STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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April 2, 1999

MMCD All Plan Letter 99005

TO: Medi-Cal Managed Care Health Plans

SUBJECT: CULTURAL COMPETENCY IN HEALTH CARE--MEETING THE NEEDS OF A CULTURALLY AND LINGUISTICALLY DIVERSE POPULATION

Medi-Cal managed care plans' (hereafter referred to as Plans) attainment of cultural competency is a dynamic and evolving process. This letter presents guidelines to assist Plans in building systems that meet the needs of culturally and linguistically diverse populations. The Plan is encouraged to demonstrate continual progress towards the attainment of a high level of organizational cultural competency that is conducive to improved health care access and service delivery for its members.

DEFINITION OF CULTURAL COMPETENCY IN HEALTH CARE

Culture is comprised of a group's learned patterns of behavior, values, norms, and practices. Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by the health care professionals of health plan members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services provided. Development and incorporation of these interpersonal and intracultural skills should effect a positive change in the manner in which health care is delivered to culturally diverse health plan members. Being culturally competent means improved communication between providers and health plan members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and health outcomes.

In the health care industry, cultural competency requires seven essential elements that are reflected organizationally as follows:

1. An unbiased attitude and organizational policy that values and respects cultural diversity; respect for the multifaceted nature and individuality of people.
2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illnesses and diseases, as well as differing communication patterns.
3. Recognition of diversity among health plan members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status).
4. Skills to communicate effectively with diverse populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care.
5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability.
6. Programs and policies that address the health needs of diverse populations.
7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of the Plan members.

GUIDELINES FOR PLAN ADMINISTRATIVE IMPLEMENTATION

All health care staff, regardless of their cultural or professional training and background, may carry a lifetime of learning (i.e., perceptions, attitudes, and ideas) of diverse cultural groups. These perceptions and attitudes may or may not be conducive to furthering their knowledge about how to interact and effectively treat health plan members seen on a daily basis. If these attitudes and perceptions present barriers to effective communication and treatment of culturally and linguistically diverse populations, the Plan is encouraged to train the health plan staff and health care professionals to overcome negative stereotypes and generalizations. This training must receive support from the highest level of administration. To ensure clarity regarding the importance of cultural competency, the Plan is encouraged to incorporate the following components in policies and procedures and in establishing performance measures and incentives:

1. Include cultural competency in the Plan mission.
2. Encourage community input and advisement on relevant issues.
3. Develop a process for evaluating and determining the need for special initiatives regarding cultural competency.

4. Include recruitment and retention of staffing that are reflective and/or responsive to community needs.
5. Continually assess the cultural competence of the Plan providers.
6. Designate staff for coordinating and facilitating the integration of cultural competency guidelines.
7. Establish an array of communication tools for distributing information to staff.
8. Participate with government, community, and educational institutions in matters related to best practices in cultural competency.
9. Establish an information system capable of identifying and profiling culturally or ethnically specific patient data.
10. Evaluate the effectiveness of strategies for improving the health status of culturally diverse populations.

GUIDELINES FOR TRAINING AND EDUCATION

I. Staff and Provider Orientation

Plans are strongly encouraged to provide orientation and training on cultural competency to staff and providers serving Medi-Cal members. The objective would be to teach participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Medi-Cal members. The orientation program will provide a forum for staff and providers to reflect on their own cultures and values and how they relate to delivery of services to those with differing beliefs and practices.

II. Ongoing Staff and Provider Education and Training

Plans are encouraged to implement a comprehensive and ongoing staff and provider (both medical and nonmedical) education program. To be effective, the program should accommodate different learning styles and strategies to promote motivation and incentives to integrate concepts into practice and behavior change. In addition, the program should include components that allow for observation, assessment, and evaluation. The education and training program may include, but is not limited to, the following components:

1. Skills and practices regarding culture-related health care issues of primary member populations, not limited to threshold populations.
2. Concepts of cultural competency; its effects on quality care and access to care.
3. Translation of written informing documents.
4. Provision of appropriate qualified interpreters.
5. Referrals to culturally and linguistically appropriate community services.

III. Ongoing Evaluation and Feedback for Cultural Competency Education and Training Programs

The Plan is encouraged to conduct ongoing evaluation of its cultural competency education and training program by using the following strategies:

1. Identify opportunities for education and training based on analysis of health outcomes impacted by cultural and linguistic issues.
2. Specifically address deficiencies found in cultural competency of health care delivery with educational solutions.
3. Institute methods to utilize and network with community-based organizations for appraisal of educational efforts.
4. Involve community leadership and decision-makers in the design and development of education evaluation programs.

Sources from these ongoing evaluations may include: encounter data analyses; feedback from members, staff and providers; self-assessments; and outside audits.

IV. Sharing and Exchange of Educational Resources

The Plan is encouraged to share and exchange education resources throughout their organization with other Plans and community organizations.

V. Dissemination of Information

The Plan is encouraged to develop a system of communication to ensure coordination and dissemination of cultural and linguistic information and activities at all levels of the organization and its subcontractors.

THE RELATIONSHIP BETWEEN CULTURAL COMPETENCY AND PLAN QUALITY IMPROVEMENT PROGRAM

The Plan is encouraged to develop quality improvement (QI) projects pertaining to cultural needs of Plans' membership. These projects may assist the Plan in refining its health care services to achieve the optimum quality of care for its culturally diverse membership.

QI is a continuous feedback loop comprised of assessment, measurement, reporting, and intervention. The purpose of quality improvement, as it is related to cultural and linguistic services, is to continuously improve service delivery and quality of care for specific ethnic populations. The QI process provides essential information to health care providers and consumers about the effectiveness and appropriateness of health plan's cultural and linguistic services. Incorporating components of cultural competency into the QI program allows consumers to determine whether a health plan meets their cultural and linguistic needs, and will provide the health plans with indicators to assist them in developing and implementing strategies to further refine health plan operations and quality of care.

The Plan is encouraged to institute the following:

1. Cultural and linguistic services evaluation within ongoing QI programs (see Appendix A).
2. Evaluation of members' grievances and complaints regarding cultural and linguistic issues.
3. Evaluations of members' satisfaction regarding culturally competent care.
4. Monitoring efforts of medical groups and other subcontractors to ensure that delegated functions meet cultural and linguistic standards.
5. Methods to identify health care needs of ethnically diverse membership, and conduct studies to monitor the effectiveness of health care services.
6. Provision of information on Plan's quality of care upon request to Medi-Cal members in a format that is easily understood.

