

April 2, 2002

Deeana Jang  
Office of Civil Rights  
Department of Health and Human Services  
Room 506F  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**Attn: LEP Comments**

Dear Ms. Jang:

The National Health Law Program submits these comments on behalf of NHeLP and the undersigned organizations in response to the Request for Comments on the "Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency" ("LEP Guidance"), re-published by the Office of Civil Rights of the Department of Health and Human Services ("OCR") in the Federal Register on February 1, 2002.

The resolve of President Bush to put "a priority on access to health care," [\(1\)](#) and the Administration's commitment to Executive Order (EO 13166) and its implementing guidances offer bright beacons of light for individuals currently consigned to the shadows of our health care system due to linguistic barriers. We applaud the Administration for recognizing the importance of ensuring the access of limited English proficient ("LEP") individuals to all government services, especially health care.

As we stated when OCR first issued this Guidance in August 2000, we strongly support OCR's effort to provide much-needed clarifying provisions for health care and social service providers pursuant to Title VI of the Civil Rights Act of 1964. As Title VI itself guarantees linguistic access, in considering whether to revise the Guidance, OCR should consider that many of the "costs" exist because of Title VI and not from the Guidance or EO 13166. We view OCR's endeavor as

critically important to ensure that limited English proficient ("LEP") persons have fair and equal access to the health care and social services to which they are entitled. The HHS LEP Guidance, historic Executive Order No. 13166, and the recently re-published Department of Justice LEP Guidance, establish the key principle that all federal services -- whether by a federal agency or a federal fund recipient -- must be accessible to every LEP person. As one of the first agencies to issue its LEP Guidance, OCR's LEP Guidance will hopefully serve as an excellent model for other agencies as they develop their own guidances. We also urge HHS to take a leadership role in developing an exemplary policy and practice for serving the LEP population in its administration of the Medicare, Medicaid and SCHIP programs.

While we enthusiastically endorse the LEP Guidance, we encourage OCR to adopt the additional recommendations which are attached. We appreciate the opportunity to submit these comments and look forward to working with OCR to implement the LEP Guidance. We have organized our comments to follow the questions raised by OCR in its Request for Comment.

Sincerely,

Mara Youdelman  
Doreena Wong  
Staff Attorneys  
National Health Law Program

The undersigned organizations support the comments submitted by NHeLP:

Asian Health Services  
Asian and Pacific Islander American Health Forum  
Asian Pacific American Legal Center of Southern California (Los Angeles, CA)  
Alameda Medical Center (Alameda, CA)  
Bay Area Legal Aid (Contra Costa, Alameda, San Francisco, Marin, San Mateo, and Santa Clara Regional Offices)  
California Healthcare Interpreters Association  
California Immigrant Welfare Collaborative (Sacramento, CA)  
California Pan Ethnic Health Network (Oakland, CA)  
Center for Public Policy Priorities (Austin, TX)  
Center on Disability and Health (Washington, DC)

Children's Hospitals and Clinics (Minneapolis, St. Paul, MN)  
Chinese for Affirmative Action  
Chinese Progressive Association (Boston, MA)  
Cleveland Immigrant Health Care Access Coalition  
Coalition for Humane Immigrant Rights of Los Angeles  
Colorado Center on Law and Policy (Denver, CO)  
Community Legal Services, Inc. (Philadelphia, PA)  
Consumers Union  
Consumers Union, Southwest Regional Office (Austin, TX)  
East Bay Community Law Center, Berkeley, CA  
East Palo Alto Community Law Project  
Easter Seals  
Epilepsy Foundation  
Families USA  
Family Voices - NJ (Newark, NJ)  
Filipino Civil Rights Advocates (Oakland, CA)  
Florida Legal Services  
Health Care For All (Boston, MA)  
Health Consumer Alliance (Oakland, CA)  
Health Law Advocates (Boston, MA)  
Interpreter Services, Alameda County Medical Center (Oakland, CA)  
L.A. Care Health Plan (Los Angeles, CA)  
Latino Legal Assistance Project, Public Justice Center (Baltimore, MD)  
Law Center For Families (Oakland, CA)  
Massachusetts Law Reform Institute  
Massachusetts Medical Interpreters Association (Boston, MA)  
NARAL/NY  
National Asian Pacific American Legal Consortium  
National Association of School Psychologists  
National Center on Poverty Law  
National Council on Interpreting in Health Care  
National Council of La Raza  
National Immigration Law Center  
National Latina Institute for Reproductive Health  
National Limited English Proficiency Advocacy Task Force  
National Women's Law Center  
New Jersey Statewide Parent to Parent, Newark, NJ  
Newcomers Health Program (San Francisco, CA)  
New York Immigration Coalition  
North Carolina Justice and Community Development Center  
Northwest Women's Law Center (Seattle, WA)  
NOW Legal Defense and Education Fund  
Orange County Asian and Pacific Islander Community Alliance (Garden Grove, CA)  
PALS for Health (Los Angeles, CA)  
Protection and Advocacy, Inc. (Sacramento, CA)  
Research Institute of Independent Living (Washington, DC)

Rural Opportunities, Inc. (Rochester, NY)  
South Asian Network (Artesia, CA)  
Statewide Parent Advocacy Network of New Jersey (Newark, NJ)  
Summit Health Institute for Research and Education  
The Legal Aid Society, Employment Law Center (San Francisco, CA)  
Universal Health Care Action Network of Ohio (Columbus)  
Vietnamese American Initiative for Development (Dorchester, MA)  
Virginia Poverty Law Center (Richmond)  
Washington Lawyers' Committee for Civil Rights and Urban Affairs  
Western Center on Law & Poverty

**1. Have persons with limited English proficiency seeking health care or social services benefitted as a result of the guidance? If so, what have been the benefits? Please be specific about your experiences.**

It is, of course, difficult to quantify the direct benefits of the Guidance. OCR has a 30 year history of implementing Title VI and the Guidance is merely the latest in a long progression of efforts by OCR to ensure access for LEP individuals in HHS' programs. Yet, the issuance of the Guidance has brought further attention to the difficulties LEP individuals face in obtaining health care. It also has raised awareness among recipients of federal financial assistance ("recipient") of the need to serve LEP individuals and that there are a varieties of ways that services can be provided, depending on the circumstances of the recipient. Thus, the benefits from the OCR Guidance arise both from its issuance and further activities OCR has taken - and will take - to ensure linguistic access in HHS' programs.

Rather than attempt to quantify the direct benefits of the Guidance, our comments will address the benefits directly attributable to ensuring linguistic access for LEP individuals. First and foremost, the major benefit of having oral and written translation services available is the quality of care that results. LEP individuals who can communicate effectively and accurately with their health care providers will reap the benefits of accessing preventive care, understanding their diagnosis and condition, making informed decisions about treatment options, recognizing the importance of monitoring a chronic condition and following through with recommended treatments.

In addition to the benefits directly ascribed to LEP individuals, providers will also garner benefits. Providers who ensure linguistic access insulate themselves from claims of malpractice and/or negligence. Providers will ensure their patients have given "informed consent" for needed tests, procedures and surgery. They will avoid complaints that the patient did not understand the doctor's diagnosis or recommended treatment. Further, a "business case" exists for ensuring linguistic access - providers can market themselves on their ability to ensure linguistic access and achieve a strong word-of-mouth reputation that will result in other LEP individuals seeking care from that provider. These steps can only help the economic viability of their practices. Thus, the Guidance serves a public awareness function by focusing on the need for linguistic access and highlighting the existing responsibilities of providers.

### ***Quality of Care***

Improvements in the quality of care LEP individuals receive will also be bolstered by full implementation of the Guidance. Preliminary findings from a study sponsored by the Robert Wood Johnson Foundation, *How Language Barriers Hinder Access and Delivery of Quality Care*, demonstrate the negative consequences created by language barriers. Twenty percent of Spanish-speaking Latinos surveyed reported not seeking medical treatment due to language barriers. Furthermore, the study documented that both patients and providers believe that language barriers present immense obstacles to achieving positive health outcomes. Among the results:

- 94% of providers said that communication is a top priority in delivering quality care and cited language barriers as a major challenge to delivering that care;
- 73% of providers say that a patient's understanding of treatment advice and of their disease is the most compromised aspect of care due to language barriers;
- 72% say barriers increase the risk of complications when the provider is unaware of other treatments being used; and
- 71% say that language barriers make it harder for patients to explain their symptoms and concerns.

According to a recent study by L.A. Care Health Plan, 51% of doctors surveyed said that their patients do not adhere to medical treatments because of culture and language barriers. [\(2\)](#) When asked whether they considered language and cultural issues important in the delivery of care to patients, 71% said that it was very important and another 21% said it was important.

Overcoming language barriers can have a dramatic impact on patients' adherence to medical treatments, with an expected rise in positive outcomes and reductions in overall healthcare costs. For example, as L.A. Care found, of the physicians it surveyed:

- 82% would make use of translated material if made available to them;
- 58% would absolutely use interpreters if available to them with another 17% most likely to use them;
- 50% would like training on how to use interpreters;
- 49% would be interested in having their staff trained as professional interpreters; and
- over 40% would want training in cultural competency or materials on the topic.

Additional studies have also highlighted the relationship between linguistic access and quality of care. These studies include:

- Judith Bernstein *et al.*, *The Use of Trained Medical Interpreters Affects Emergency Department Services, Reduces Charges and Improves Follow-Up* , Boston Medical Center (2001);
- IS Wall, D. Howell, L Lo, *The health care experience and health behavior of the Chinese: a survey based in Hull* , 15 J. Public Health Med. 129 (1993);
- SA Fox, JA Stein, *The effect of physician-patient communication on mammography utilization by different ethnic groups* , 29 Med. Care 1065 (1991);
- Jeannette Naish *et al.*, *Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening* , 309 BMJ 1126 (Oct. 29, 1994);
- Louis Hampers *et al.*, *Language Barriers and Resource Utilization in a Pediatric Emergency Department* , 103 Pediatrics 1253 (June 1999);

- Aaron Manson, *Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma*, 26 Medical Care 1119 (Dec. 1988);
- Robert Wood Johnson Foundation, "How Language Barriers Hinder Access and Delivery of Quality Care", [www.rwjf.org](http://www.rwjf.org)
- The Commonwealth Fund, *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans*, [www.cmwf.org](http://www.cmwf.org).

### ***Business Case for Ensuring Linguistic Access***

In an example of the "business case" for ensuring language access, many health providers are affirmatively hiring bilingual staff. For example, in Texas, the need for bilingual employees is fueled by the boom in the Hispanic population. Hispanics now make up 32 percent of Texas' population, and health care providers are competing for their business. <sup>(3)</sup> To help meet the need for more competent bilingual health care providers, El Centro College began offering Spanish courses for medical workers.

For years, Kaiser Permanente has been recognized as a leader on these issues. Gouverneur Hospital in New York City has also identified the business case for providing interpreters, as highlighted in our report attached as Appendix B. And as mentioned in our answer to Q. 5, both L.A. Care Health Plan and Alameda Alliance for Health have made business decisions that ensuring linguistic access will bolster their organizations' financial stability.

### ***Public Awareness***

While the requirements to ensure linguistic access have existed since 1964, many doctors remain unaware of them. For example, in a study conducted by L.A. Care Health Plan, less than 24% of physicians surveyed said they were familiar with existing laws. <sup>(4)</sup> In a Provider Needs Assessment survey conducted by the University of California, Irvine, and Pacific Asian Language Services (PALS) for Health in Los Angeles, only 39% of the providers were aware of their legal obligations and 82% were inappropriately asking their patients to bring their own

interpreters. <sup>(5)</sup> In another survey by the same authors on the impact of interpreter services on the attitudes, beliefs, and behaviors of clients, 96% of patients surveyed noted that interpretation services improved their health and well-being.

<sup>(6)</sup> NHeLP has also witnessed a marked increase in requests for trainings for consumers, advocates, and providers on federal and state linguistic access requirements since the issuance of the Guidance on 2000. From NHeLP's participation in trainings and conferences, we have noticed an increased public awareness by all stakeholders regarding Title VI and its legal requirement to provide meaningful access to health care services. Thus, the Guidance has served a significant public awareness function by bringing increased attention to the issue, including the statutory requirements to provide language assistance.

<sup>(7)</sup>

Another benefit from the Guidance is the recognition of significant drawbacks when untrained interpreters, including family members/friends, can create. Because of OCR's outreach and trainings, as well as other community advocates' educational efforts, many people are much more aware of the dangers of using untrained interpreters, especially minors. Thus the Guidance has educated providers about the need for heightened awareness of the problems that can arise from the use of family members/friends and of the benefits of using trained interpreters. (See answer to Q. 2.)

**2. Have persons with limited English proficiency faced challenges or problems in accessing health care or social services following issuance of the guidance? If so, what have been the challenges or problems? Please be specific about your experiences.**

Unfortunately, despite over thirty years of enforcement and publication of the recent Guidance, many LEP individuals continue to face challenges and problems in accessing health care. And despite publication of this Guidance, a significant period during which implementation of EO 13166 was in doubt has resulted in continued challenges of LEP individuals in accessing health care. Thus, the true benefits of the Guidance have yet to be realized; we sincerely hope that additional educational and training efforts will be conducted now that the Guidance has been re-published.

There also continues to be the need for OCR to send a strong message to its recipients that they must ensure meaningful access for LEP individuals because serious problems still persist. Since issuance of the initial Guidance in August, 2000, NHeLP has been collecting "real-world" cases that illustrate the dramatic and sometimes life-threatening consequences to individuals' health and lives when linguistic access does not exist. We have included a sample of these cases below and attached additional ones as Appendix A.

### ***The Dire Consequences of Care without Linguistic Access***

As these and countless other examples illustrate, ineffective language assistance can have significant, even life-threatening, consequences.

