consciousness issues, psychiatric issues, or pain issues that the deaf or hard of hearing individual may have;
- Whether the deaf or hard of hearing individual is under the influence of medicine or other drugs;
- Whether the deaf or hard of hearing individual's emotional state impacts their ability to communicate;
- Whether the degree of pain and/or discomfort the deaf or hard of hearing individual may be experiencing impacts their ability to communicate;
- Whether the deaf or hard of hearing individual's ability to focus on the VRI screen impacts their ability to communicate;
- Whether the deaf or hard of hearing individual is a minor;
- Whether there are multiple people present;
- Whether information exchanges are complex and/or fast;
- **Whether the discussions involve high-risk situations, including but not limited to: informed consent discussions, discussions regarding surgery or other high-risk**

treatment options, discussions immediately prior to and after surgery or other high-risk treatment, and discussions about diagnosis, treatment, and prognosis;

- Whether the discussions involve highly sensitive communications, including but not limited to: diagnosis, treatment, prognosis of a life-threatening or life-changing illness, discussions regarding limb amputation or organ removal, and discussions regarding hospice and/or other end-of-life considerations;
- Whether the deaf or hard of hearing individual reacts negatively and/or becomes exceedingly stressed with the use of VRI;
- Whether the communication is taking place in areas of the facility that do not have readily accessible Internet access;
- Whether the treatment is taking place in a room where there are space restrictions that render the use of VRI difficult.

Conclusion

As technology and services are consistently evolving, it is critical to engage the deaf or hard of hearing community when adopting new technology and services to ensure that it is aligned with their goals. Medical providers planning to implement VRI services should consult with deaf and hard of hearing individuals in their community. Additionally, medical providers should conduct regular outreach and education programs to introduce the system to the community. These education programs should include the medical provider's policy and procedures on providing and using VRI services and the provision of on-site interpreters; how deaf and hard of hearing individuals should notify medical provider 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. Medical providers should make their VRI policies available on their websites and patient handbooks.

VRI is a technological tool that may be used by medical providers to ensure immediate communication access with deaf and hard of hearing individuals who communicate in sign language. It is the position of the NAD and DSA that the use of on-site qualified sign language interpreters should always be the first approach with deaf and hard of hearing patients and companions who use sign language. 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 and hard of hearing individuals.

This position statement was prepared by the NAD-DSA VRI Task Force, and approved on July 1, 2016 by the NAD Board of Directors.

References:

1. See *US DOJ Effective Communication Regulations*, available at: www.ada.gov/effective-comm.htm

2. See *Recommended Guidelines for Video Remote Interpreting (VRI) for ASL-Interpreted Events*, Judicial Council of California, 2012.
3. NAD Position Statement: VRI Services in Hospitals. *See http://nad.org/issues/technology/vri/position-statement-hospitals* (last visited May 16, 2016).

Updated February 13, 2018

[1] 42 U.S.C. § 12101, *et seq.*
[2] 29 U.S.C. § 701 *et seq*.
[3] For the remainder of this statement, the use of the terms "deaf" or "deaf and hard of hearing" are intended to encompass all deaf, hard-of-hearing, and DeafBlind individuals, including those with additional disabilities except where specifically distinguished.
[4] 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).
[5] A "q*ualified 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.
[6] 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).
[7] The guidance provided in this position statement focuses on the use of VRI services by medical providers, including but not limited to hospitals, in-patient hospital settings, clinics, urgent care, and physicians' offices.
[8] In the context of a medical 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 medical provider. 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 here.
[9] NAD Model Policy for Effective Communication in Hospitals.
[10] Dep't of Justice, Title III Technical Assistance Manual, Section III-4.3200.
[11] 28 C.F.R. § 35.160(b)(2); 45 C.F.R. § 92.202 (effective July 18, 2016).
[12] 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.
[13] *See 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.
[14] 28 C.F.R. § 35.104 (for Title II of the ADA); 28 C.F.R. § 36.303(b)(1) (for Title III of the ADA).
[15] 28 C.F.R. § 35.160(a)(1); 28 C.F.R § 36.303(c)(1).
[16] 28 C.F.R. § 35.160(d); 28 C.F.R § 36.303(f).
[17] See this.

[18] Initial contacts include phone calls in advance of arrivals.
[19] The medical provider shall maintain at least one contract with a local interpreting services provider.