If you have any questions regarding this all plan letter, please contact your contract manager.

Susanne Hughes

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosure

APPENDIX A

Quality Measurement should be based on timely, valid and reliable data that considers race, ethnicity, and language. Sources of data may include, but are not limited to the following:

1. Self-assessment survey data.
2. Patient satisfaction survey data.
3. Provider survey data.
4. Disenrollment survey data.
5. Quality of care studies.
6. Provider office review instruments.
7. External audits.
8. Administrative data.
9. Group Needs Assessment results.
10. Community Advisory Committee feedback and advice.

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April 2, 1999

MMCD Policy Letter 99-03

TO:
[X] County Organized Health Systems Plans
[X] Geographic Managed Care Plans
[X] Prepaid Health Plans
[X] Primary Care Case Management Plans
[X] Two-Plan Model Plans

SUBJECT: LINGUISTIC SERVICES

PURPOSE

This policy letter provides clarification regarding Medi-Cal managed care plans' (hereafter referred to as Plans) contract requirements relative to the provision of cultural and linguistic services.

GOAL

To assure the limited English proficient (LEP) Medi-Cal Plan members equal access to health care services through the provision of high quality interpreter and linguistic services.

POLICY

I. Civil Rights Act of 1964

Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, **all** Plans must ensure that all Medi-Cal LEP members have equal access to all health care services.

To comply with the Civil Rights Act of 1964, **all** Plans must develop and implement policies and procedures for ensuring access to interpreter services for all LEP members. (all LEP members mean all members who are limited English proficient, including those who speak a language other than one of the threshold languages defined below.) The Plan's procedures must include ensuring compliance of the subcontracted providers to these requirements. An option for ensuring subcontractors' compliance is via their subcontracts. In addition, Plan's procedures must ensure that LEP members will not be subjected to unreasonable delays in receiving appropriate interpreter services when the need for such services is identified by the provider or requested by the LEP member.

Interpreter services must be available on a 24-hour basis. This can be accomplished by on-site interpreters or by assigning a LEP member to a physician able to provide services in the member's language. In addition, Plans may employ bilingual or multilingual membership staff who can interpret for providers or use contracted community-based organization for interpreter services. If these face-to-face services are not feasible, Plans may use the telephone language lines for interpreter services. The intent of the contractual requirement is not to have Plans rely solely on telephone language lines for interpreter services. Rather, telephone interpreter services should supplement face-to-face interpreter services, which is a more effective means of communication.

Plans must not require, or suggest to LEP members, that they must provide their own interpreters. The use of family, friends, and particularly minors, may compromise the reliability of medical information. LEP members may be reluctant to reveal personal and confidential information to family members, friends or minors. In addition, family, friends and minors are not trained in interpretation skills. Use of such persons could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. In a medical setting, reluctance or failure to reveal critical personal information could have serious, even life threatening, health consequences. In addition, family, friends and minors may not be competent to act as interpreters, since they may lack familiarity with specialized terminology. However, a family member or friend may be used as an interpreter if this is requested by the LEP individual after being informed he/she has the right to use free interpreter services. The use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality. Plans must ensure that their providers document the request or refusal of language/interpreter services by a LEP member in the medical record.

[illegible]
[illegible]

II. Threshold Languages

Threshold languages in each county are designated by the Department of Health Services. These are primary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible beneficiaries residing in a county. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes, are also considered threshold languages for a county.

Plans with threshold language requirements must provide the following:

1. Interpreter services at key points of contact (medical and nonmedical) for members whose language proficiency is in one of the threshold languages. Medical points of contact include face-to-face or telephone encounters with providers (physicians, physician extenders, registered nurses, pharmacist, or other personnel) who provide medical or health care advice to members. Plans are encouraged to maintain a provider network (at a minimum, primary care providers) with sufficient number of bilingual and multilingual providers and provider staff who speak some of the threshold languages. Plans must list the language capabilities of these providers in their network directories (see Policy Letter 98-12). Plans must also ensure access to interpreter services at all network pharmacy sites during pharmacy service hours. At a minimum, telephone interpreter services must be available in the threshold languages if requested by a LEP member for pharmacy counseling on drug dosages, drug interactions, contraindications, adverse reactions, etc.
   Nonmedical points of contacts include membership services, appointment services, and member orientation sessions.
2. Procedures for referring members to culturally and linguistically appropriate services. Plans must ensure that network providers are aware of these services.
3. Signage and written materials which have been translated into threshold languages.

III. Assessing and Monitoring Effectiveness of Linguistic Services

Some Plans have the following contract requirements:

1. "Assess, identify, and report the linguistic capabilities of interpreters or bilingual health plan and contracted staff."

2. "Develop and implement standards and performance requirements for the provision of linguistic services and monitor the performance of the individuals who provide linguistic services."

Plans with these contract requirements must implement procedures to monitor the language capability of providers listed in the provider directory as speaking specific languages. At a minimum, there must be documentation of whether it is the provider or the office staff who has the language skill(s), and this information must be updated at least annually. Plans must also implement performance requirements for interpreters. At a minimum, Plans must develop procedures for assessing interpreters' capabilities. These may include, but are not limited to, the following:

1. Written or oral assessment of bilingual skills.
2. Documentation of the number of years of employment the individual has as an interpreter and/or translator.
3. Documentation of successful completion of a specific type of interpreter training programs (i.e., medical, legal, court, semi-technical, etc.).
4. Other reasonable alternative documentation of interpreter capability.

Plans must also continuously evaluate the effectiveness of its linguistic services program. Plans' review and monitoring of its linguistic services must have a direct link to the Plans' quality improvement processes. Procedures for continuous evaluation of the effectiveness of linguistic services may include, but are not limited to, analysis of grievances and complaint logs regarding communication or language problems and assessment of member satisfaction with the quality and availability of interpreter services.

Plans are strongly encouraged to centralize the coordination and monitoring of linguistic services within one department or by a coordinator. This coordinator or department would oversee the educational program(s) developed for Plan staff, providers, and provider staff on interpreter services, implementation of bilingual proficiency guidelines, and the coordination and monitoring of interpreter services.

IV. Member Informing

All Plans must inform their members of the availability of linguistic services. At a minimum, the membership material must include information regarding the member's right to:

1. Interpreter services at no charge when accessing health care. For example, at the time appointments with primary care providers are made, interpreter services should be offered to LEP patients.
2. Not use friends or family members as interpreters, unless specifically requested by the member. The Plan or plan provider must document member's refusal to accept the services of a qualified interpreter.
3. Request face-to-face or telephone interpreter services during discussions of complex medical information such as diagnoses of complex medical conditions and accompanying proposed treatment options; explanations of complicated plans of care or discussions of complex procedures.
4. Receive informing documents translated into threshold languages (Refer to Translation of Written Informing Materials, MMCD Policy Letter 99-04).
5. File grievances or complaints if linguistic needs are not met.