- *a pregnant woman lost her baby when her doctor, using an untrained interpreter, failed to communicate adequately that she needed an immediate Caesarian section, and the woman returned home. Her child was ultimately stillborn.*
- *despite statements that it used a language line when interpreters were unavailable, one hospital asked a Spanish-speaking nurse to interpret for a Bosnian patient.*
- *on multiple occasions, women who did not speak English have been denied epidurals during labor and delivery.*
- *a patient underwent a battery of expensive tests for angina after an emergency room physician misunderstood his complaints of "urgina" - Russian for sore throat.*
- *a child being treated at a hospital had a feeding tube inserted without anyone explaining the procedure to his Spanish-speaking mother or obtaining her consent. When the child was sent home with an oxygen tank, no one explained to his mother how to operate it.*
- *a bilingual Spanish-speaking patient in a hospital's ICU was asked by medical staff to interpret for another ICU patient.*
- *a Spanish-speaking patient in a hospital's post-surgery ward lay on the floor for hours calling for help with no response.*

For additional case studies, see Appendix A.

### ***Using Family Members, Friends and Minors as Interpreters Is Not a Solution***

In addition to the consequences an individual may suffer because language barriers hinder understanding a diagnosis or treatment, LEP individuals continue to face significant challenges and problems when health care providers use untrained interpreters, particularly family members and/or friends to interpret for patients. Research and anecdotal information reveal many problems that result from this practice. [\(8\)](#) The widespread use of family members and friends as interpreters by health care providers is a significant problem in accessing quality care.

Adult family members and/or friends who serve as interpreters may not accurately interpret, which can limit communication between a provider and patient. Untrained interpreters are prone to omissions, additions, substitutions, volunteered answers and other problematic practices. For example, family members/friends may not understand the need for complete and accurate translation and may summarize information from the patient, inject their own opinions/observations, or impose their own values/judgments as they translate. Many untrained interpreters, family members and friends used as interpreters are themselves limited in their English language abilities and may be completely unfamiliar with medical terminology, which diminishes their capacity to accurately interpret. Further, this practice raises confidentiality questions, as many patients will not disclose sensitive or private information to family members/friends, resulting in incomplete information that can negatively impact a provider's ability to diagnose a condition.

As the Guidance recognizes, significant drawbacks arise from using family members/friends and it encourages the use of trained interpreters whenever possible. [\(9\)](#) Thus the Guidance educates providers about the need for heightened awareness of the problems that can arise from the use of family members/friends and of the benefits of using trained interpreters.

While many problems exist with the use of adult family members/friends as interpreters, additional challenges to LEP individuals arise when the interpreter is a minor. [\(10\)](#) Some of

these concerns include:

- requiring children to take on additional burdens, decision-making and responsibilities;
- causing friction and a role reversal within the family structure, which can even lead to child abuse situations; and
- violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services.

Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information.

[\(11\)](#)

Children who act as language brokers often influence the content of the messages they translate, which in turn affects the ultimate decisions of their parents.

A Los Angeles Times article about children who translate for their parents illustrates the potential for harm: a 13-year-old boy described feeling tongue-tied on a recent visit to a health clinic with his mother when the doctor asked him to explain the medicine that the doctor was prescribing to the child's mother. [\(12\)](#) The potential for harm is exacerbated when providers use children to translate in gynecological or reproductive health settings, as in this situation: a provider performing an ultrasound on a pregnant LEP patient instructed the patient's seven-year-old daughter to tell her mother that the baby was stillborn. Only when the daughter became upset and refused to interpret the message was a professional medical interpreter called.

Further exemplifying the problems of using children as interpreters, a study of 150 Vietnamese- and Mexican-American women who are or had been welfare recipients in California found that more than half (53.3%) used their children to translate for them. Most use their children for communicating with schools and government agencies, and filling out forms. More than half of the women who use their children as interpreters identified problems with this practice. The top four problems were:

- the child translated incorrectly;

- the child left out information;
- the information was too technical for the child; and
- the child was unable to properly translate due to limited English skills.

Additionally, several of the Mexican-American women reported that their children sometimes answered questions without first checking with them.

The following case study provides a first-hand account of the emotional toll interpreting takes on a child. It was written by a 17-year old junior at Galileo High School in San Francisco.

"My mom has cancer. I still remember when I accompanied her to San Francisco General Hospital for the first time last year. My older sister couldn't come home from college, so I had to get out of school. It was my turn to interpret.

"I don't much like sitting in the hospital with my mother. I'd rather be in school or hanging out with friends. But, since she does not speak English, my mom wouldn't understand what was going on without one of us there. Thankfully, my sister had been with my mom when she was first diagnosed. I don't think I could have handled that. We waited for what seemed like hours. I had just gotten up to walk around, when my mother suddenly called me back. The doctor had arrived. I explained to the doctor that my mother only speaks Cantonese, and that I would have to interpret for her.

"I also wanted to tell him that I didn't want to be there, that a public hospital in a city where so many people are not fluent in English should have someone on staff available to speak directly to my mother. But I kept that to myself. The doctor looked only at me and began to talk about my mom's medical condition. He seemed used to explaining all of this to a child. He tried to use simple words. My mom kept staring at me with worried eyes as he was speaking, not understanding a word.

"Then he said it - despite her radiation treatment, my mother's cancer would require surgery. I looked at my mom, searching for the words in Cantonese that could communicate what the doctor had explained to me. I didn't know the Cantonese terms for the organ parts he described. I didn't know how to say "chemotherapy." I didn't know how even to say "surgery." So instead, I had to resort to a crude description of what would happen. I had to tell her that there would be

needles, and knives, and incisions into her body. My mother began to weep and kept asking me if she was going to be okay. And I didn't know how to console her.

"My family left Vietnam when I was just 15 days old. Ethnically Chinese, we speak Cantonese in our home. While both of my sisters and I are completely fluent in English, my parents prefer to speak in their native language. With all of their responsibilities and the pressure to support a family in a country to which they came with nothing, as political refugees, they have had little time to take English classes. Instead, their children are their eyes and ears to the outside world.

"Now that my older sister has moved out of the house, I translate for them every single day - bills, government letters, applications, pretty much anything mailed to our house in English. While my English is very good, my parents often do not understand why I sometimes don't know what an English word means, let alone how to say it in Cantonese. They do not understand how much pressure I feel when their well-being depends on me. When my father was recently pulled over by a police officer, I was in the car and I had to speak on his behalf. But I didn't know how to translate what was on the ticket. The police officer scolded me for taking too long. When my parents have to go to the DMV to get a driver's license, either my older sister or I go with them.

"Since my mother became ill, I have felt the need to speak up not only for my parents, but also for all of my peers who share this responsibility of being a voice for their parents. I want families like mine to be able to communicate with government agencies without having to depend on children. Our families work hard jobs, pay taxes, and contribute to the community in many ways. Our parents deserve to have access to basic services.

"When people say that the government should provide services only in English, they do not understand that they may be putting their own health or safety at risk when doctors cannot communicate with patients or police officers cannot speak to residents.

"My younger sister, who is 13, is beginning to take on some of the translation responsibilities. I am glad she is around. When I move out, there will still be someone at home to translate for my parents. I don't know what will happen when she finally leaves the house too."

### ***Lost Productivity***

Another problem faced by individuals unable to access health care results from missing unnecessary work days and enduring decreased productivity. An individual who does not access needed care, especially one with a chronic or potentially debilitating condition, may ultimately face the problem of being unable to work to support his or her family, thus increasing the strain on the social welfare system. Thus, the lost productivity and work days of LEP individuals because of language barriers remain challenges to obtaining care.

When providers have not adequately planned, there is also lost productivity by those workers who are haphazardly pulled off their jobs and used to interpret. Moreover, if there is no established procedure for obtaining interpreters, or when staff or providers are unaware of the procedure for obtaining interpreters, time may be wasted in trying to identify and contact available interpreters.

Thus, contrary to the notion that the guidance has caused any challenges or problems since its issuance, it should be credited with substantially improving access to health care services for LEP persons.

**3. Have health care or social services providers faced challenges or problems in providing these services to persons with limited English proficiency as a result of this guidance? If so, what have been the challenges or problems? Please be specific about your experiences. The Secretary is particularly interested in the experiences of small providers.**

While we recognize that some providers may have faced challenges or problems in providing these services, we believe that the initial threshold OCR must address is what problems/challenges are *directly associated with the Guidance* as opposed to the expected and ongoing challenges of implementing Title VI of the Civil Rights Act of 1964. We do not believe that the challenges are new but rather, due to heightened awareness of this issue created by the Guidance, more individuals are seeking efficient and cost-effective ways to provide linguistic access.

Further, as recognized in the Guidance, no new requirements or mandates have been effectuated by the Guidance. Rather, the Guidance merely clarifies the existing responsibilities of recipients of federal financial assistance. *Since providers have been mandated to provide access to LEP individuals for over thirty-five years, OCR should not be assessing problems/challenges with implementing the Guidance but determining how to best assist providers in meeting their longstanding obligations under Title VI.*

Further, many requirements to ensure linguistic access are required by other laws and/or policies and thus challenges to ensuring linguistic access can not be solely attributable to OCR's Guidance. These include requirements for providers to comply with:

- state and local laws/ordinances regarding language assistance and/or cultural competency;
- federal and/or state contract requirements to provide language assistance and/or cultural competency; and
- the requirements of accrediting organizations.

### ***State Laws and Local Ordinances***

A number of states and localities have applicable laws and ordinances which require providing language assistance and/or culturally competent care. For localities where such requirements exist, providers have responsibilities independent of Title VI to ensure linguistic access, regardless of the Guidance.

In a 1998 study, NHeLP identified 151 state laws that require language services in health care, many tied to specific health services or providers. [\(13\)](#) Six state laws set forth a general responsibility for health care facilities to ensure proper communication with non-English speaking providers: CA, FL, IL, NJ, NY, and VT.

[\(14\)](#)

Since 1998, at least two states enacted new laws: Massachusetts now requires emergency rooms and acute-care psychiatric facilities to provide interpreters to LEP individuals; Rhode

Island requires hospitals, as a condition of licensure, to provide qualified interpreters if appropriate bilingual clinicians are not available. A listing of state law requirements addressing language and cultural needs in health care is attached as Appendix C.

### ***Contractual Requirements***

In addition to state laws and local ordinances requiring linguistic access, many states have addressed linguistic access in their contracts with health care providers. For the most part, these contracts arise in the Medicaid context. For example, states often require managed care organizations (MCOs) participating in Medicaid to provide translation services and address cultural competence, and presumably take these requirements into consideration in developing capitation rates. According to George Washington University's Center for Health Services Research and Policy, the majority of Medicaid managed care contracts or requests for proposals require MCOs to provide materials in other languages (36 states), require services for persons whose primary language is not English (31 states) or include a cultural competence requirement (25 states). [\(15\)](#)

### ***Accreditation Requirements***

To obtain accreditation, the two major healthcare accrediting organizations require linguistic access for LEP individuals. The Joint Committee on Accreditation of Healthcare Organizations (which accredits hospitals and other health care institutions) and the National Committee for Quality Assurance (accrediting managed care organizations) both require language assistance in a number of situations.

### ***Concerns regarding Costs***

One concern raised by providers is the issue of funding for ensuring linguistic access. We recognize that many small providers may not have the financial resources to provide linguistic access. And indeed, the DOJ Guidance, clarified by its October 26, 2001 memorandum, recognizes this concern by directly defining cost as one of the factors to be considered in determining whether a provider has taken "reasonable steps" to ensure meaningful access for LEP individuals. Thus, when the cost of providing linguistic access would "unduly burden" the provider (see EO 13166), the Guidance recognizes different expectations regarding linguistic access. Yet, the costs for ensuring linguistic access need not be prohibitive - a recent report from the Office of Management and Budget estimates that language services would cost only an extra .5% of the average cost per visit. [\(16\)](#) And as OMB noted,

Almost all individuals, LEP and non-LEP, need to access the healthcare system at multiple points in their lives. Making these interactions more effective and more accessible for LEP persons may result in a multitude of benefits, including: increased patient satisfaction; decreased medical costs; improved health; sufficient patient confidentiality in medical procedures; and true "informed consent " and understanding of other legal issues. [\(17\)](#)

Many of the concerns about costs could be addressed by HHS if more states were encouraged to take advantage of existing funding to provide linguistic access. As a "Dear State Medicaid Director" letter noted, federal reimbursement is available through Medicaid and SCHIP (the State Children's Health Insurance Program) for enrollees. Yet only five states -- Hawaii, Maine, Minnesota, Utah and Washington -- have created the mechanisms to provide reimbursement. If more states provided reimbursement, providers would have less concerns about costs and the costs of health care would be reduced as effective treatment would be available without unnecessary diagnostic testing, and overuse of emergency departments. We have also identified additional funding sources, outlined in our draft report in Appendix B.

A forthcoming study from The Access Project surveyed uninsured individuals who had received care in the previous year. Analysis compared those who did not need an interpreter, those who needed and received an interpreter, and those who needed but did not receive an interpreter. [\(18\)](#)

A higher proportion of individuals needing and receiving an interpreter rated their experiences with medical staff and support staff as "satisfactory" or "very satisfactory" than individuals needing but not receiving interpreters and individuals not needing interpreters. Further, individuals needing but unable to receive interpreter assistance were more likely to find their encounters with medical staff moderately but significantly more unsatisfactory than those not

needing interpreters and those needing and receiving an interpreter. Additionally, over 25% of those needing but not receiving an interpreter did not understand their medication instructions, compared with about 2% for each of the other groups.

