

Reducing Risk

A Publication on Healthcare Risk Management from Princeton Insurance

The Americans with Disabilities Act

Introduction

The Americans with Disabilities Act (“ADA”) guarantees people with disabilities equal opportunity in public accommodations, employment, transportation, government services, and telecommunications.

The ADA requires all private medical and dental offices to ensure that the goods, services, and facilities they provide are accessible to all individuals with disabilities. The ADA impacts various areas of office practice management including physical access; patient care issues such as communicating with deaf or blind patients; and employment issues such as hiring practices and job descriptions.

Title III ADA Obligations

Title III of the ADA requires that places of “public accommodation” which includes medical and dental offices, be made free of barriers to effective communication and physical access. Title III obligations apply to all private healthcare providers, regardless of the size of their office or the number of employees. Individuals protected from discrimination under Title III include patients, visitors, and office staff.

Although the size and financial resources of a business may affect the type or extent of the accommodations required to meet the obligations imposed by the ADA, small size alone does not relieve a small business from the responsibility of meeting its Title III obligations.

Failure to comply with the ADA places a medical or dental practice at risk for litigation, imposition of court orders, and money damages, including fines. Intent to discriminate against an individual with a disability is not required; failure to provide an accommodation is enough to establish a violation.

The ADA and New Jersey Law

The ADA and the New Jersey Law Against Discrimination, N.J.S.A. 10:5-1 *et seq.* (“LAD”) are related. The LAD prohibits discrimination against any individual who has or previously had a physical or mental handicap. Courts in New Jersey look to federal law on the ADA and an earlier federal law, The Rehabilitation Act of 1973, Section 504, for guidance in cases involving discrimination claims by individuals with handicaps or disabilities.

Protected Individuals

The ADA protects “individuals with disabilities.” An individual is considered to have a disability if he or she:

- Has a physical or mental impairment that substantially limits a major life activity such as self-care, walking, seeing, hearing, speaking, breathing, learning, and working
- Has a record of having such an impairment—e.g. a person who recovered from cancer
- Is regarded as having such an impairment—e.g. a person with a severe facial deformity

Specifically named disabilities in Title III include:

- Vision, speech or hearing impairments
- Physiological conditions or disorders such as cancer, heart disease, diabetes, cerebral palsy, multiple sclerosis
- Cosmetic disfigurements and anatomical losses
- Alcoholism
- Mental or psychological disorders
- Contagious and non-contagious diseases, whether or not symptomatic (TB and HIV/AIDS are specifically named)
- Drug addiction (current illegal users of drugs are specifically excluded)

Modifications in Policies, Practices, and Procedures

The ADA requires that “reasonable modifications” be made to policies, practices, and procedures that are necessary to accommodate individuals with disabilities. Modifications are not required where either a fundamental alteration in the nature of the goods or services provided, or an “undue burden” would result. For example, a physician is not required to accept patients outside of his or her specialty, as that would fundamentally alter the nature of the medical practice.

An “undue burden” is something that involves a “significant difficulty or expense.” Factors to consider include the nature and cost of the accommodation, the overall financial resources of the practice, the number of employees, and the difficulty of locating or providing the aid or service. The issue of whether or not a modification would be an undue burden is determined on an individual basis.

Effective Communication Using Auxiliary Aids and Services

Healthcare providers have a duty to provide effective communication, using auxiliary aids and services, to patients, customers, and other individuals with disabilities who are seeking or using their services. This duty extends to individuals who may not be patients, such as the deaf parent of a hearing child.

The communication with individuals with disabilities must be as effective as communication with others. The healthcare provider should consult with the individual with the disability and consider the individual’s self-assessed needs as to which auxiliary aid or service will achieve effective communication.

A healthcare provider may not charge a patient for the cost of providing an auxiliary aid or service, either directly or through the patient's insurance. The costs of providing auxiliary aids and services are to be treated as part of the annual overhead costs of operating a business. However, tax credits for a portion of the eligible costs of providing auxiliary aids and services, and other costs of ADA compliance, are available.

Blind or Vision Impaired Patients

For the patient who is blind or has impaired vision, auxiliary aids and services include:

- Qualified readers
- Braille or large print literature
- Audio recordings
- Computer disks

Deaf or Hard of Hearing Patients

For a patient who is deaf or hard of hearing, auxiliary aids, and services include:

- Qualified sign language or other interpreter, versed in medical or dental terms and concepts, and not related to the patient
- Written forms or information sheets
- Exchange of written notes
- Teletypewriter (TTY, also known as a TDD)
- Telephones that have amplifiers or are compatible with hearing aids

Situations Where an Interpreter for the Deaf May Be Required

Some patient encounters, due to their complexity, critical nature, or length, may require a qualified sign language or other interpreter for effective communication. Examples are:

- Discussing a patient's symptoms and medical history
- Explaining medical conditions, tests, treatment options, medications, surgery
- Providing a diagnosis, prognosis and treatment recommendation
- Communicating information to obtain an informed consent
- Communicating with a patient during treatment and testing procedures
- Providing mental health services
- Providing information about blood or organ donations
- Discussing billing or insurance matters
- Presenting education programs such as diabetes management or nutrition

Barrier Removal in Existing Facilities

The ADA requires barrier removal in existing facilities only where it is “readily achievable” to accomplish. “Readily achievable” means the barrier removal can be easily accomplished without much difficulty or expense. Examples of “readily achievable” barrier removal include rearranging furniture, building a ramp over a few stairs used to enter the facility, installing grab bars where only routine reinforcement of the wall is required, lowering telephones, and posting permanent large print signage.

In leased places of public accommodation such as professional offices, the ADA places the legal obligation for barrier removal and the provision of auxiliary aids and services on both the landlord and tenant. The terms of a lease may specify who is to make the changes and provide the aids and services, but both the landlord and tenant remain legally responsible for ADA compliance.

All alterations to an existing facility that could affect the usability of the facility must be made ADA compliant to the maximum extent possible. However, the requirements for additional accessibility are only required to the extent that they are technically feasible and the cost does not represent a disproportionate percentage of the total cost of the renovations.

An important exception is the ADA requirement that if renovations are to be performed to a multistory building containing the offices of healthcare providers, an elevator must be added to the building. Finally, the building must be more accessible at the completion of the alterations or renovations than it was before they were started.

For more information about reducing risk at your practice, please view our risk management newsletter at www.RiskReviewOnline.com. To access additional Reducing Risk documents, visit our website at www.PrincetonInsurance.com and click on “healthcare risk services.”

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