DISCUSSION

Guidelines for Determining Bilingual Proficiency

Plans are encouraged to use the following guidelines for ensuring appropriate bilingual proficiency in nonmedical and medical settings. These guidelines apply to both on-site and telephone interpretation.

- Nonmedical Key Points of Contact

  It is important for persons providing interpretation in nonmedical environments to have conversational fluency in both the target language and English. This includes speaking in a grammatically correct manner for statements and questions, comprehension of spoken language related to both health care settings and Plan member services. Adequate vocabulary includes fluent use and accurate pronunciation of managed care terminology, forms of address, greetings, directions, time of day, days of the week, names of the months, Plan services process, and personnel. Nonmedical interpreters are able to assist limited English proficient members to complete forms, in English, appropriate to the specific setting or circumstance. Individuals interpreting in nonmedical settings should also be able to precisely explain nonclinical consent forms (transfer of medical records, admission forms, advance directives).

- Medical Key Points of Contact

  Persons providing language services at medical points of contact should have all of the language skills required of those who interpret at nonmedical points of contact listed above, as well as proficiency related to clinical settings. Persons who interpret in medical settings should be fluent in medical terminology in both languages (anatomical terms, body processes and physiology, symptoms, common disease names and processes, common etiologic terms, clinical procedures, instructions, and treatment plans). These persons should have the appropriate training to take or assist with gathering information for an accurate medical history; they should also be able to assist providers by interpreting clinically related consent forms.

Guidelines for Plans' Staff and Providers' Education

It is important for the Plan managers, staff, and providers to participate in a cultural and linguistic education and awareness program. Such a program provides an understanding of the role of skilled interpretation in the provision of high quality health care services to LEP members. It enhances the Plan's ability to meet the cultural and linguistic contract requirements and serves to remind network providers of their obligation to bridge communication gaps. Quality interpreter services provided in a culturally competent manner enhances the ability of the members to comply with treatment programs, thereby enhancing the potential for good outcomes and reducing the potential for legal liabilities. Educational programs may be implemented through newsletters, one-on-one instruction, the provider manual, workshops, or other methods as determined by the Plan.

The educational and informational program may include, but is not limited to, the following:

1. The Department of Health and Human Service's Guidance Memorandum on Title VI Prohibition Against National Origin Discrimination--Persons with Limited-English Proficiency (Enclosure I).
2. Information on Plan and provider legal vulnerability with respect to inadequate provision of interpreter services. The National Health Law Institute's report on "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities," 1998, Executive Summary (Enclosure II).
3. Senate Bill 1840 amended the Section 1259, Health and Safety Code, (Enclosure III).
4. A list of resources to assist medical interpreters (e.g., glossaries and dictionaries).

5. Information on appropriate skills for persons who interpret, e.g., medical terminology, interactive skills, ethics related to confidentiality, and accuracy.
6. Lists of training and testing resources for maintaining and enhancing interpreter skills.
7. Tips or training for providers on how to work effectively with interpreters.

If you have any questions regarding this policy letter, please contact your contract manager.

Susanne Hughes

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

ENCLOSURE I

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Region IX
Office for Civil Rights
50 United Nations Plaza
San Francisco, CA 94102

GUIDANCE MEMORANDUM
Title VI Prohibition Against National Origin Discrimination--Persons with Limited-English Proficiency

I. BACKGROUND

This memorandum is intended to offer guidance to staff of the Office for Civil Rights (OCR) with respect to its enforcement of the responsibilities of recipients of Federal financial assistance from HHS to persons with Limited-English Proficiency (LEP), pursuant to Title VI of the Civil Rights Act of 1964, 2000d *et seq.* ("Title VI"). Such recipients include hospitals, managed care providers, clinics and other health care providers as well as social service agencies and other institutions or entities that receive assistance from HHS. This document will provide guidance to OCR investigators in assessing compliance, negotiating voluntary compliance, and providing technical assistance. It also stresses flexibility, particularly for small providers, in choosing methods to meet their responsibilities to LEP persons. Through OCR's investigative activities in this area, both recipients and LEP beneficiaries will be made more aware of their respective obligations with respect to the provision and receipt of services.

The guidance is intended to clarify standards consistent with case law and well established legal principles that have been developed under Title VI.

Section 601 of Title VI states that "no person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Regulations implementing Title VI which are published at 45 C.F.R. Part 80, specifically provide that a recipient may not discriminate and may not, directly or through contractual or other arrangements, use criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular, race, color or national origin.

The statute and regulations prohibit recipients from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of beneficiaries in their programs, benefits or activities on the basis of race, color or national origin. Accordingly, a recipient must ensure that its policies do not have the effect of excluding from, or limiting the participation of, such persons in its programs and activities, on the basis of national origin. Such a recipient should take reasonable steps to provide services and information in appropriate languages other than English in order to ensure that LEP persons are effectively informed and can effectively participate in and benefit from its programs.

English is the predominant language of the United States and according to the 1990 Census is spoken by 95% of its residents. Of those residents who speak languages other than English at home, the 1990 Census reports that 57% of U.S. residents above the age of four speak English "well to very well." The United States is also, however, home to millions of national origin minority individuals who are limited in their ability to speak, read, write and understand the English language. The language barriers experienced by these LEP persons can result in limiting their access to critical public health, hospital and other medical and social services to which they are legally entitled and can limit their ability to receive notice of or understand what services are available to them. Because of these language barriers, LEP persons are often excluded from programs or experience delays or denials of services from recipients of Federal assistance. Such exclusions, delays or denials may constitute discrimination on the basis of national origin, in violation of Title VI.

LEP persons can and often do encounter barriers to health and social services at nearly every level within such programs. The primary reason for this difficulty is the language barrier that often confronts LEP persons who attempt to obtain health care and social services. Many health and social service programs provide information about their services in English only. Many LEP persons presenting at hospitals or medical clinics are faced with receptionists, nurses and doctors who speak English only, and often interviews to determine eligibility for medical care or social services are conducted by intake workers who speak English only.