## ***Legal Claims***

Ensuring linguistic access can also eliminate concerns of liability in legal suits and malpractice claims brought against providers and others who fail to ensure a patient understands necessary treatment. For example, in a striking California case, a 51-year old mother of seven came to America as a refugee from Laos. She was diagnosed with tuberculosis. Her disease, which was not contagious at the time, was determined to be a drug-resistant form that required long-term therapy. But Mrs. Souvannarath ceased taking the medication because the side effects led her to believe the drugs were going to kill her. County health officials - one Hmong worker and one Thai, neither of whom spoke her language - could not explain the need for treatment and a Lao interpreter was never provided. County health authorities jailed Mrs. Souvannarath for failing to take her medications. At the jail, a Hmong officer who spoke no Lao misinterpreted for her. She thought he asked if she was afraid of dying so she said "yes." The actual question was if she was thinking of killing herself, and her "yes" answer led the jail to put her on a suicide watch. She was jailed for ten months without a court order. Attorneys representing Mrs. Souvannarath subsequently filed a federal complaint for damages and equitable relief that was settled for \$1.2 million. <sup>(19)</sup> This entire situation could have been easily avoided had an interpreter been provided.

**4. Are there areas of the guidance that you believe need to be clarified or modified? If so, please explain what areas, why the area(s) need clarification or modification, and provide any suggestions for clarification or modification.**

We wholeheartedly support OCR's Guidance as proposed and believe that the clarification of Title VI will greatly facilitate the process of opening the doors to health and social services for the LEP population. Similar to the spirit of cooperation expressed by OCR in the LEP Guidance between HHS and its recipients in finding ways to overcome barriers facing LEP individuals, the following suggestions are presented with the goal of complementing and strengthening the LEP Guidance to hasten full compliance with Title VI. We will first discuss our general comments to the overall LEP Guidance. Our comments on specific provisions of the Guidance, as we submitted in 2000, are attached as Appendix D.

**Restatement of Current Law** - We fully agree with OCR that the newly released Guidance merely clarifies its current policy and interpretation of Title VI which it has been enforcing for over three decades, and we welcome the more explicit and useful provisions described in the new Guidance.

**Flexibility** - With regard to OCR's point regarding the flexibility of providers to meet their legal obligations under Title VI, we strongly recommend that OCR clearly state that such flexibility means that each facility must take whatever steps necessary to comply with the law, taking into account the particular circumstances of the provider. Although we view the Guidance as a critically important affirmative step toward removing linguistic barriers for LEP persons, we understand the Guidance to be the minimum that must be done to comply with Title VI.

**Use of Untrained Interpreters** - We recommend stronger guidance with regard to the use of untrained interpreters, such as family members or friends, particularly regarding the use of minors as interpreters. We would recommend OCR include a prohibition against use of any untrained interpreter, and any use of minors as interpreters, except in emergencies. (For specific information on this issue, see our answer to Q. 2, *supra* .)

**Competence of Interpreters** - In addition to the need to discourage the use of untrained interpreters, we concur that all interpreters must be qualified and trained to act as competent interpreters. Although there are few approved certification programs anywhere in the U.S., we would encourage OCR to recommend a minimum of 40 hours training in a qualified training program which has been advised by various professional medical interpreter associations. ( See Section II(C)(5)(b) in Appendix D)

**Written Translations** - We strongly support the inclusion of the "safe harbor" provisions to offer providers ways to ensure compliance with Title VI. As OCR recognizes, non-compliance with the safe harbors does not equate non-compliance with Title VI since one must examine the totality of the circumstances. But for providers who wish certainty of their compliance with Title VI, the safe harbors offer a means to this end.

**Oral Interpretation** - We strongly support the Guidance's recognition that oral interpreters be provided regardless of whether written translations are available. We believe that OCR should further clarify this. While the Guidance lists a number of methods for providing oral

interpretation, we believe it should specifically state that, at a minimum, telephone interpreters must be provided. OCR should inform providers about the variety of efficient and cost-effective methods of providing interpretation.

**Compliance and Enforcement** - We suggest that OCR include information in the Guidance that informs recipients of the type of uniform data collection activities that would assist them with monitoring LEP service use and Title VI compliance and OCR with its compliance responsibilities. It should include collecting and reviewing data regarding the provision of language assistance for each recipient's service provided to LEP persons, including data collected by the recipient regarding the frequency of delivery of those services, and segregating the collected data by primary language. Such uniform data collection activities would help both the recipients and OCR with their goals of reducing racial disparities in health care. [\(20\)](#) ( See Section II(F) in Appendix D)

**Civil Rights Impact Study** - We urge OCR to include a provision for a language access impact analysis. 45 C.F.R. §80.3(b)(2) requires recipients, in determining what types of services, financial aid, benefits, or facilities will be provided, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, or have the effect of defeating or substantially impairing accomplishment of the objectives of the programs. Subsection (b)(3) of the regulation also contains similar language regarding decisions regarding site locations. By recommending a civil rights impact study before making decisions that would have a major impact and/or substantially alter an LEP individual's access to health and social services, OCR would have an effective and efficient means of assuring that federal fund recipients do not make changes that would result in criteria or methods of administration that have the effect of defeating or substantially impairing an LEP person's rights under Title VI.

**Regional Enforcement of Title VI** - We commend OCR's initiative in dealing head-on with the language access problems facing the LEP population and are delighted that OCR is publicizing the release of the LEP Guidance. Because we realize that the key to success of OCR's effort is effective enforcement of the LEP Guidance, we hope that the agency will be well prepared to respond to any Title VI complaint filed in its regional offices, and is provided the necessary staffing and funding to enforce Title VI properly. We support the efforts to adequately staff regional OCR offices and the continuous training of OCR staff. We hope that each office prioritizes the prompt and effective handling of all Title VI complaints.

**Appendices** - We think that the Appendices provide useful information for recipients, especially Appendix A (the Question and Answer document) which further articulates the practical application of the Guidance. The document provides important insight into issues which the LEP Guidance does not cover. In our comments, we have suggested additional information which could be included in the Appendices.

**Opportunity for Public Input** - Similar to Executive Order 13166's mandate that the federal agencies "shall ensure that stakeholders, such as

LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input," we would recommend that OCR add language to the Guidance encouraging ongoing public input into federal financial recipients' development and implementation of written plans.

**Annual Review** - In order for increased public accountability of recipients to their clients and communities, we recommend that an annual review, to show the effectiveness of its language assistance programs, be included as a component of a model plan. The audit could assist the recipient as an outreach and public education tool for its intended beneficiaries, as well as monitor its progress towards achieving the goal of cultural and linguistic competence. It could include valuable information for the community such as the demographics of the patient population, statistics related to interpreter use and availability, translated materials, staff training, and financial reports on cultural and linguistic expenditures. One health plan, Harvard Pilgrim Health Center, produces a regular "Diversity Report" that includes a qualitative narrative of the progress and goals of the plan related to serving its diverse populations. [\(21\)](#)

**Cultural Competence** - We understand that the broader issue of "cultural competence" in health care and social services may be beyond the scope of this LEP Guidance. However, we encourage OCR seriously to consider the issuance of guidance on "cultural competence" since it too is related to ethnic and national origin discrimination under Title VI. [\(22\)](#) We believe that it would be very useful for OCR to provide guidance on this timely issue, which encompasses the topic of this Guidance: language access or competence. To ensure meaningful access to health care and social services (similar to the requirement that the services must be linguistically appropriate), the recipient must provide culturally appropriate services to all of its intended beneficiaries. Specific suggestions related to the cultural competence of staff and interpreters will be more thoroughly discussed in the relevant sections.

**5. Has the guidance been effective in identifying reasonable ways of providing services to individuals with limited English proficiency? What are some of the cost-effective ways that are used successfully to provide services for persons with limited English proficiency that are not included in the guidance? Again, the Secretary is particularly interested in the experiences of small providers.**

As noted above, many states already require linguistic access for LEP individuals in health care settings. The Guidance has been helpful in identifying reasonable ways of providing services. In addition, since issuance of the Guidance, the attention raised on this issue has led to additional research of promising practices for providing services. And a recent report documents that the costs for ensuring linguistic access need not be prohibitive - the Office of Management and Budget estimates that language services would cost only an extra .5% of the average cost per visit. [\(23\)](#) OMB cites anecdotal evidence to suggest that the average charge for this service runs at about \$20 per hour. [\(24\)](#) In the healthcare arena, the following chart documents other examples of rates for interpretation.

## Examples of Payment Rates

Program	Payment
Hawaii Medicaid (Fee-for-Service)	\$25-45/hour
Maine Medicaid (Fee-for-Service)	\$30/hour (during normal business hours); \$40 (during non-business hours)
Minnesota Medicaid (Fee-for-Service)	\$12.50/15-minute intervals
Utah Medicaid (Fee-for-Service)	\$35/hour - face-to-face (1 hr. min.)

\$22/hour - telephonic

Washington Medicaid (Fee-for-Service)	\$33.60-\$39/hour
Alameda Alliance for Health (Oakland, CA)	\$100/minimum 2 hours

Stipends to Providers:

- \$30 Face-to-Face
- \$20 Telephonic

Multi-cultural Association of Medical Interpreters (Orinda, CA)  
 \$45-\$60/hr. (with NY counted contract rates)

The National Health Law Program, pursuant to a grant from The Commonwealth Fund, will release a report in late April identifying both promising practices and funding sources for ensuring linguistic access in health care. As identified in the report, numerous sources of funding and support are available to cover costs associated with providing language assistance for Limited English Proficiency (LEP) individuals in the health care context. As described below, the federal government, states, foundations and non-profit organizations will all pay for these services in whole or in part.

## Federal Government

- **Medicaid/SCHIP** -- Under both programs, Federal matching funds are available for state expenditures on language assistance for recipients, including staff and contract interpreters, or a telephone service. See Dear State Medicaid Director Letter (August 31, 2000)

available at

<http://www.hcfa.gov/Medicaid/smd83100.htm>

- **HHS Office of Minority Health (OMH)** -- OMH provides funding for language assistance through the Bilingual/Bicultural Service

Demonstration Grant Program. It awards funds to community-based organizations to provide language assistance to LEP individuals seeking health care.

*See* 42 U.S.C. § 300u-6 (b)(7), (e)(1).

- **HHS Health Resources Services Administration (HRSA)** -- While not directly funding language assistance services, HRSA identifies and promotes the replication of innovative community-based models under its "Models that Work" campaign. The campaign highlights programs that have demonstrated efficient and successful ways to assist LEP individuals in accessing health care.

*See*

<http://bphc.hrsa.gov/mtw>

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- **HHS HRSA Bureau of Primary Health Care** - Under a reauthorization bill currently being debated in Congress, community health centers would receive specific funding for interpreters.

### State/Local Government

- **State Departments of Health (DOH) and Departments of Social Services (DSS)** -- Many states provide funds for language assistance through these departments, often focused on individuals seeking assistance at state offices. South Carolina DSS, however, provides language assistance anywhere its clients need it, including medical settings.

- **County Health Departments** -- Some county health departments (such as Fayette Co., KY) provide funding for language assistance. Assistance may be limited to those who access benefits at the county office.

- **Refugee Offices** -- Some state refugee offices provide funds to refugee organizations for language assistance to refugees.

### Other

- **Foundations** -- A number of foundations provide funds for language assistance services, often in specific health care fields such as treatment of HIV, diabetes or cancer. For example:

- The Fund for Immigrants and Refugees awards grants to develop interpreter training programs and other activities designed to dismantle language and cultural barriers for LEP individuals.
  
- Grantmakers Concerned with Immigrants and Refugees which offers a comprehensive website including an interactive map displaying statistics on immigrants and refugees in all 50 states. See <http://www.gcir.org>.
  
- The California Endowment has made cultural competence and linguistic access a major funding initiative, funding research, education, organizational development and standards of interpreter services, language access policy and advocacy, and interpreter training and consumer education.
  
- The Robert Wood Johnson Foundation recently initiated *Hablamos Juntos* (We Speak Together) which will provide grants to health care provider organizations to develop and tests systems of medical interpretation, signage, and print materials across multiple delivery points within the health care system..
  
- **Non-profit organizations** -- Non-profit organizations may provide language assistance. But it is important to note, however, that problems may arise from over-reliance on free services from public and private agencies whose interpreters may not be trained in either the ethics of interpreting or medical interpretation. Further, reliance should not be placed on non-profit organizations to provide interpretation unless they are funded to do so.

The report also highlights fourteen promising practices from a range of health care settings -- statewide Medicaid/SCHIP reimbursements, managed care organizations, hospitals, community based organizations and educational models. In addition, a listing of over 60 programs of a variety of models are also included. A draft of this report is attached as Appendix B. Among the programs highlighted in the report:

### **Statewide Medicaid/SCHIP Reimbursement:**

The Hawaii, Maine, Minnesota, Utah, and Washington Medicaid agencies obtain federal matching payments for language services provided to Medicaid and State Children's Health Insurance Program enrollees. The report profiles Minnesota and Washington. [\(25\)](#)

### **State and Local Government Initiatives:**

- The State of Massachusetts has implemented an emergency room interpreter law that requires general hospitals and acute psychiatric hospitals to offer no-cost interpreters to persons using their emergency rooms and in-patient psychiatric facilities. The State legislature appropriated \$1.1 million to implement the program next year.

- The Hennepin County Office of Multi-Cultural Services is engaged in a number of activities to coordinate interpreters with health care providers.

### **Managed Care Organizations:**

- In addition to paying for trained medical interpreters, the Alameda Alliance for Health in Oakland, California has instituted a stipend policy to encourage physicians and physician extenders to use professional medical interpreters. The Alliance pays \$30 per visit using an in-person interpreter and \$20 per visit using a telephone interpreter.

- The L.A. Health Care Plan has developed a Health Care Interpreter Pilot Program, which offers training and certification to L.A. Health Care providers and staff.

### **Hospitals:**

- Gouverneur Hospital, along with the New York City Health and Hospital Corporation and the Center for Immigrant Health of the NYU School of Medicine, is operating a remote simultaneous medical interpreting program.

- Maine Medical Center in Portland has worked with the United States Office for Civil Rights to develop a tailored plan for providing language access that reflects the suggestions made by the HHS Office for Civil Rights in its LEP Guidance.