The language barrier faced by LEP persons in need of medical care and/or social services severely limits their ability to gain access to these services and to participate in these programs. In addition, the language barrier often results in the denial of medical care or social services, delays in the receipt of such care and services, or the provision of care and services based on inaccurate or incomplete information. Services denied, delayed or provided under such circumstances could have serious consequences for an LEP patient as well as for a provider of medical care. Some states recognize the seriousness of the problem and require providers to offer language assistance to patients in certain medical care settings.

This guidance sets out factors for OCR staff to consider in determining whether federally-assisted providers of medical care or social services are taking steps to overcome language barriers to health care and social services encountered by LEP persons. The guidance emphasizes flexibility to providers in choosing the language assistance options they will employ. Thus, small providers and/or providers who serve only one or two language groups may be able to meet their responsibilities by choosing fewer or different options than the options selected by larger providers or those providers serving many language groups.

The U.S. Supreme Court, in Lau v. Nichols, 414 U.S. 563 (1974), recognized that recipients of Federal financial assistance have an affirmative responsibility, pursuant to Title VI, to provide LEP persons with meaningful opportunity to participate in public programs. In Lau v. Nichols, the Supreme Court ruled that a school system's failure to provide English language instruction to students of Chinese ancestry who do not speak English denied the students a meaningful opportunity to participate in a public educational program in violation of the Civil Rights Act of 1964.[1]

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[1] The Lau decision affirmed the U.S. Department of Education's Policy Memorandum issued on May 25, 1970, titled "Identification of Discrimination and the Denial of Services on the Basis of National Origin", 35 Fed. Reg. 11,595. The memorandum states in part: "Where the inability to speak and understand the English language excludes national origin minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students."

Since the Lau decision, OCR has conducted a number of complaint investigations and compliance and pre-grant reviews involving language barriers that impede the access of LEP persons to federally-assisted health and medical care and social services. OCR has found that where language barriers exist, eligible LEP persons are often excluded from programs, denied medical services or suffer long delays in the receipt of health and social services. Where such barriers discriminate or have had the effect of discriminating on the basis of national origin, OCR has required recipients to provide language assistance to LEP persons.

OCR's position as set forth in this document is fully consistent with a government-wide Title VI regulation issued by the Department of Justice (DOJ) in 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs," 28 C.F.R. Subpart F. The DOJ regulation addresses the circumstances in which recipients must provide language assistance, in written form, to LEP persons.[2] The DOJ regulation does not address the question of oral language assistance. OCR's experience in conducting complaint investigations and compliance and pre-grant reviews demonstrates that oral communication between recipients and program beneficiaries is an integral part of the exchange that must occur in order for assisted programs and activities to appropriately function. Thus, OCR's longstanding position has been that recipients may be required to provide oral language assistance in languages other than English. This statement affirms this position.

II. DISCUSSION

A. Who is Covered

All entities that receive Federal financial assistance from HHS, either directly or indirectly through a subgrant or subcontract, are covered by this guidance. Covered entities would thus

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[2] The DOJ coordination regulations at 28 C.F.R. Section 42.405 (d)(1) provide that "[w]here a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program (e.g. affected by relocation) needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

include any state or local agency, private institution or organization, or any public or private individual that operates, provides or engages in health, medical or social service programs and activities that receive or benefit from HHS assistance.

B. Ensuring Equal Access to LEP Persons

All recipients have the responsibility for ensuring that their policies and procedures do not deny or have the effect of denying such LEP persons equal access to federally assisted health, medical and social service programs, benefits and services for which such persons qualify.

The key to ensuring equal access to benefits and services for LEP persons, is to ensure the service provider and the LEP client can communicate effectively, i.e., the LEP client should be given information about, and be able to understand, the services that can be provided by the recipient to address his/her situation and must be able to communicate his/her situation to the recipient service provider. Recipients are more likely to utilize effective communication if they approach this responsibility in a structured rather than on an ad hoc basis.[3]

Developing policies and procedures for addressing the language assistance needs of LEP persons may best be accomplished through an assessment of the points of contact in the program or activity where language assistance is likely to be needed, the non-English languages that are most likely to be encountered, the resources that will be needed to fulfill this responsibility and the location and/or availability of such resources. In identifying available resources, recipients may find it helpful to consult with national origin organizations and groups in their service areas. Achieving effective communication with LEP persons may require the recipient to take all or some of the following steps at no cost or additional burden to the LEP beneficiary:

- Have a procedure for identifying the language needs of patients/clients.
- Have ready access to, and provide services of, proficient interpreters in a timely manner during hours of operation.
- Develop written policies and procedures regarding interpreter services.
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to LEP persons.

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[3] A requirement to ensure effective communication is also found in the area of disability discrimination law. See 28 C.F.R. Section 35.160(a), 45 C.F.R. Section 84.52(c) and 45 C.F.R. Section 85.51(a).

C. Interpreter Services

In determining the type of interpreter services that will be provided, a recipient has several options. To meet its Title VI responsibility with respect to the provision of interpreter services a recipient may:

- Hire bilingual staff
- Hire staff interpreters
- Use volunteer staff interpreters
- Arrange for the services of volunteer community interpreters
- Contract with an outside interpreter service
- Use a telephone interpreter service such as the AT&T Language Line
- Develop a notification and outreach plan for LEP beneficiaries.

Factors that may be considered by a recipient in determining which option(s) will best meet its needs and the needs of its LEP beneficiaries are its size, the size of the LEP population it serves, the setting in which interpreter services are needed, the availability of staff members and/or volunteers to provide interpreter services during its hours of operation and the proficiency of available staff members or volunteers available to provide the needed services.

A recipient should not require a beneficiary to use friends or family members as interpreters. Use of such persons could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations, to family or friends. In a medical setting, reluctance or failure to reveal critical personal information could have serious, even life threatening, health consequences. In addition, family and friends may not be competent to act as interpreters, since they may lack familiarity with specialized terminology. However, a family member or friend may be used as an interpreter if this approach is requested by the LEP individual and the use of such a person would not compromise the effectiveness of services or violate the beneficiary's confidentiality, and the beneficiary is advised that a free interpreter is available.

A recipient should ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, though this certification generally is preferable. However, the competency requirement does contemplate proficiency in both English and the other language, orientation or training which includes the ethics of interpreting, and fundamental knowledge in both languages of any specialized terms and concepts peculiar to the recipient's program or activity. For example, a hospital or medical clinic could use a nurse as a volunteer staff interpreter for a Hispanic beneficiary if the nurse speaks both English and Spanish proficiently. It can be assumed that in addition to language skills enabling the relay of critical information about the patient to medical personnel, the nurse will be sufficiently familiar with medical terminology to convey the medical meaning and importance of what is being communicated to the LEP patient. However, it would be inappropriate to use a person who had little knowledge of medical terms or a person who spoke English poorly. Similarly, it would be inappropriate to rely on a medical student who worked part-time and had learned some Spanish but did not speak the language proficiently. While the student would understand the medical terminology, and the use of part-time staff would be appropriate in many circumstances, it is unlikely that such a student would have sufficient Spanish language skills to communicate what is being said and its importance, by and to the LEP patient.

The options available to recipients for providing interpreter services to LEP persons have differing weaknesses and strengths depending on the situation. Hiring bilingual staff for certain critical positions, e.g., for patient or client contact positions, would facilitate participation by LEP persons. However, where there are several LEP language groups in a recipient's service area this option may be impractical as the only interpreter option, and additional language assistance options may be required.

Use of staff or community volunteers may provide recipients with a cost-effective method for providing interpreter services. However, recipients should ensure that such a system is sufficiently organized so that interpreters are readily available during all hours of its operation. In addition, recipients should ensure that such volunteers are qualified, trained and capable of ensuring patient confidentiality.

The use of contract interpreters may be an option for recipients that are small, have a significant but small LEP population, have less common LEP language groups in their service areas, or need to supplement their in-house capabilities on an as needed basis. Such contract interpreters should be readily available, qualified and trained.

Paid staff interpreters are especially appropriate where there is a very large LEP presence in a few major language groups. As in other options, these persons should be qualified and available. In most instances these employees are salaried and are entitled to the same benefits received by other employees.

A telephone interpreter service such as the AT&T language line may be a useful option as a supplemental system, or may be useful when a recipient encounters an unusual language that it cannot otherwise accommodate. Such a service often offers interpreting services in many different languages and usually can provide the service in quick response to a request. However, recipients should be aware that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service or may require special arrangements to use such persons.

III. Compliance and Enforcement

The recommendations outlined in Section II(B) are not intended to be exhaustive. Recipients are not required to use all of the suggested methods and options listed. However, recipients should establish and implement policies and procedures for fulfilling their Title VI equal opportunity responsibilities to LEP persons in the population eligible to be served.

In determining a recipient's compliance with Title VI, OCR's concern will be whether the recipient's system allows LEP beneficiaries to overcome language barriers and thus have equal access to, and an equal opportunity to participate in, health care and social service programs and activities. While a recipient is not required to use the options listed, and may use options that are equally effective, a recipient's appropriate use of the options and methods discussed in this guidance, will be viewed by OCR as evidence of a recipient's intent to comply with its Title VI obligations.

For example, a small health care clinic that accepts patients by appointment only and serves a small but significant LEP population may be able to meet its responsibility to its LEP clients by making arrangements for interpreter services on an as needed basis, and appropriately publicizing the availability of such arrangements.

On the other hand, the emergency room in a large hospital located in an area with a larger and more diverse LEP population may require a combination of language assistance options. In this setting, there are likely to be a variety of patient contact points, and immediate and accurate information to and from patients is usually critical. In such a situation the recipient also should have staff that are bilingual in English and other frequently encountered languages, in critical patient contact positions. If available staff is insufficient, the recipient should employ other staff interpreters and/or make other language assistance arrangements to ensure that there are no delays in providing medical care and no misunderstandings when conveying information to, or obtaining information or informal consent from, patients.

The procedural provisions of the regulations implementing Title VI, found at 45 C.F.R. Sections 80.6 through 80.10, are applicable to all complaints or compliance reviews regarding a recipient's compliance with its Title VI responsibility to LEP beneficiaries.

ENCLOSURE- I-I

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Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities

Jane Perkins, *et. al.*, National Health Law Program
January 1998, 190 pgs.

Overcoming language barriers to health care is critical to the well-being of millions of immigrants in the United States today, who face substantial communication problems at almost every level of the health care delivery system. At the administrative level, simply scheduling an appointment can be an ordeal for people with Limited English Proficiency. At the clinical level, proper medical care can be a near impossibility when communication barriers prevent health care providers from understanding their patients' symptoms.

This manual shows advocates how to overcome language barriers to obtain appropriate medical care for their clients. It outlines language access responsibilities under federal and state law, as well as in the private sector, and offers recommendations for addressing identified problems.

The manual is organized as follows:

- Section I offers background information on the scope of the problem. This information is based on a review of the literature and a national survey conducted by the National Health Law Program.
- Section II discusses federal requirements for linguistic access, including Title VI of the Civil Rights Act of 1964, Hill-Burton obligations, Medicaid and Medicare requirements, the Emergency Treatment and Active Labor Act, and provisions of the United States Constitution. A docket of OCR decisions is included.
- Section III describes the growing body of state requirements, including state statutes, that require translation services in health care settings. A state-by-state description of laws is included.
- Section IV looks at activities by the managed care and private accreditation organizations
- Section V offers recommendations for addressing the identified problems.

This report is now available free of charge from the Kaiser Family Foundation.
To order a copy, call 1-800-656-4533 and ask for publication #1362.

An executive summary can be found on National Health Law Program's web site at www.healthlaw.org

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ENSURING LINGUISTIC ACCESS IN HEALTH CARE SETTINGS: LEGAL RIGHTS AND RESPONSIBILITIES

EXECUTIVE SUMMARY

January 1998

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Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities

Executive Summary

Overcoming language barriers to health care is critical to the well-being of millions of immigrants in the United States today. This report reviews public and private sector linguistic access responsibilities for the health care setting. Immigrants with limited English proficiency (LEP) often face substantial communication problems at almost every level of the health care delivery system. At the administrative level, simply scheduling an appointment can be an ordeal for LEP patients.

At the clinical level, when communication barriers prevent health care providers from understanding their patients' symptoms, proper medical care can be a near impossibility. The absence of a trained interpreter not only may lead to improper diagnoses and care, but also may call into question the doctor's ability to obtain a patient's informed consent.

In most cases, providers have the means to overcome language barriers. Providers that serve large numbers of LEP patients can hire bilingual providers and staff interpreters. Local language banks and community-based organizations can provide contract interpreters who are fluent in various languages. When necessary, telephone translation services can furnish interpreter services in over 140 different languages.

Yet in communities throughout the country, providers continue to muddle through their contacts with LEP patients, relying upon their own rudimentary skills, patients' family members, hospital service employees, and other untrained interpreters. In some cases, these practices may reflect an assumption that providers have no obligation to bridge language barriers with limited-English speaking patients. In most instances, this assumption is wrong as a matter of law.