- Eight health care facilities in Dane County, Wisconsin are operating a collaborative to develop standardized interpreter policies and assess individuals' abilities to be competent interpreters for the collaborating facilities.

### **Community Based Organizations:**

- Community based organizations are working with hospitals and individual health care providers to make qualified interpreters available to them. The language banks of the New York Multi-cultural Association of Medical Interpreters and the Northern Virginia Area Health Education Center are described.

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### **Educational Models:**

- Entities are focusing on making educational modules and courses available so that the number of competent interpreters can be

increased. This report highlights the *Bridging the Gap* curriculum developed by the Cross Cultural Health Care Program in Seattle, which is being used nationwide, and three programs that are benefitting local communities: a home study certification program operated out of the HealthReach Community Care Clinic in Waukegan, Illinois and for-credit courses in medical interpreting that are being offered by colleges in Massachusetts and South Carolina.

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For additional information on these and other programs, see the full text of the report in Appendix B. In addition, the California Primary Care Association (CPCA) recently released *Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices*. This report outlines steps that members of CPCA - primarily community health centers - have taken to ensure linguistic access of LEP individuals.

[\(26\)](#)

### **6. What technical assistance from the Office for Civil Rights (OCR) and other components of HHS would be most helpful to recipients/covered entities?**

We would suggest that OCR conduct trainings in each region for OCR regional staff and for recipients of federal financial assistance to work on effective methods of implementing the Guidance. We also suggest that OCR, through funding and technical assistance, encourage each regional office to undertake education and outreach to providers, particularly small providers. Although we are aware that regional offices respond to requests for Title VI trainings from community groups and providers, (to which NHeLP has also participated), we would encourage regional offices to convene conferences such as the one recently held in Los Angeles on March 6, 2002. The event was extremely successful and drew several hundred participants. Such educational efforts are critical to ensure that the public is aware of their rights and federal fund recipients are aware of their responsibilities.

In addition, OCR should work with the Centers for Medicare and Medicaid Services (CMS) to undertake specific education and technical assistance for states to adopt mechanisms to obtain federal funding for linguistic access as is currently available under Medicaid and SCHIP. One of our prior recommendations to the Guidance was to include additional information regarding the availability of federal matching funds for any language assistance services for Medicaid and SCHIP beneficiaries, such as including the "Dear State Medicaid Letter" dated August 31, 2000 re: LEP in Appendix A of the Guidance. (See Section II(C)(2) in attached Appendix D.) Only five states currently have established reimbursement mechanisms -- Hawaii, Maine, Minnesota, Utah and Washington. Further written guidance from OCR/CMS regarding the proper

procedures for establishing such reimbursement from CMS would be extremely helpful. NHeLP has received calls from advocates in other states with questions about the process to seek federal funding for language assistance services and is working with advocates to obtain federal matching funds. We believe that many of the concerns raised by providers about the costs of ensuring linguistic access will be alleviated if funding were readily available to pay for interpreters and translators.

Finally, it would be extremely helpful if OCR would work with other organizations to collect and disseminate model programs and "best practices" which providers have used to provide language assistance services for LEP persons. NHeLP has received such requests and strongly believes that an established clearinghouse or resource bank would allow increased sharing of information.

**7. In providing services to persons with limited English proficiency, what costs have health care or social services providers incurred in providing translation, interpreter or other language services? Please be specific about your experiences. The Secretary is particularly interested in the experiences of small providers. In health care or social services providers have not yet provided translation, interpreter or other language services for persons with limited English proficiency, what costs are anticipated? Please provide the basis for your estimate.**

We recognize that providers incur costs to provide linguistic access, yet that is a specific condition upon which the receipt of federal financial assistance is predicated. Thus, providing linguistic access is an expected cost for providers participating in federal programs. Further, as stated above, the Office of Management and Budget estimates that language services would cost only an extra .5% of the average cost per visit. [\(27\)](#)

Many of the concerns about cost arise from the lack of established mechanisms to reimburse providers. As mentioned above, a "Dear State Medicaid Director" letter from August 31, 2000, specified that federal reimbursement is available for Medicaid and SCHIP enrollees yet only five states have set up the necessary billing codes to allow reimbursement.

As the Guidance recognizes, the actual costs incurred by providers will necessarily depend on the nature and quantity of encounters a provider will have with LEP individuals. And as the Executive Order recognizes, providers will not have to endure any undue burdens to ensure linguistic access -- if the costs of providing interpreters would be too costly when balanced with the needs for linguistic access, the provider will not have to pay for the interpreter. The NHeLP report referred to in Q.5 also identifies some cost estimates for providing linguistic access, as does the forthcoming report from the Office of Management and Budget.

### ***Lack of Interpreters Increases the Costs of Care***

In addition to the direct costs of hiring interpreters and translators, the costs of not having linguistic access should be considered in evaluating

the Guidance. The most recent Census data publicly available documents over 32 million individuals who speak a language other than English at home. It is expected by all that this number will increase once the 2000 Census data is tabulated. While this reality can be viewed as a cultural strength of our nation, in the health care context, an individual's limited English proficiency can result in the provision of care based on inaccurate or incomplete information. Less obviously, it also increases the cost of care. Language barriers are a primary reason why non-English speaking populations disproportionately underutilize cost-effective preventive care. In addition, an inability to comprehend the patient mixed with a fear of liability leads some doctors to order expensive, otherwise avoidable tests.

Individuals who can not communicate with their providers often delay seeking necessary care. <sup>(28)</sup> Language barriers are frequently cited by immigrants as a major problem in obtaining health care, as is actual or perceived discrimination by providers. According to the 1990 National Health Interview Study, immigrants, especially those who do not speak English, were far less likely to have seen a doctor than were citizens.

<sup>(29)</sup>

Yet, individuals with unmet healthcare needs are more prone to suffering exacerbated health problems that require costly and avoidable emergency treatments. The unmet needs of individuals, in the aggregate, result in a health care system that is burdened by an increasing number of people with complex or multiple - and often preventable - chronic conditions. <sup>(30)</sup> This creates a strain on personnel, resources, and financing. According to the Robert Wood Johnson Foundation, the unmet needs of individuals with chronic conditions lead to exacerbated health problems, costly treatments, and unnecessary pain and suffering.

<sup>(31)</sup>

The lack of access to care takes a serious toll on one's health. <sup>(32)</sup> Individuals with reduced access to health care over many years, and in some cases for even relatively short periods, suffer deficiencies in their health as compared to individuals with regular access. Data on this issue is most prevalent when analyzing the lack of access of uninsured individuals. Their lack of access mirrors that of LEP individuals (both insured and uninsured) because neither group can access needed care - the uninsured because of barriers created by a lack of insurance and LEP individuals because of language barriers. For example, the uninsured are hospitalized 50%-70% more than the insured for "avoidable hospital conditions," such as pneumonia, and are more than twice as likely to be hospitalized for conditions which should be treated on an outpatient basis, like diabetes and malignant hypertension. <sup>(33)</sup>

For individuals whose language barriers create an inability to understand their diagnosis or treatment, serious health consequences can result. For example, a Russian speaking patient profiled by the PBS program *Healthweek* <sup>(34)</sup> was diagnosed with diabetes. Because the doctor did not ensure the patient understood his diagnosis and treatment, the patient left without knowing he had to change his diet to avoid further complications. A few months later, with his blood sugar levels dangerously high, and suffering bouts of dizziness and weakness, the patient returned to the doctor. With family members interpreting, he was finally able to understand his diagnosis. If he had not received treatment, he faced life-threatening complications - diabetes is the leading cause of new cases of blindness in adults age 20-74, of end-stage chronic irreversible kidney disease, and of lower-extremity amputations (not related to injury).

<sup>(35)</sup>

The LEP patient's risk of complications is easily remedied - and further costs avoided - if interpretation is provided to explain the diagnosis and treatment.

Many other examples exist regarding diseases that require early treatment to alleviate further complications and costs. By providing interpreters

to LEP individuals diagnosed with these diseases, the result can be a better quality of life as well as decreased health care costs. For example, early detection of cancer is crucial to obtaining life-saving treatment. Treatment of late-stage cancers yields a lower rate of remission and recovery than early intervention. And the costs of terminal care significantly exceed initial diagnosis and treatment costs. <sup>(36)</sup> For individuals diagnosed with end-stage renal disease, dialysis treatments can enable them to maintain normal functioning and hold most symptoms at bay. Without dialysis, they will suffer recurrences of renal failure, or develop hypertension, which can lead to strokes or cerebral bleeding. Strokes or cerebral bleeding in turn induce a deterioration of health status, including the possibility of paralysis or loss of functional ability - conditions which would not have resulted had an individual received sufficient interpretation to explain the need for ongoing utilization of preventive care. In the absence of such interpretation, the costs of treating the complications often outweigh the costs of providing an interpreter.

In addition, a study conducted at the Boston Medical Center documents that the use of trained medical interpreters impacts Emergency Department (ED) services and reduces charges. <sup>(37)</sup> Individuals who needed but did not receive interpretation returned to the ED more frequently and visited out-patient clinics less than those who obtained interpretation. In addition, these individuals received the fewest ED services and spent the least time in the ED, indicating that much of their treatment did not need ED attention but could have been addressed in clinics. Overall, the use of trained medical interpreters can increase the appropriate use of clinics, decrease expensive repeat ED visits, decrease the cost of care, and decrease disparities between English and non-English speakers in intensity of medical care received.

<sup>(38)</sup>

**8. Some may assert that the guidance has materially assisted in achieving the goal of access to health or social services by limited English proficient individuals. Others may assert that the guidance has unintentionally had the opposite effect. Is there actual experience to support either view? Please describe.**

The Guidance has materially assisted in achieving the goal of access. NHeLP's recent survey found over 60 programs, newly formed or recently reinvigorated, working to remove barriers for LEP individuals. The Guidance has certainly raised awareness of this issue and brought focused attention by both providers and advocates to develop and implement effective and cost-efficient methods of providing language assistance.

NHeLP has seen a marked improvement in response from providers when they have been informed of their legal obligations under Title VI. The Guidance has been instrumental in our advocacy efforts on behalf of LEP persons to secure linguistic access to health care services. The ability to use the Guidance as the federal government's official interpretation of the requirements pursuant to Title VI cannot be overemphasized. It has been critical in garnering the attention of hospital administrators and managed care plans and persuasive in increasing access to health care services for many LEP persons. For example, in Los Angeles County, advocates have been meeting with the Director of the Los Angeles Department of Health and have successfully convinced the government officials to post notices in 24 languages at all of its health care facilities about the provision of free interpreters.

We are also aware of several OCR complaints which have been resolved using the model language assistance program provided in the guidance as a template in resolution agreements. <sup>(39)</sup> Therefore, we strongly believe that the guidance has been invaluable in increasing

access to health care services for LEP individuals.

**9. Based on your experience, does the guidance and/or OCR's application of the guidance in practice, strike the right balance with respect to the factors enunciated in the Department of Justice's October 26, 2001 memorandum: (1) the number or proportion of limited English proficient persons, (2) the frequency of contact with the program, (3) the nature and importance of the program, and (4) the resources available? Please note that these factors are discussed in greater detail in the Department of Justice memorandum. In particular, in considering the resources available, does the guidance and/or OCR's application of the guidance adequately factor in the costs of providing translation, interpreter or other language services to limited English proficient individuals, as well as the resources available to the recipient/covered entity?**

Similar to the October 26, 2001 Department of Justice (DOJ) memorandum, the guidance stresses flexibility in determining compliance with Title VI. It sets out similar factors as enumerated by DOJ: the size of the recipient, the size of the eligible LEP population it serves, the nature of the program or service, the objectives of the program, the total resources available to the recipient, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. In fact, it appears to take into account the resources available to a greater extent given the three additional factors it includes: the size of the recipient and the objectives of the program, and the frequency of languages encountered.

Given the guidance's further explanation that there is no "one size fits all" and that assessment is made on a case by case basis, it is clear that the cost of providing language services and the resources of the recipient is given considerable weight in determining compliance with Title VI. Throughout the guidance, the issue of small providers is addressed more directly than the DOJ memo and provides useful clarifications regarding their obligations. For example, in section C(4) of the guidance, it provides an example of how OCR would assess "meaningful access" with regard to a sole practitioner. <sup>(40)</sup> In section F, the guidance explicitly states that smaller recipients, "such as sole practitioners, those with more limited resources, and recipient/covered entities who serve small numbers of LEP persons on an infrequent basis will have more flexibility in meeting their obligations to ensure meaningful access for LEP persons."

[44](#)

Moreover, in Appendix A, one of the question and answers deals directly with the guidance's application to small providers, "How Does the Guidance Affect Small Practitioners and Providers?"

Although we believe that the guidance has struck a fine balance between the various factors, we are concerned that the factors may not be weighed evenly and that only one of the factors, the cost or resources available, has been given more attention than the other factors. The fact that this notice focuses much of its request for comments on the issue of costs of providing language assistance, especially on small providers, reflects an overemphasis on this one factor. We feel that because the costs involved has been the main criticism of the guidance, it has received excessive attention and has diverted the discussion away from the serious need for language assistance for LEP persons and finding ways to meet that need towards finding ways or excuses for providers to avoid their obligations. Therefore, we believe that the guidance has established reasonable criteria which should be evaluated equally.

The Guidance also provides further helpful instruction than the DOJ memo in setting out four key elements to ensure meaningful access. However, it should specifically ensure meaningful access. For example, the guidance should state that they are mandatory minimum requirements. It also does not mention as one of the major elements the need for community input, such as through a Community Advisory Committee or Board which could provide valuable input into the needs assessment. Community-based organizations located in the recipient's service area could provide much assistance to the recipient in any development, implementation and monitoring of its language assistance program.