The Need for Linguistically Appropriate Healthcare Services

About thirty-two million people in the United States, 13.8 percent of the population, speak a language other than English at home. However, despite this large constituency, and laws that require recipients of government funds to provide appropriate language access to health care services, the current state of linguistic access to health care leaves much to be desired. The National Health Law Program has identified three factors that contribute to this problem.

First, the number of different languages spoken in the United States has increased dramatically over the last thirty years. The current health care system is not equipped to operate in an environment where numerous languages are spoken.

Second, current levels of funding often are inadequate to meet the rising demand for interpretive services. While the exact costs of these services are difficult to quantify, a recent survey of eight Seattle-area institutions shows that the added expense of working with LEP patients does impact a health care provider's budget. Unfortunately, the current situation is exacerbated by the federal cutbacks on public benefits for immigrants.

And, third, while both federal and state laws require access to linguistically appropriate health care, these laws are little known and rarely enforced.

The Current State of Affairs

These factors have resulted in an unhealthy reliance on untrained interpreters. Most encounters with limited-English speakers are handled by employees untrained as interpreters or by friends or family of the patient. Researchers have found that untrained interpreters are prone to errors that can seriously impair the health care delivery process.

A less commonly used method that involves volunteer interpreters from community agencies holds some promise in that the agencies often take a leadership role in advocating for linguistic access to health care. Unfortunately, because volunteers may not be trained in medical interpreting, many of the concerns about untrained interpreters may apply.

Trained interpreters are used much less frequently. A small number of providers employ staff interpreters. Other providers have turned to contract interpreters and language banks that employ contract interpreters to assist in communicating with patients. Yet other providers use telephone interpretation services to meet the needs of patients.

Language Access Responsibilities under Federal Laws

In the 1960s, with the passage of federal civil rights laws and the Medicaid Act, the federal government launched a major effort to protect the civil rights of minorities and safeguard the health of millions of indigent people. As both enforcer of civil rights laws and as a major purchaser of health care services, the federal government continues to have a pivotal role in making health services more available to linguistic minorities. A number of federal laws address requirements for language access in health care.

- **Title VI of the Civil Rights Act of 1964.** Title VI of the Civil Rights Act of 1964 states "No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[1] Because federal funding of health care is pervasive, nearly every health care provider is bound by Title VI. The U.S. Department of Health and Human Services (HHS) has long recognized that Title VI requires linguistic accessibility to health care. In addition, the Office for Civil Rights (OCR) within HHS has consistently interpreted Title VI to require the provision of qualified interpreter services and translated materials at no cost to patients.

- **The Hill-Burton Act.** Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a "community service obligation" that lasts in perpetuity. OCR has consistently taken the position that this obligation requires Hill-Burton fund recipients to address the needs of LEP patients.
- **Medicaid.** Medicaid is a cooperative federal-state medical assistance program that provides health insurance coverage to indigent aged, blind, and disabled people; poor families with children; and poor children and adolescents. Medicaid regulations explicitly require state programs to operate consistent with Title VI of the Civil Rights Act. The Health Care Financing Administration (HCFA), the agency in charge of Medicaid at the federal level, requires states to communicate with beneficiaries both orally and in writing in a language understood by the beneficiary and to provide interpreters at Medicaid hearings. Medicaid regulations also provide heightened protections for people who reside in long-term care facilities and to children and adolescents who are part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- **Medicare.** Medicare is the federal health insurance program that covers people aged 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medicare provides reimbursement to Medicare-participating hospitals for bilingual services to inpatients and has initiated pilot programs employing the use of bilingual forms and educational materials.
- **Federal Categorical Grant Programs.** Community health centers and migrant health centers that receive federal funding must agree to provide services in the language and cultural context most appropriate to their patients.
- **Emergency Medical Treatment and Active Labor Act.** The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals that participate in the Medicare program and

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[1] 42 U.S.C § 2000d. See also 45 C.F.R. § 80, app. A (1994) (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

have an emergency department to treat patients in an emergency (including women in labor) without regard to their ability to pay. EMTALA sets forth diagnosis and treatment responsibilities that may be difficult or impossible to meet for hospitals that fail to overcome language barriers with their patients.

Language Access Responsibilities Under State Law

In recent years, state legislatures and administrative agencies have begun to recognize the growing need for linguistically appropriate health care and to adopt measures that require or encourage health care providers to take steps to overcome language barriers.

- **Language Access Laws.** A few states have passed comprehensive language access laws that set forth a general responsibility for health care facilities to ensure communication with LEP patients. Some of these laws, such as those passed in California, Massachusetts, and New York, detail specific guidance to providers on what they must do. In other states, such as Illinois, the legislation notes the importance of translation services, but leaves it largely to the health care provider to decide on the services it will offer. Many more states have tied language access laws to specific categories of health services. Not surprisingly, states have reserved some of the most stringent requirements for mental health and long term care facilities.

  Many states also have enacted provisions that encourage or require both state agencies and social service agencies with whom they contract to provide language appropriate services to LEP patients. Model legislation in California, called the Dymally-Alatorre Bilingual Services Act, imposes direct obligations on state and local agencies to provide appropriate translation services. The Act requires, for example, that agencies translate materials explaining their services into languages spoken by five percent or more of the populations that they serve and employ sufficient numbers of bilingual persons to ensure access for non-English speaking persons.

- **State Civil Rights Laws.** State civil rights laws provide another source of authority for the imposition of language access requirements on health care providers. For example, California's civil rights statute prohibits recipients of state funds from discriminating on the basis of ethnic identification, religion, age, sex, color, or physical or mental disability.

- **Malpractice Laws.** State statutes and common law rules governing professional malpractice are yet another important source of language access obligations. Inadequate communication with patients may result in liability under tort principles in three ways. First, providers may discover that they are liable for damages resulting from treatment in the absence of informed consent. Second, providers face potential claims that their failure to bridge communication gaps breaches professional standards of care. Third, a provider's violation of language access laws may raise a presumption of negligence in some states.

- **English-only Laws.** At least eighteen states have enacted laws that make English the official state language. While many of these laws are purely symbolic, some require public officials to speak EnglishÑand no other languageÑwhen conducting state business. Even the most strict of these laws, however, includes exceptions for law enforcement and public health activities. The effect on language access of a public health exception contained in such laws is hard to measure. Some state agencies may interpret the exception broadly, while other agencies may choose to invoke the exception only in very specific public health activities involving, for example, infectious diseases.