With regards to factor (1), we believe that assessment is the key factor to ensure meaningful access to LEP individuals. If a recipient/covered entity does not assess the numbers - and needs - of the LEP population it serves, it will be unable to effectively provide meaningful access. The list OCR included in the Guidance on how a recipient/covered entity should assess language needs is helpful in explaining the process of conducting an assessment. However, in the list of factors, we recommend that OCR add a requirement that recipients/covered entities should also identify potential sources of new translation resources and ensure that the recipient have an ability to collect, report and review data on the racial and ethnic composition and primary languages of the recipient's service area.

We also suggest that, within the contours of flexibility, the Guidance clarify that OCR expects that no federal fund recipient will rely on impressions or word of mouth in reaching conclusions regarding the need to provide translation services, but rather each will periodically engage in an objective community needs assessment to accurately verify the extent of need. This will assist the federal fund recipient in operational and clinical planning and will enable the facility to justify its translation policies to OCR.

Appendices

A - NHeLP, *Executive Order 13166 and Its Implementing Guidance Are Vital to Reduce Medical Harm to LEP Individuals*

B - Draft Report, Forthcoming from The Commonwealth Fund, April 2002

*Providing Services to Limited English Speakers: Examples From the Field*

C - State law requirements from Appendix G, NHeLP's *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (January, 1998), published by The Henry J. Kaiser Family Foundation with selected updates from 1998.

D - NHeLP Comments on OCR Guidance, 2000

Appendix A

Executive Order 13166 and Its Implementing Guidance

Are Vital to Reduce Medical Harm to LEP Individuals

- a pregnant woman lost her baby when her doctor, using an untrained interpreter, failed to communicate adequately that she needed an immediate Caesarian section, and the woman returned home. Her child was ultimately stillborn.
- despite statements that it used a language line when interpreters were unavailable, one hospital asked a Spanish-speaking nurse to interpret for a Bosnian-speaking patient.
- a patient underwent a battery of expensive tests for angina after an emergency room physician misunderstood his complaints of "urgins" - Russian for sore throat.
- a child being treated at a hospital had a feeding tube inserted without anyone explaining the procedure to his Spanish-speaking mother or obtaining her consent. When the child was sent home with an oxygen tank, no one explained to his mother how to operate it.

Events like these should not be occurring more than thirty years after enactment of Title VI. Over twenty-five years ago, the Supreme Court decided in *Lau v. Nichols* that recipients of federal financial assistance have an affirmative responsibility under Title VI to provide individuals with limited English proficiency (LEP) a meaningful opportunity to participate in public programs. [Lau v. Nichols](#) Yet, as the examples above and in the Appendix demonstrate, it is often impossible to provide even adequate, much less quality, care without the ability to communicate clearly with the patient. This fact alone offers a compelling human reason for the Administration to reaffirm Executive Order 13166 and its implementing guidance, including the one from the Department of Health and Human Service's (HHS) Office for Civil Rights (OCR).

The need for Executive Order 13166 and its implementing guidance cannot be overstated. LEP individuals - many of whom initially enter the United States as refugees and asylees - endure restricted access to critical public health, hospital and medical services which they often desperately need. The most recent Census data publicly available documents over 32 million individuals, over one in nine Americans, speak a language other than English at home. [Census.gov](#) While this reality should be viewed as a cultural strength of our nation, in the health care context an individual's limited English proficiency often results in the provision of care based on inaccurate or incomplete information. This is not only unhealthy, but often more expensive. An inability to comprehend the patient, mixed with a fear of liability, leads some doctors to order expensive, otherwise avoidable tests. Conversely, because of communication problems, non-English speakers often avoid seeking treatment until it is absolutely necessary, which disproportionately causes them to underutilize cost-effective preventive care.

Some healthcare providers have expressed concerns about the financial issues associated with providing language assistance. Yet the real problem is not a lack of funds, but a lack of information on available reimbursement. An August 31, 2000 Dear State Medicaid Director letter from the Health Care Financing Administration (HCFA) informed states that federal matching administrative funds are available for expenditures on both oral and written translation activities and services in Medicaid and SCHIP. This is so whether language assistance services are provided by staff interpreters, contract interpreters, or through a telephone service. Any state that opts to provide language assistance as a covered service under its State Plan would obtain an even higher matching rate. Consequently, the obligation to comply with Title VI by providing meaningful access to LEP patients is not an unfunded mandate. The money is there. States should be encouraged to notify providers of this fact and build effective reimbursement mechanisms and rates into their systems.

Indeed, many states have independently recognized the needs of LEP individuals and require language assistance in certain categories of health services, especially mental health and long term care. Some states - including California, New York, Massachusetts and Washington - have language access laws addressing assistance to LEP individuals. Many others provide language assistance services with funds from state Departments of Health, refugee resettlement programs, foundations, and payments from disproportionate share hospital and charity care.

Title VI never imposed a one-size-fits-all mandate on how providers must serve LEP individuals, and Executive Order 13166 and the OCR guidance do not change that. OCR repeatedly stresses flexibility for small providers and its legal obligation to seek voluntary compliance. Those who serve small numbers of LEP individuals or serve them on an infrequent basis will have substantial flexibility in deciding how to provide language assistance.

We therefore urge the Administration to take this opportunity to reaffirm its commitment to improving access to health care by supporting implementation of Executive Order 13166 and the requisite guidance from each executive agency. These policies will have a profound positive impact on ensuring that all individuals, regardless of language, are afforded quality care and that disparities in health care access and outcomes due to language barriers are addressed by federal fund recipients.

**Appendix A: the Consequences of Ineffective Language Assistance**

The following are additional actual examples of the consequences of a lack of language assistance. As these and countless other examples illustrate, ineffective language assistance can have significant, even life-threatening, consequences.

- A Korean woman appeared for a gynecology exam, but no interpreter or language line assistance was provided. The clinician used the 16-year-old son of a complete stranger to translate.
- A woman requiring treatment for a uterine cyst was unable to receive treatment on two separate occasions because an interpreter was unavailable.
- A man suffering from a skin condition requiring laser treatment underwent treatment for over a year. The man endured days of pain after each treatment, but was unable to communicate this because he was never provided with an interpreter. Only after a community organization intervened did the clinic understand the patient's pain and adjust the treatment.

- A Russian-speaking woman experienced life-threatening complications from prescribed medications. Without an interpreter or use of a language line, doctors in the emergency room were unable to treat her. Only because a Russian-speaking young girl happened by and agreed to help were doctors able to save the woman's life.

- An elderly Vietnamese-speaking man visited a dental clinic for treatment. Without an interpreter, the man was told to sign an English consent form asking if he agreed to the extraction of a large number of teeth. The man placed a mark in the signature space, was placed under anaesthesia and, only after the procedure, found out what had been done.

- A Russian-speaking woman's nine-year-old son had to translate before and after his mother's angioplasty. The hospital refused to use a language line and the child translated for several hours each time.

- A refugee from Laos, fleeing persecution in her own country, mistakenly did not take tuberculosis medication. She was jailed for ten months on the orders of a county health officer, without a proper court order, after the county health department sent workers to visit her who did not speak her language - one was Hmong and the other was Thai.

- Many Spanish-speaking immigrants, eligible for health care from county hospitals and clinics on a sliding scale basis, paid full out-of-pocket fees because eligibility materials were not provided in Spanish.

- A 36-year-old Laotian woman, residing in a county nursing facility for nearly five years, was never provided an interpreter, could not communicate with nursing staff and was not informed about alternative services in the community, which would have cost less than the nursing facility.

- An elderly Chinese immigrant was forced to remain for over one year in a psychiatric institution because she was not provided an interpreter and could not communicate her desire to leave. Once she was connected to a Chinese-speaking community-based social worker, she was able to leave the psychiatric facility for a community care facility with Chinese-speaking staff.

- A relative interpreting for an LEP patient failed to interpret adequately. Based on the misinformation conveyed, the doctor scheduled the patient for surgery. On the morning of the procedure, a trained interpreter conveyed information that showed that the surgery was not only unnecessary, but likely to be harmful to the patient.

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Appendix C

Summary of State Law Requirements Addressing Language and Cultural Needs in Health Care (Appendix G)

from NHeLP's *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (January, 1998), published by The Henry J. Kaiser Family Foundation

State	Provision	Requirements
AL	Alaska Stat. §§ 47.30.735, 745	During 30 and 90 day involuntary commitment hearings, patients have the right to an interpreter.
Alaska Stat. § 47.30.860	When practicable, notices and documents served on mental patients must be explained in a language understood by the patient or the patient's adult designee.	
Alaska Stat. § 47.30.855	Patient rights must be explained in languages understood by mental patients.	
Alaska Stat. § 47.30.675	All applicants for voluntary treatment must receive an explanation of rights in languages that they understand.	
AK	25 Ark. Code. Ann. §15-101	Non-English speaking persons are entitled to the assistance of interpreters in administrative proceedings. If an individual cannot afford to pay for an interpreter, the agency may appoint one.
AZ	Ariz. Admin. Code § R9-21-305(B)(9)	Case management services employed by the Department of Health Services must assess communication skills of each eligible mentally ill client, including clients' abilities to read, hear, understand, and communicate.

CA
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22 Cal. Code Regs. § 98211(c)	Recipients of state funds may not discriminate against ethnic minorities by failing to provide alternative communication services for individuals who are unable to read, speak or write in the English language, except when the state determines that such a requirement would be in the best interests of the individual.
Cal. Health and Safety Code § 1259	General acute care hospitals must provide language assistance services for language groups that comprise 5% or more of the facility population. Acute care hospitals must develop policies on the provision of interpreter services to LEP patients and must review the effectiveness of these services annually.
Cal. Welfare and Institutions Code §§ 5804, 5868	County mental health demonstration programs and children's mental health programs must make provisions for staff with necessary linguistic skills to remove barriers to mental health care for non-English speaking patients.
22 Cal. Code of Regs. § 73501	Intermediate Care Facilities must use interpreters and other methods to ensure adequate communication between staff and patients.
Cal. Well. and Inst. Code	§ 14552(e) An adult day care provider serving a "substantial number" of participants of a particular racial group, must employ staff of that particular racial or linguistic group at all times. The term "substantial number" shall be determined by the local health officer.
22 Cal. Code of Regs.	§ 54401 Adult day care centers must include ethnic and linguistic staff as indicated by participant characteristics.
Cal. Gov't Code § 11513(d)	States must make available certified interpreters to non-English speaking individuals upon request to interpret at administrative hearings.
Cal. Well. and Inst. Code § 7290 et seq.	

## NHeLP Comments to HHS' Office for Civil Rights on Limited English Proficiency Guidance

State and local agencies must provide bilingual services to non-English speaking persons. Local agencies must provide services for languages spoken by substantial numbers of non-English speaking persons, defined as 5 percent or more of the population served by a state or local facility. Both state and local agencies must employ sufficient bilingual personnel to provide such services.

9 Cal. Code of Regs. § 862, 22 Cal. Code of Regs. §§ 70577, 71507, 72453, 73391, 73392, 73393, 73394, 73395, 73396, 73397, 73398, 73399, 73400, 73401, 73402, 73403, 73404, 73405, 73406, 73407, 73408, 73409, 73410, 73411, 73412, 73413, 73414, 73415, 73416, 73417, 73418, 73419, 73420, 73421, 73422, 73423, 73424, 73425, 73426, 73427, 73428, 73429, 73430, 73431, 73432, 73433, 73434, 73435, 73436, 73437, 73438, 73439, 73440, 73441, 73442, 73443, 73444, 73445, 73446, 73447, 73448, 73449, 73450, 73451, 73452, 73453, 73454, 73455, 73456, 73457, 73458, 73459, 73460, 73461, 73462, 73463, 73464, 73465, 73466, 73467, 73468, 73469, 73470, 73471, 73472, 73473, 73474, 73475, 73476, 73477, 73478, 73479, 73480, 73481, 73482, 73483, 73484, 73485, 73486, 73487, 73488, 73489, 73490, 73491, 73492, 73493, 73494, 73495, 73496, 73497, 73498, 73499, 73500, 73501, 73502, 73503, 73504, 73505, 73506, 73507, 73508, 73509, 73510, 73511, 73512, 73513, 73514, 73515, 73516, 73517, 73518, 73519, 73520, 73521, 73522, 73523, 73524, 73525, 73526, 73527, 73528, 73529, 73530, 73531, 73532, 73533, 73534, 73535, 73536, 73537, 73538, 73539, 73540, 73541, 73542, 73543, 73544, 73545, 73546, 73547, 73548, 73549, 73550, 73551, 73552, 73553, 73554, 73555, 73556, 73557, 73558, 73559, 73560, 73561, 73562, 73563, 73564, 73565, 73566, 73567, 73568, 73569, 73570, 73571, 73572, 73573, 73574, 73575, 73576, 73577, 73578, 73579, 73580, 73581, 73582, 73583, 73584, 73585, 73586, 73587, 73588, 73589, 73590, 73591, 73592, 73593, 73594, 73595, 73596, 73597, 73598, 73599, 73600, 73601, 73602, 73603, 73604, 73605, 73606, 73607, 73608, 73609, 73610, 73611, 73612, 73613, 73614, 73615, 73616, 73617, 73618, 73619, 73620, 73621, 73622, 73623, 73624, 73625, 73626, 73627, 73628, 73629, 73630, 73631, 73632, 73633, 73634, 73635, 73636, 73637, 73638, 73639, 73640, 73641, 73642, 73643, 73644, 73645, 73646, 73647, 73648, 73649, 73650, 73651, 73652, 73653, 73654, 73655, 73656, 73657, 73658, 73659, 73660, 73661, 73662, 73663, 73664, 73665, 73666, 73667, 73668, 73669, 73670, 73671, 73672, 73673, 73674, 73675, 73676, 73677, 73678, 73679, 73680, 73681, 73682, 73683, 73684, 73685, 73686, 73687, 73688, 73689, 73690, 73691, 73692, 73693, 73694, 73695, 73696, 73697, 73698, 73699, 73700, 73701, 73702, 73703, 73704, 73705, 73706, 73707, 73708, 73709, 73710, 73711, 73712, 73713, 73714, 73715, 73716, 73717, 73718, 73719, 73720, 73721, 73722, 73723, 73724, 73725, 73726, 73727, 73728, 73729, 73730, 73731, 73732, 73733, 73734, 73735, 73736, 73737, 73738, 73739, 73740, 73741, 73742, 73743, 73744, 73745, 73746, 73747, 73748, 73749, 73750, 73751, 73752, 73753, 73754, 73755, 73756, 73757, 73758, 73759, 73760, 73761, 73762, 73763, 73764, 73765, 73766, 73767, 73768, 73769, 73770, 73771, 73772, 73773, 73774, 73775, 73776, 73777, 73778, 73779, 73780, 73781, 73782, 73783, 73784, 73785, 73786, 73787, 73788, 73789, 73790, 73791, 73792, 73793, 73794, 73795, 73796, 73797, 73798, 73799, 73800, 73801, 73802, 73803, 73804, 73805, 73806, 73807, 73808, 73809, 73810, 73811, 73812, 73813, 73814, 73815, 73816, 73817, 73818, 73819, 73820, 73821, 73822, 73823, 73824, 73825, 73826, 73827, 73828, 73829, 73830, 73831, 73832, 73833, 73834, 73835, 73836, 73837, 73838, 73839, 73840, 73841, 73842, 73843, 73844, 73845, 73846, 73847, 73848, 73849, 73850, 73851, 73852, 73853, 73854, 73855, 73856, 73857, 73858, 73859, 73860, 73861, 73862, 73863, 73864, 73865, 73866, 73867, 73868, 73869, 73870, 73871, 73872, 73873, 73874, 73875, 73876, 73877, 73878, 73879, 73880, 73881, 73882, 73883, 73884, 73885, 73886, 73887, 73888, 73889, 73890, 73891, 73892, 73893, 73894, 73895, 73896, 73897, 73898, 73899, 73900, 73901, 73902, 73903, 73904, 73905, 73906, 73907, 73908, 73909, 73910, 73911, 73912, 73913, 73914, 73915, 73916, 73917, 73918, 73919, 73920, 73921, 73922, 73923, 73924, 73925, 73926, 73927, 73928, 73929, 73930, 73931, 73932, 73933, 73934, 73935, 73936, 73937, 73938, 73939, 73940, 73941, 73942, 73943, 73944, 73945, 73946, 73947, 73948, 73949, 73950, 73951, 73952, 73953, 73954, 73955, 73956, 73957, 73958,