Language Access Responsibilities in the Private Sector

The provision of publicly-financed health care services is rapidly being delegated to the private sector, with significant effect on the provision of language services. Two developments are particularly noteworthy — the increased reliance on for-profit managed care plans and the growing influence of private accreditation organizations.

- **Managed Care.** Some innovative HMOs are employing novel programs to provide linguistically appropriate services to LEP patients. Harvard Community Health Plan, for example, has adopted interpreting policies that encourage pre-scheduling of appointments and use of on-staff interpreters.

  State governments also can play an important role by adopting base-line standards that managed care companies doing business in the state must meet. While there has been little legislative activity to date in this area, about half of the 80 or so Medicaid managed care contracts reviewed for this manual addressed the need for culturally sensitive services. California, for example, has not only passed legislation that encourages assessment of the linguistic accessibility of managed care plans, but also has inserted noteworthy linguistic accessibility provisions in its Medicaid managed care contracts, including provisions that require health plans to assess the language capability of their service areas and to develop plans explaining how they will serve LEP populations within those service areas.

- **Accrediting Agencies.** State and federal agencies increasingly relying on private accreditation entities to set standards and monitor compliance with those standards. Both the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions (e.g. psychiatric facilities, home health agencies), and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health

MCOs, have adopted standards that require language access in health care.

JCAHO standards require hospitals to employ policies that provide effective communication means for each patient served. For example, on admission, patients must be informed of their rights. If these rights are listed on written notices and postings that the patient cannot understand, then the patient should be informed of his or her rights in a manner that he or she can understand. The NCQA accreditation process calls for MCOs to be able to provide materials in languages understood by LEP enrollees if they serve major non-English speaking populations (at least 10 percent of membership). NCQA's Health Plan Employer Data and Information Set (HEDIS) 3.0 presents a set of performance measures for commercial, Medicare, and Medicaid managed care plans. It includes questions regarding bilingual doctors and staff, availability of trained interpreters, and whether materials are printed in languages other than English.

Recommendations

Based on the research conducted for this manual, the National Health Law Program has identified the following key provisions as critical to the delivery of health care to LEP populations.

1. Health care providers and purchasers need education on the federal and state laws governing linguistic access, particularly Title VI of the Civil Rights Act.
2. Government agencies and citizens need to enforce the civil rights laws.
3. Efforts to collect data on LEP health status and utilization need to be increased.
4. Hospitals and managed care organizations need to hire and contract with bilingual providers/interpreters who can meet the needs of their patients.
5. The linguistic measures in HEDIS 3.0 should be strengthened. In the meantime, existing provisions need to be taken seriously by insurance purchasers and MCOs—and the results need to be made accessible to the public.
6. State Medicaid agencies should review their Medicaid provider manuals and guidelines and contracts with managed care organizations to assure that, at a minimum, they comply with the requirements for linguistic access that have been announced in OCR decisions.
7. State laws and contract provisions should be monitored and enforced by the state, and offending providers should be sanctioned.

8. States and health plans need to assure that affected LEP consumers' views are understood and incorporated.
9. Advocacy organizations that work on behalf of limited English speaking populations and that work to improve health care access should continue to be involved in efforts to improve linguistic access.
10. Principles of interpreter services need to be established and followed to assure the availability of qualified interpreter services.

Conclusion

Immigrants are coming to the United States in increasing numbers, and they will continue to come here to stay. This influx represents new challenges to health care providers and purchasers, and it opens up new health care markets.

Unfortunately, the health care system is not adequately equipped to serve limited English speaking populations, and it has only begun to recognize the marketing opportunities that these populations present. Yet, the problems are not going unaddressed. Innovative approaches to serving limited English speaking persons are being developed across the United States.

In addition to a growing awareness that population shifts are creating a greater need for translation services, there are laws that require linguistic access. Numerous federal and state civil rights laws protect limited English speakers against discrimination in the delivery of health care. Unfortunately, states, health care providers, and managed care organizations are largely unfamiliar with these legal requirements—even though most of those who are participating in Medicare and Medicaid have signed contracts that explicitly require them to adhere to the civil rights laws, particularly Title VI of the Civil Rights Act. Consumers and consumer organizations also are not fully informed. Clearly, there is much that needs to occur in the areas of development, education, and enforcement.

To request a free copy of the full report please call 1-800-656-4533 and ask for publication #1362.

ENCLOSURE III

Senate Bill No. 1840

CHAPTER 672

An act to add Section 1259 to the Health and Safety Code, relating to hospital interpreters.

[Approved by Governor September 9, 1990. Filed with Secretary of State September 12, 1990.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1840, Kopp. General acute care hospitals: interpreters.

Existing law requires a general acute care hospital, as defined, to obtain a license from the State Department of Health Services and meet prescribed standards.

This bill would, in addition, require a licensed general acute care hospital to review its existing policies regarding interpreters, as defined, for patients with limited-English proficiency and for patients who are deaf and to adopt and annually review a policy for providing language assistance services to patients with language or communication barriers, as specified.

The bill would, among other things, require a licensed general acute care hospital to develop and post notices, as specified, to advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter, and the telephone numbers where complaints can be filed. It would require the hospital to identify and record a patient's primary language and dialect on one or more specified medical information items. It would further require the hospital to prepare and maintain as needed a list of interpreters and to notify employees of the hospital's commitment to provide interpreters to all patients who request them.

The bill would require the hospital to review all standardized written material to determine whether to translate it into languages other than English.

The bill would make noncompliance with the above-mentioned provisions reportable to licensing authorities.

Under existing law, violations of these provisions would be a misdemeanor.

This bill would make that existing law inapplicable to this bill.

The people of the State of California do enact as follows:

SECTION 1. Section 1259 is added to the Health and Safety Code, to read:

1259. (a) The Legislature finds and declares that California is becoming a land of people whose languages and cultures give the state a global quality. The Legislature further finds and declares that access to basic health care services is the right of every resident of the state, and that access to information regarding basic health care services is an essential element of that right.

Therefore, it is the intent of the Legislature that where language or communication barriers exist between patients and the staff of any general acute care hospital, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff.

(b) As used in this section:

(1) "Interpreter" means a person fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language. Interpreters shall have the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages. Interpreters may include members of the medical or professional staff.

(2) "Language or communication barriers" means:

(A) With respect to spoken language, barriers which are experienced by individuals who are limited-English-speaking or non-English-speaking individuals who speak the same primary language and who comprise at least 5 percent of the population of the geographical area served by the hospital or of the actual patient population of the hospital. In cases of dispute, the state department shall determine, based on objective data, whether the 5 percent population standard applies to a given hospital.