22 Cal. Code of Regs.	§§ 79111, 79113	Chemical dependence recovery hospitals must post notice of patients rights in English or the predominant language of the community and must explain these rights in a language or manner understood by the patient.
Cal. Well. and Inst. Code	§ 4503	State hospitals and community care facilities must post notice of the rights of developmentally disabled persons in Spanish and English.
Cal. Health and Safety Code § 1599.74	Department of Health Licensing is directed to translate enumerated patient rights into Spanish, Chinese, and every other language spoken by 1% or more of the state's nursing home population. Nursing facilities must give translated versions to non-English-speaking patients.	
Cal. Health and Safety Code § 124300	Local health departments are directed to make family planning pamphlets and circulars available in languages spoken by 10% or more of the county's population.	
16 Cal. Code of Regs.	§ 1003	Dental health experimental programs must post notices describing the nature and intent of the program in English and a second language if warranted by the needs of the local community.
22 Cal. Code of Regs.	§ 79799	Correctional facilities must post notice of rights of inmate-patients in English and Spanish.
Cal. Well. and Inst. Code § 14191, 22 Cal. Code of Regs.	§§ 51305.4, 70707.4	Physicians and hospitals performing voluntary, non-emergency sterilizations on Medi-Cal beneficiaries must provide informed consent forms in English and Spanish.
Cal. Well. and Inst. Code § 5325	Individuals subjected to involuntary mental health treatment must receive an explanation of their rights in a language and modality that is accessible to them.	
Cal. Health and Safety Code § 1568.02(c)(4)	Residential care facilities for persons with chronic, life-threatening illness must demonstrate ability to provide linguistic services for non-English speaking patients as a condition of licensure.	
22 Cal. Code of Regs.	§§ 72528, 73524	Nursing facilities must obtain informed consent from non-English speaking patients through use of an interpreter who is fluent in English and patients' language for the use of psychotropic medications.
Cal. Well. and Inst. Code § 10746	Informational materials about state administration of public assistance must be produced in both English and Spanish.	
17 Cal. Code of Regs.	§ 6824(b)(3)(B)	Medicaid beneficiaries who cannot understand English must be informed "appropriately" of the Early Periodic Screening Diagnosis and Treatment program.
Cal. Well. and Inst. Code	§ 14007.5(j)	Local offices must explain Medicaid alien eligibility rules to aliens who are not fluent in English in a language that is understood by them.
Cal. Well. and Inst. Code	§§ 4710.8(d), 4712(k)	State or service delivery agency must provide non-English speaking claimants with interpreters at fair hearings and informal meetings challenging decisions regarding services for the hearing impaired.
CO	Colo. Rev. Stat. § 26-4-703(d)(3)	Directing the Department of Health Services to consider the special cultural and linguistic needs of patients in developing a Medicaid waiver.
CT	Conn. Agencies Regs. § 17-134d-41	Coordinating, Assessment and Monitoring Agencies that provide assessment and case management services for patients receiving long term care or community based services recipient.
Conn. Gen. Stat. § 19a-490g	Requiring Department of Public Health to develop a bilingual consumer guide on home health services.	
DE	16 Del. Code § 5161	Mental health hospitals and residential centers must display patient rights in English and Spanish and must provide a list of rights to each patient.
DC	D.C. Code § 31-2711(a)	Establishing the Office of Interpreter Services to facilitate the use of interpreters in administrative, judicial, and legislative proceedings.
FL	Fla. Stat. § 381.026(4)(b)(7)	A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services, "if the facility has a person readily available who speaks the patient's language."
Fia. Admin. Code § 59A-3.207	Each hospital offering emergency services must post notices in English and Spanish clearly stating patient's rights to receive such services and hospital's capacity to provide such services.	
Fia. Code §§ 636.015, 641.305 and 641.421	Prepaid limited health service organizations, health maintenance organizations, and prepaid health clinics that negotiate contract in languages other than English, must provide non-English speaking members with written translations of their contract. These translations must be in the language of the contract.	
HA	Haw. Rev. Stat. Ann. § 321-301	

Establishing state sponsored bilingual health education aide program to assist in the provision of health education and public health services to non-English speaking and limited English speaking persons.		
Haw. Rev. Stat. Ann.	§ 334-13	Establishing a bilingual mental health division within the Department of Health to provide outreach, education, case finding, screening, referral, consultation, crisis stabilization, commu
IL	210 Ill. Comp. Stat. 87/5 et seq., 77 Ill. Admin. Code § 250.265	

NHeLP Comments to HHS' Office for Civil Rights on Limited English Proficiency Guidance

Because access to information regarding basic health care services is an essential right, communication barriers must be removed by proper arrangements for interpreters or bilingual professional staff. If a person speaks a language other than English, the health care provider must make every effort to ensure that the person understands the health care provider's instructions and that the person understands the health care provider's instructions and that the person understands the health care provider's instructions.				
405 Ill. Comp. Stat. 75/1	State-operated mental health and developmental facilities must provide qualified Spanish speaking interpreters to overcome barriers to care and treatment if at least one percent of the facilities total annual admissions for inpatient or outpatient care consists of patients who do not understand English.			
405 Ill. Comp. Stat.	5/3-204	Patients admitted to mental health facilities must who do not understand English must receive an explanation of all communications required by law in their primary language.		
405 Ill. Comp. Stat.	5/3-205	Patients admitted to mental health facilities who do not understand English must receive an explanation of their legal rights in their primary language "within a reasonable time before a hearing or trial."		
59	Ill. Admin. Code	\$ 112.20		Mental health and developmental disability facilities must notify non-English speaking patients and the public of the availability of interpreter services.
20	Ill. Comp. Stat.	2310/55.66		The Department of Public Health is required to publish and distribute pamphlets to women on reproductive health services.
89	Ill. Admin. Code	§§ 302.30(c) and 308.30(b)		In delivering social services to children and their families, the Department of Children and Family Services must ensure that the services are provided in the primary language of the child and family.
89	Ill. Admin. Code	\$ 140.461		Federally qualified health centers must comply with federal and state laws and regulations governing the provision of health care services.
89	Ill. Admin. Code	\$ 716.200(d)(2)		Providers contracting with the Department of Rehabilitative Services to provide case management services must ensure that the services are provided in the primary language of the client.
89	Ill. Admin. Code	\$ 1200.10(d)(1)		Information, forms, and applications distributed by the Division of Specialized Care for Children shall be in the primary language of the child and family.
KS	Kan. Admin. Regs. § 28-4-550(h)(1)(A) and (w)	Informed consent for services under part H of the Individuals With Disabilities Education Act (IDEA) must be obtained from parent(s) in their native language.		
LA	40 La. Rev. Stat. § 1299.35.6.B(2)(4)	Specified oral information and written materials about abortion and abortion alternatives must be provided to the patient at least 24 hours before the procedure is performed. If an interpreter is needed, the patient must be provided with an interpreter.		
ME	5 Me. Rev. Stat. § 51	State must provide qualified interpreters or utilize a professional telephone-based interpretation service when a non-English person is subject of a proceeding before an agency or a court.		
MA	114.3 Mass. Regs. Code §§ 3.02 and 3.06	Home health agencies may apply for adjustment in rates for provision of interpreters to non-English speaking patients.		
102 Mass. Regs. Code	§§ 3.03(6)(a)(1)(a.), 6.05(6)(a)(1)(a)	Group care facilities for children must maintain records of the primary language of children in their care.		
105 Mass. Regs. Code	\$ 127.021	As a condition of licensing, mammography facilities must provide specified information to patients. The official commentary to this regulation states that facilities that serve linguistically diverse populations must provide interpretation services.		
105 Mass. Regs. Code	§§ 150.001 and 150.004(H)	Skilled nursing facilities for AIDS patients must provide access to sufficient bilingual services to meet the cultural and language needs of non-English speaking residents.		
105 Mass. Regs. Code	§§ 160.303(B)(1)	Substance abuse treatment facilities must keep data listing primary language spoken by patients if other than English.		
105 Mass. Regs. Code	\$ 130.615(C) and (E)	Maternal-newborn service must make available health education materials and activities in languages spoken by any non-English speaking groups that comprises at least 10% of the population of the service area.		
117 Mass. Regs. Code	§§ 8.08(d)	Community health centers must post notice of the availability of free care in any language spoken by 10% or more of the residents in the centers' service area.		
MI	Mich. Stat. Ann. § 14.15(b) and (c)	Consequences of abortion must be explained in language understood by patient and consent forms must be printed in English, Aramaic and Spanish.		
MN	Minn. Stat. §§ 144.651(4)	Health care facilities must make reasonable accommodations to inform non-English speaking patients of their legal rights.		
Minn. Stat.	\$ 148B71(1)	Mental health facilities must make reasonable accommodations to inform non-English speaking patients of their legal rights.		
Minn. Stat.	\$ 256.01 (13)	Mandating pilot projects for language assistance for individuals applying for or receiving aid through county social service agencies.		
NE	40 Nev. Rev. Stat. § 442.253 (1) and (3)	Consequences of abortion must be explained in language understood by patient and consent forms must be written in language understood by her.		
NJ	8 N.J. Admin. Code §§ 31B-4.37(a)(1), 31B-4.41C	Hospitals must post notices regarding availability of charity care in Spanish, English and any other language spoken by more than 10% of the population of the hospital's service area.		
8 N.J. Admin. Code	§§ 33-4.10(a)(8), 33A-1.29(b)(3)(i)-4.10(a)(8)	For approval of certificate of need, hospital must show how the project will promote access for racial and ethnic minorities and must document effective communication between the staff and patients.		
26 N.J. Rev. Stat. § 2-168	Department of Health must disseminate informational brochure on breast cancer in English and Spanish.			
26 N.J. Rev. Stat.	\$ 2H-12.8.h.	Patients have the right to expect that within their capacity, hospitals will make reasonable response to request for services, including the services of an interpreter if 10% or more of the population of the hospital's service area speaks a language other than English.		
8 New Jersey Administrative Code §33E-1.5a	For approval of certificate of need for intensive cardiac care units, hospitals should have bilingual clinical personnel available who can overcome language barriers and know and understand cultural differences among patients to the extent possible.			
30 N.J. Rev. Stat.	\$ 4-27.11	Patients admitted to psychiatric facilities have the right to have examinations and services provided through interpreters in their primary means of communication at the earliest possible time.		
8 N.J. Admin. Code	§§ 42A-6.10, 42B-6.6(e)	Drug and alcohol treatment facilities must provide interpreter services if their patient population is non-English speaking.		
8 N.J. Admin. Code	§§ 43H-6.1(a)(14)	Rehabilitation hospitals must provide interpreter services if their patient population is non-English speaking.		
8 N.J. Admin. Code	§§ 43F-6.6	Adult day care centers must provide interpreter services if their patient population is non-English speaking.		
30 N.J. Stat. § 1-1.1	Requiring the Department of Human Services to establish a comprehensive social services information hotline operating in Spanish and English.			
10 N.J. Admin. Code	\$ 74-1.3	To meet requirements for bilingual services, Medicaid managed care plans must be able to provide services in Spanish and English and in any other language spoken by more than 10% of the population of the service area.		
NY	10 N.Y. Comp. Codes R. & Reg. § 405.7 (a)(7)	Hospitals must provide skilled interpreters and translations of all significant forms to ensure effective oral and written communication with all persons receiving treatment regardless of their primary language.		
N.Y. Consolidated Laws Service, Mental Hygiene § 41.47(f)(3)	Directing the Office of Mental Health and local mental health agencies to consider the availability of services for non-English speaking persons as part of the process of contracting with community support services programs.			
N.Y. Consolidated Law Service, Mental Hygiene §§ 7.09(h)(i) and 13.09(e) (1995)	Directing the Office of Mental Health and Office of Mental Retardation and Developmental Disabilities to promulgate rules that address the communications needs of non-English speaking persons and to require facilities to use reasonable means to accommodate them.			