(B) With respect to sign language, barriers which are experienced by individuals who are deaf and whose primary language is sign language.

(c) To ensure access to health care information and services for limited-English-speaking or non-English-speaking residents and deaf residents, licensed general acute care hospitals shall:

(1) Review existing policies regarding interpreters for patients with limited-English proficiency and for patients who are deaf, including the availability of staff to act as interpreters.

(2) Adopt and review annually a policy for providing language assistance services to patients with language or communication barriers. The policy shall include procedures for providing, to the extent possible, as determined by the hospital, the use of an interpreter whenever a language or communication barrier exists, except where the patient, after being informed of the availability of the interpreter service, chooses to use a family member or friend who volunteers to interpret. The procedures shall be designed to maximize efficient use of interpreters and minimize delays in providing interpreters to patients. The procedures shall ensure, to the extent possible, as determined by the hospital, that interpreters are available, either on the premises or accessible by telephone, 24 hours a day. The hospital shall annually transmit to the state department a copy of the updated policy and shall include a description of its efforts to ensure adequate and speedy

communication between patients with language or communication barriers and staff.

(3) Develop, and post in conspicuous locations, notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter and the telephone numbers where complaints may be filed concerning interpreter service problems, including, but not limited to, a T.D.D. number for the hearing impaired. The notices shall be posted, at a minimum, in the emergency room, the admitting area, the entrance, and in outpatient areas. Notices shall inform patients that interpreter services are available upon request, shall list the languages for which interpreter services are available, shall instruct patients to direct complaints regarding interpreter services to the state department, and shall provide the local address and telephone number of the state department, including, but not limited to, a T.D.D. number for the hearing impaired.

(4) Identify and record a patient's primary language and dialect on one or more of the following: patient medical chart, hospital bracelet, bedside notice, or nursing card.

(5) Prepare and maintain as needed a list of interpreters who have been identified as proficient in sign language and in the languages of the population of the geographical area serviced who have the ability to translate the names of body parts, injuries, and symptoms.

(6) Notify employees of the hospital's commitment to provide interpreters to all patients who request them.

(7) Review all standardized written forms, waivers, documents, and informational materials available to patients upon admission to determine which to translate into languages other than English.

(8) Consider providing its nonbilingual staff with standardized picture and phrase sheets for use in routine communications with patients who have language or communication barriers.

(9) Consider developing community liaison groups to enable the hospital and the limited-English-speaking and deaf communities to ensure the adequacy of the interpreter services.

(d) Noncompliance with this section shall be reportable to licensing authorities.

(e) Section 1290 shall not apply to this section.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
BOX 942732
SACRAMENTO, CA 94234-7320
(916) 445-3054

June 19, 1992

TO: GENERAL ACUTE CARE HOSPITALS

SUBJECT: IMPLEMENTATION OF SB 1840, CHAPTER 672, STATUTES OF 1990, HEALTH AND SAFETY CODE, SECTION 1259, HOSPITAL INTERPRETER SERVICE

Senate Bill 1840, Statutes of 1990, Chapter 672, added Section 1259 to the Health and Safety Code (H&S Code) regarding hospitals providing interpreter services for non-English speaking and deaf patients whose primary language is sign language. This statute became effective January 1, 1991.

The enclosed documents are intended to provide an understanding of what is required for compliance with this law.

The development of policies and posting of notices consistent with H&S Code, Section 1259, is required. Submit the policies within 60 days of receipt of this letter to your local Licensing and Certification District Office, District Administrator, list enclosed. Thereafter, updated or revised policies are to be submitted annually to your local Licensing and Certification District Office.

Margaret DeBow

Margaret DeBow
Deputy Director
Licensing and Certification

Enclosures

cc: Ms. Susan Harris
Vice President Professional Services
California Association of Hospital and
Health Systems
1050 20th Street, Suite 800
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Sacramento, CA 95812-1100

RECEIVED
JUL 08 1992
ADMINISTRATION

SUMMARY OF SENATE BILL 1840
CHAPTER 672
HEALTH AND SAFETY CODE, SECTION 1259

The intent of this statute is to ensure that patients with limited English proficiency and those who are deaf are not denied access to basic health care services. Where language or communication barriers exist between patients and the staff of any general acute care hospital, arrangements are required for interpreters or bilingual professional staff.

The law defines a language or communication barrier as one which is experienced by individuals who are limited-English-speaking or non-English-speaking individuals who speak the same primary language and who comprise at least five percent of the population of the geographical area served by the hospital or of the actual patient population of the hospital. With respect to sign language, communication barriers are experienced by individuals who are deaf and whose primary language is sign language. In cases of dispute, the Licensing and Certification (L&C) District Office shall determine, based on objective data, whether the five percent population standard applies to a given hospital.

The law requires hospitals to:

1. Review existing policies regarding interpreter services for conformance with the above definitions.

2. Adopt and review annually policies regarding language assistance for any patients with language and communication barriers.

3. Hospitals which do not meet the five percent criteria noted above must maintain documentation as to how that determination was made.

4. Annually submit copies of revised interpreter service policies and procedures to the local District Office of Licensing and Certification.

5. Develop and implement methods for identifying a patient's primary language and dialect during his/her hospital stay.

6. Conspicuously post notices informing patients and their families of the availability of interpreters and the languages for which interpreter services are available. These notices must include the local address and telephone number (including Telecommunications Device for the Deaf [TDD] number) to contact for registering complaints concerning interpreter services provided by the hospital.

   The notices must also instruct patients on how to direct complaints regarding interpreter services to the local L&C District Office.

The notices shall provide the local address and telephone number of Licensing and Certification, including, but not limited to, a TDD number for the hearing impaired. The Department's TDD number for the hearing impaired is provided through the California Relay Service. The TDD number for complaints regarding interpreter services to L&C is 1-800-735-2929. The California Relay Service voice number is 1-800-735-2922.

7. Record the primary language of each patient admitted to permit identification of language groups needing interpreters under this law.

8. Prepare and maintain, as needed, a list of interpreters who are identified as proficient in sign language and in the other primary languages of the population within the geographic area served.

9. Notify employees of the hospital's commitment to providing interpreters to patients needing the service.

10. Review all standardized forms and other documents to determine the need for translating them into the identified languages.

11. Consider the use of standardized picture and phrase sheets by non-bilingual staff.

12. Consider developing community liaison groups to enable the hospital and limited-English-speaking and deaf communities to ensure adequacy of interpreter services.