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New York Consolidated Laws Service, Mental Hygiene § 81.07(b)	Orders to show cause in proceedings for appointment of a guardian must be translated into languages other than English when necessary to apprise patients of proceedings.	
14 New York Consolidated Law Service, Mental Hygiene § 21.7	Non-English speaking mental patients must be provided with qualified translation services to facilitate written communication.	
New York Consolidated Law Service, Social Services § 473-a.4.(c)(vii) (1995)	Petition for involuntary commitment must state that if a patient is non-English speaking, reasonable efforts have been made to communicate with her.	
NC	10 N.C. Admin. Code § 508.0203(c)(5)	Requiring the county department of social services to verify eligibility information when an applicant is unable to speak English.
OH	Ohio Admin. Code § 5124-2-01(D)(4)	Hospitals and mental health clinical facilities must ensure that all non-English speaking patients meet with a client advocate who can explain their rights regarding involuntary commitment.
Ohio Admin. Code, Chapter 3793, § 2-1-12(G)	Licensed referral and information services for drug and alcohol addiction must provide access to patients who speak a language other than English.	
Ohio Admin. Code, Chapter 5101, Section 3-2-0717(D)(3)	Hospitals receiving state payments for indigent must post notice of patient rights to free care.	
PA	55 Pa. Admin. Code § 1140.41(12)	Providers that contract with state's Healthy Beginnings Plus program must ensure use of qualified interpreters for each non-English speaking patient.
35 Pa. Stat. § 449.36	Health care practitioners that treat non-English speaking Medicare beneficiaries must post translated signs of patients rights supplied by Pennsylvania's Bureau of Professional and Occupational Affairs.	
28 Pa. Admin. Code	§§ 201.29(k) and 201.30(h)	Nursing homes must make arrangements to communicate patient rights to non-English speaking patients.
28 Pa. Admin. Code	§ 553.12	Ambulatory surgery patients who do not speak English shall have access to an interpreter where possible.
28 Pa. Admin. Code	§ 201.29(x)	Hospitals must translate notices of patient rights for non-English speaking patients.
35 Pa. Stat. § 449.36(c)	Hospitals must post translated notices of patient rights for non-English speaking Medicare beneficiaries.	
RI	23 R.I. Gen. Laws § 17.5-18(3)	Nursing homes serving non-English speaking patients must attempt to find interpreters to allow patients to exercise their rights.
TX	25 Tex. Admin. Code § 29.609(c)(3)	Disproportionate share hospitals must post notices of right to charity care in English and Spanish.
25 Tex. Admin. Code § 405.88	Facilities for the mentally retarded must make necessary provisions to assess non-English speaking individuals.	
40 Tex. Admin. Code 25 §§ 147.35(10), 153.36(13)	Alcohol and drug abuse education programs and drug offender education programs must make provisions for persons who are unable to read or speak English.	
Tex. Health and Safety Code §§ 161.132(e), 161.134(j), 161.135(h), 321.002(h), 25 Tex. Admin. Code §§ 405.82(b)(2), 405.84(a), 405.85(a), 405.86(a), 405.87(a), 405.88(a), 405.89(a), 405.90(a), 405.91(a), 405.92(a), 405.93(a), 405.94(a), 405.95(a), 405.96(a), 405.97(a), 405.98(a), 405.99(a), 406.01(a), 406.02(a), 406.03(a), 406.04(a), 406.05(a), 406.06(a), 406.07(a), 406.08(a), 406.09(a), 406.10(a), 406.11(a), 406.12(a), 406.13(a), 406.14(a), 406.15(a), 406.16(a), 406.17(a), 406.18(a), 406.19(a), 406.20(a), 406.21(a), 406.22(a), 406.23(a), 406.24(a), 406.25(a), 406.26(a), 406.27(a), 406.28(a), 406.29(a), 406.30(a), 406.31(a), 406.32(a), 406.33(a), 406.34(a), 406.35(a), 406.36(a), 406.37(a), 406.38(a), 406.39(a), 406.40(a), 406.41(a), 406.42(a), 406.43(a), 406.44(a), 406.45(a), 406.46(a), 406.47(a), 406.48(a), 406.49(a), 406.50(a), 406.51(a), 406.52(a), 406.53(a), 406.54(a), 406.55(a), 406.56(a), 406.57(a), 406.58(a), 406.59(a), 406.60(a), 406.61(a), 406.62(a), 406.63(a), 406.64(a), 406.65(a), 406.66(a), 406.67(a), 406.68(a), 406.69(a), 406.70(a), 406.71(a), 406.72(a), 406.73(a), 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# NHeLP Comments to HHS' Office for Civil Rights on Limited English Proficiency Guidance

Cal. Well. and Inst. Code § 7290 et seq.

State and local agencies must provide bilingual services to non-English speaking persons. Local agencies must provide services for languages spoken by substantial numbers of non-English speaking persons, defined as 5 percent or more of the population served by a state or local facility. Both state and local agencies must employ sufficient bilingual personnel to provide such services.

9 Cal. Code of Regs. § 862, 22 Cal. Code of Regs. §§ 70577, 71507, 72453, 73399, 77000 and 77001  
Nursing facilities must post notice of patients' rights in English and Spanish.

22 Cal. Code of Regs.	§§ 79111, 79113	Chemical dependence recovery hospitals must post notice of patients rights in English or the predominant language of the community and must explain these rights in a language or mode of communication understood by the patient.
Cal. Well. and Inst. Code	§ 4503	State hospitals and community care facilities must post notice of the rights of developmentally disabled persons in Spanish and English.
Cal. Health and Safety Code § 1599.74	Department of Health Licensing is directed to translate enumerated patient rights into Spanish, Chinese, and every other language spoken by 1% or more of the state's nursing home population. Nursing facilities must give translated versions to non-English-speaking patients.	
Cal. Health and Safety Code § 124300	Local health departments are directed to make family planning pamphlets and circulars available in languages spoken by 10% or more of the county's population.	
16 Cal. Code of Regs.	§ 1003	Dental health experimental programs must post notices describing the nature and intent of the program in English and a second language if warranted by the needs of the local community.
22 Cal. Code of Regs.	§ 79799	Correctional facilities must post notice of rights of inmate-patients in English and Spanish.
Cal. Well. and Inst. Code § 14191, 22 Cal. Code of Regs.	§§ 51305.4, 70707.4	Physicians and hospitals performing voluntary, non-emergency sterilizations on Medi-Cal beneficiaries must provide informed consent forms in English and Spanish.
Cal. Well. and Inst. Code § 5325	Individuals subjected to involuntary mental health treatment must receive an explanation of their rights in a language and modality that is accessible to them.	
Cal. Health and Safety Code § 1568.02(c)(4)	Residential care facilities for persons with chronic, life-threatening illness must demonstrate ability to provide linguistic services for non-English speaking patients as a condition of licensure.	
22 Cal. Code of Regs.	§§ 72528, 73524	Nursing facilities must obtain informed consent from non-English speaking patients through use of an interpreter who is fluent in English and patients' language for the use of psychotherapy.
Cal. Well. and Inst. Code § 10746	Informational materials about state administration of public assistance must be produced in both English and Spanish.	
17 Cal. Code of Regs.	§ 6824(b)(3)(B)	Medicaid beneficiaries who cannot understand English must be informed "appropriately" of the Early Periodic Screening Diagnosis and Treatment program.
Cal. Well. and Inst. Code	§ 14007.5(j)	Local offices must explain Medicaid alien eligibility rules to aliens who are not fluent in English in a language that is understood by them.
Cal. Well. and Inst. Code	§§ 4710.8(d), 4712(k)	State or service delivery agency must provide non-English speaking claimants with interpreters at fair hearings and informal meetings challenging decisions regarding services for the hearing impaired.
CO	Colo. Rev. Stat. § 26-4-703(d)(3)	Directing the Department of Health Services to consider the special cultural and linguistic needs of patients in developing a Medicaid waiver.
CT	Conn. Agencies Regs. § 17-134d-41	Coordinating, Assessment and Monitoring Agencies that provide assessment and case management services for patients receiving long term care or community based services recipient.
Conn. Gen. Stat. § 19a-490g	Requiring Department of Public Health to develop a bilingual consumer guide on home health services.	
DE	16 Del. Code § 5161	Mental health hospitals and residential centers must display patient rights in English and Spanish and must provide a list of rights to each patient.
DC	D.C. Code § 31-2711(a)	Establishing the Office of Interpreter Services to facilitate the use of interpreters in administrative, judicial, and legislative proceedings.
FL	Fla. Stat. § 381.026(4)(b)(7)	A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services, "if the facility has a person readily available who speaks the patient's language."
Fla. Admin. Code § 59A-3.207	Each hospital offering emergency services must post notices in English and Spanish clearly stating patient's rights to receive such services and hospital's capacity to provide such services.	
Fla. Code §§ 636.015, 641.305 and 641.421	Prepaid limited health service organizations, health maintenance organizations, and prepaid health clinics that negotiate contract in languages other than English, must provide non-English speaking members with written translations of their contract. These translations must be in the language of the contract.	
HI	Haw. Rev. Stat. Ann. § 321-301	

Establishing state sponsored bilingual health education aide program to assist in the provision of health education and public health services to non-English speaking and limited English speaking persons.

Haw. Rev. Stat. Ann. § 334-13  
Establishing a bilingual mental health division within the Department of Health to provide outreach, education, case finding, screening, referral, consultation, crisis stabilization, community support, and other mental health services to non-English speaking persons.

IL	210 Ill. Comp. Stat. 87/5 et seq., 77 Ill. Admin. Code § 250.265
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Because access to information regarding basic health care services is an essential right, communication barriers must be removed by proper arrangements for interpretation of all professional staff. Departments providing health care services to patients in language groups constituting 5 percent or more of the population of the facility.
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405 Ill. Comp. Stat. 75/1	State-operated mental health and developmental facilities must provide qualified	Spanish speaking interpreters to overcome barriers to care and treatment if at least one percent of the facilities total annual admissions for inpatient or outpatient care consists of patients who do not understand English.
405 Ill. Comp. Stat.	5/3-204	Patients admitted to mental health facilities must who do not understand English must receive an explanation of all communications required by law in their primary language.
405 Ill. Comp. Stat.	5/3-205	Patients admitted to mental health facilities who do not understand English must receive an explanation of their legal rights in their primary language "within a reasonable time before a patient is admitted to the facility."
59 Ill. Admin. Code	§ 112.20	Mental health and developmental disability facilities must notify non-English speaking patients and their guardians of the right to challenge diagnoses of mentally retardation and results of psychological testing.
20 Ill. Comp. Stat.	2310/55.66	The Department of Public Health is required to publish and distribute pamphlets to women on reproductive health issues in English and Spanish.
89 Ill. Admin. Code	§§ 302.30(c) and 308.30(b)	In delivering social services to children and their families, the Department of Children and Family Services shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any other applicable federal, state, and local laws, rules, and regulations.
89 Ill. Admin. Code	§ 140.461	Federally qualified health centers must comply with federal and state laws and regulations governing the provision of adequate notice to persons who are unable to read or understand English.
89 Ill. Admin. Code	§ 716.200(d)(2)	Providers contracting with the Department of Rehabilitative Services to provide case management services to persons with AIDS must agree to comply with Title VI of the Civil Rights Act of 1964 and any other applicable federal, state, and local laws, rules, and regulations.

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89 Ill. Admin. Code	§ 1200.10(d)(1)	Information, forms, and applications distributed by the Division of Specialized Care for Children shall be available in English and Spanish.
KS	Kan. Admin. Regs. § 28-4-550(h)(1)(A) and (w)	Informed consent for services under part H of the Individuals With Disabilities Education Act (IDEA) must be obtained from parent(s) in their native language.
LA	40 La. Rev. Stat. § 1299.35.6.B(2)(4)	Specified oral information and written materials about abortion and abortion alternatives must be provided to the patient at least 24 hours before the procedure is performed. If an interpreter is not available, the patient must be provided with written information in their native language.
ME	5 Me. Rev. Stat. § 51	State must provide qualified interpreters or utilize a professional telephone-based interpretation service when a non-English person is subject of a proceeding before an agency or a court.
MA	114.3 Mass. Regs. Code §§ 3.02 and 3.06	Home health agencies may apply for adjustment in rates for provision of interpreters to non-English speaking patients.
102 Mass. Regs. Code	§§ 3.03(6)(a)(1)(a.), 6.05(6)(a)(1)(a)	Group care facilities for children must maintain records of the primary language of children in their care.
105 Mass. Regs. Code	§ 127.021	As a condition of licensing, mammography facilities must provide specified information to patients. The official commentary to this regulation states that facilities that serve linguistically diverse populations must provide information in the patient's language.
105 Mass. Regs. Code	§§ 150.001 and 150.004(H)	Skilled nursing facilities for AIDS patients must provide access to sufficient bilingual services to meet the cultural and language needs of non-English speaking residents.
105 Mass. Regs. Code	§§ 160.303(B)(1)	Substance abuse treatment facilities must keep data listing primary language spoken by patients if other than English.
105 Mass. Regs. Code	§ 130.615(C) and (E)	Maternal-newborn service must make available health education materials and activities in languages spoken by any non-English speaking groups that comprises at least 10% of the population of the service area.
117 Mass. Regs. Code	§§ 8.08(d)	Community health centers must post notice of the availability of free care in any language spoken by 10% or more of the residents in the centers' service area.
MI	Mich. Stat. Ann. § 14.15(b) and (c)	Consequences of abortion must be explained in language understood by patient and consent forms must be printed in English, Aramaic and Spanish.
MN	Minn. Stat. §§ 144.651(4)	Health care facilities must make reasonable accommodations to inform non-English speaking patients of their legal rights.
Minn. Stat.	§ 148B71(1)	Mental health facilities must make reasonable accommodations to inform non-English speaking patients of their legal rights.
Minn. Stat.	§ 256.01 (13)	Mandating pilot projects for language assistance for individuals applying for or receiving aid through county social service agencies.
NE	40 Nev. Rev. Stat. § 442.253 (1) and (3)	Consequences of abortion must be explained in language understood by patient and consent forms must be written in language understood by her.
NJ	8 N.J. Admin. Code §§ 31B-4.37(a)(1), 31B-4.41C	Hospitals must post notices regarding availability of charity care in Spanish, English and any other language spoken by more than 10% of the population of the hospital's service area.
8 N.J. Admin. Code	§§ 33-4.10(a)(8), 33A-1.29(b)(3)(i)-4.10(a)(8)	For approval of certificate of need, hospital must show how the project will promote access for racial and ethnic minorities and must document effective communication between the staff and patients.
26 N.J. Rev. Stat. § 2-168	Department of Health must disseminate informational brochure on breast cancer in English and Spanish.	
26 N.J. Rev. Stat.	§ 2H-12.8.h.	Patients have the right to expect that within their capacity, hospitals will make reasonable response to request for services, including the services of an interpreter if 10% or more of the population of the hospital's service area speaks a language other than English.
8 New Jersey Administrative Code §33E-1.5a	For approval of certificate of need for intensive cardiac care units, hospitals should have bilingual clinical personnel available who can overcome language barriers and know and understand cultural differences among patients to the extent possible.	
30 N.J. Rev. Stat.	§ 4-27.11	Patients admitted to psychiatric facilities have the right to have examinations and services provided through interpreters in their primary means of communication at the earliest possible time.
8 N.J. Admin. Code	§§ 42A-6.10, 42B-6.6(e)	Drug and alcohol treatment facilities must provide interpreter services if their patient population is non-English speaking.
8 N.J. Admin. Code	§§ 43H-6.1(a)(14)	Rehabilitation hospitals must provide interpreter services if their patient population is non-English speaking.
8 N.J. Admin. Code	§§ 43F-6.6	Adult day care centers must provide interpreter services if their patient population is non-English speaking.
30 N.J. Stat. § 1-1.1	Requiring the Department of Human Services to establish a comprehensive social services information hotline operating in Spanish and English.	
10 N.J. Admin. Code	§ 74-1.3	To meet requirements for bilingual services, Medicaid managed care plans must be able to provide services in Spanish and English and in any other language spoken by more than 10% of the population of the hospital's service area.
NY	10 N.Y. Comp. Codes R. & Reg. § 405.7 (a)(7)	Hospitals must provide skilled interpreters and translations of all significant forms to ensure effective oral and written communication with all persons receiving treatment regardless of language spoken.
N.Y. Consolidated Laws Service, Mental Hygiene § 41.47(f)(3)	Directing the Office of Mental Health and local mental health agencies to consider the availability of services for non-English speaking persons as part of the process of contracting with community support services programs.	
N.Y. Consolidated Law Service, Mental Hygiene §§ 7.09(h)(i) and 13.09(e) (1995)	Directing the Office of Mental Health and Office of Mental Retardation and Developmental Disabilities to promulgate rules that address the communications needs of non-English speaking persons and to require facilities to use reasonable means to accommodate them.	
New York Consolidated Laws Service, Mental Hygiene § 81.07(b)	Orders to show cause in proceedings for appointment of a guardian must be translated into languages other than English when necessary to apprise patients of proceedings.	
14 New York Consolidated Law Service, Mental Hygiene § 21.7	Non-English speaking mental patients must be provided with qualified translation services to facilitate written communication.	
New York Consolidated Law Service, Social Services § 473-a.4.(c)(vii) (1995)	Petition for involuntary commitment must state that if a patient is non-English speaking, reasonable efforts have been made to communicate with her.	
NC	10 N.C. Admin. Code § 50B.0203(c)(5)	Requiring the county department of social services to verify eligibility information when an applicant is unable to speak English.
OH	Ohio Admin. Code § 5124-2-01(D)(4)	Hospitals and mental health clinical facilities must ensure that all non-English speaking patients meet with a client advocate who can explain their rights regarding involuntary commitment.
Ohio Admin. Code, Chapter 3793, § 2-1-12(G)	Licensed referral and information services for drug and alcohol addiction must provide access to patients who speak a language other than English.	
Ohio Admin. Code, Chapter 5101, Section 3-2-0717(D)(3)	Hospitals receiving state payments for indigent must post notice of patient rights to free care.	
PA	55 Pa. Admin. Code § 1140.41(12)	Providers that contract with state's Healthy Beginnings Plus program must ensure use of qualified interpreters for each non-English speaking patient.
35 Pa. Stat. § 449.36	Health care practitioners that treat non-English speaking Medicare beneficiaries must post translated signs of patients rights supplied by Pennsylvania's Bureau of Professional and Occupational Affairs.	
28 Pa. Admin. Code	§§ 201.29(k) and 201.30(h)	Nursing homes must make arrangements to communicate patient rights to non-English speaking patients.
28 Pa. Admin. Code	§ 553.12	Ambulatory surgery patients who do not speak English shall have access to an interpreter where possible.
28 Pa. Admin. Code	§ 201.29(x)	Hospitals must translate notices of patient rights for non-English speaking patients.
35 Pa. Stat. § 449.36(c)	Hospitals must post translated notices of patient rights for non-English speaking Medicare beneficiaries.	
RI	23 R.I. Gen. Laws § 17.5-18(3)	Nursing homes serving non-English speaking patients must attempt to find interpreters to allow patients to exercise their rights.
TX	25 Tex. Admin. Code § 29.609(c)(3)	Disproportionate share hospitals must post notices of right to charity care in English and Spanish.
25 Tex. Admin. Code § 405.88	Facilities for the mentally retarded must make necessary provisions to assess non-English speaking individuals.	

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40 Tex. Admin. Code 25 §§ 147.35(10), 153.36(13)	Alcohol and drug abuse education programs and drug offender education programs must make provisions for persons who are unable to read or speak English.	
Tex. Health and Safety Code §§ 161.132(e), 161.134(j), 161.135(h), 321.002(h)	Chemical dependency services must post notice of patient rights, patient abuse reporting responsibilities, and right to be free from retaliation for reporting violations of law, in English and a language understood by the patient.	
Tex. Health & Safety Code § 161.136(a)	State health care regulatory agencies are empowered to require mental health services providers to furnish patients with brochures in English and Spanish summarizing laws prohibiting sexual exploitation of patients.	
25 Tex. Admin. Code	§§404.161(f), 404.162(d)	Mental health facilities must provide patient rights brochures to teens and children in English and Spanish.
UT	Utah Admin. Code § R501-2-9(J)	Human service programs that contract with the state must employ staff as necessary to communicate with consumers whose primary language is not English.
VT	18 Vt. Stat. Ann. § 1852	Hospital patients who do not understand English have a right to an interpreter if the language barrier presents a continuing problem to patient understanding of the care and treatment.
33 Vt. Stat. Ann. § 7301	Nursing homes must make reasonable accommodations to communicate patients' rights to non-English speaking residents.	
WA	Wash. Admin. Code §§ 440-22-160 and 440-22-310(b)	Chemical dependency service providers must make available certified interpreters or other acceptable alternatives for persons with Limited English Proficiency and must accommodate their needs.
Wash. Rev. Code § 74.04.025(1)	The Department of Social and Health Services and the Office of Administrative Hearings shall insure that bilingual services are provided to non-English speaking recipients and applicants. The department shall employ bilingual staff if the number of applicants and recipients exceeds 100.	
Wash. Admin. Code § 246-452-010	Written explanations about charity care must be provided in any language spoken by more than ten percent of the population in the hospital's service area and must be interpreted for other non-English speaking patients.	
Wash. Rev. Code §§ 2.43.010 and 2.43.020, Wash. Admin. Code § 10-08-150	Interpreters must be provided to non-English speaking persons in legal proceedings, including administrative proceedings.	
WI	Wis. Admin. Code, Chapter HSS, § 102.01(b)(4)	In administering state Medicaid program, agencies that serve substantial non-English speaking or limited-English speaking populations must take whatever steps are necessary to communicate with those persons.
Wis. Stat. Ann. § 253.10(3)(d)	Written information about abortion alternatives must be provided to patients in English, Spanish and languages spoken by a significant number of state residents.	
Wis. Dep't. of Health and Social Services Administrative Directive AD-52 (May 24, 2005)	DHSS divisions must translate program information into languages spoken by at least 5% or 1,000 individuals in the agencies service area. All individuals accessing DHSS services are entitled to the assistance of qualified interpreters at the time they apply for and receive services.	

Selected State Laws and Local Ordinances

Enacted Since 1998

State/

Locality

Provision	Requirements	
State Laws		
FL	Fla. Stat. § 641.54	Each health maintenance organization shall provide to subscribers, upon request, policies and procedures for addressing the needs of non-English-speaking subscribers.
MA	Emergency Room Interpreter Law, 105 Mass. Regs. Code § 130.1100 et Seq.	The state must compensate hospitals for interpreting costs in emergency rooms and inpatient psychiatric facilities.

State Dept. of Public Health website on Hospital-Based Interpreter Services (with best practices, resources, information) - <http://www.state.ma.us/dph/omh/interp/interpreter.htm>

MN	Minn. Stat. § 62Q.07	All health plan companies that issue or renew a health plan (defined in § 624.01) must annually file an "action plan" that must include a detailed description of the company's policies and procedures for addressing the needs of non-English speaking persons.
MT	Mont. Code Ann. § 33-36-201	Each managed care plan in the state must submit an access plan including the health carrier's efforts to address the needs of covered persons with limited English proficiency.
Administrative Codes		
ID	Id. Code 16.03.09.090	When obtaining consent for sterilization in the Medical Assistance Program, an interpreter must be provided if the recipient does not understand the language used on the consent form.
NM	13 N.M. Admin. Code 10.13.29	The managed health care plan must ensure that information and services are available in languages other than English, and that services are provided in a manner that takes into account the needs of non-English speaking persons.

Each managed health care plan must submit a plan which shall address: how it will identify the language needs of enrollees and measures to be taken to ensure access for limited-English-proficient (LEP) enrollees in both administrative and health care encounters with the plan and its providers; steps it will take to ensure availability of adequate interpretation services; and how it will ensure that all enrollees, regardless of language proficiency, have access to the same quality of care as English-speaking enrollees.

OR  
Or. Admin. R. 410-141-0760  
Primary Care Case Managers (PCCMs) are expected to have a plan to access qualified interpreters who can interpret in the primary language of each substantial population of non-English speaking PCCM Members.

PCCMs shall provide education on the use of services, including Urgent Care Services and Emergency Services; the Medical Assistance Program may provide PCCMs with appropriate written information on the use of services in the primary language of each substantial population of non-English speaking PCCM Members.

TX	25 Tex. Admin. Code § 30.27	Managed Care Organizations (MCOs) shall develop a written cultural competency plan describing how the MCO will effectively provide health care services to members from varying cultural backgrounds.
Local Ordinances		
CA (San Francisco)	Equal Access to Services	City Departments must offer information and services in each language spoken by a substantial number of LEP people and covered departments (those that provide direct services and those that provide support services).

"Concentrated number of limited English speaking people" - 5% of district where covered department facility located or 5% of those persons who use the services provided by the covered department facility.

"Substantial number of limited English speaking people" - 10,000 city residents or 5% of those who use the Department's services.

CA (Oakland)  
Equal Access to Services  
City departments must offer bilingual services and materials if a substantial portion of the public utilizing city services does not speak English effectively.

"Substantial number of limited English speaking persons group" - at least 10,000 LEP city residents who speak a shared language other than English.

Appendix D

See <http://www.healthlaw.org/pubs/200010/lepguidance.html>

Address to the Joint Session of Congress, February 27, 2001.

Cho, J. and Solis, B.M., *Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on their Diverse Member Population*, (L.A. Care Health Plan, January 2001) (hereinafter L.A. Care Report).

Dallas Morning News, *Business: Demand for bilingual health workers on the rise* (December 18, 2001).

Five percent said they were not familiar with the laws and 51% said they were not sure. L.A. Care Report.

Tanjasiri, S., *Pacific Asian Language Services (PALS) for Health: Provider Needs Assessment Survey* (June 6, 2001) [Mara - PALS is also submitting this survey but I thought it wouldn't hurt to cite it, too.]

*Id.*

L.A. Care Report.

See e.g., Woloshin, S. et al., *Language Barriers in Medicine in the United States*, JAMA, Vol. 273, No. 9 (March 1, 1995); Perkins, J. et al., *Ensuring Linguistic Access: Legal Rights and Responsibilities*, Kaiser Family Foundation (January 1998).

See 65 Fed. Reg. at 52769-80 (August 30, 2000).

See e.g., Kratochvil, *Translating for Parents Means Growing Up Fast*, The New York Times (Aug. 26, 2001).

See generally, McQuillan & Tse, *Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy*, Language and Education, 9(3) at 195-215 (1995).

Gold, *Small Voice for Her Immigrant Parents*, Los Angeles Times, A1 (May 24, 1999).

See Perkins, J. et al., *Ensuring Linguistic Access: Legal Rights and Responsibilities*, Appendix G, Kaiser Family Foundation (January 1998)

For example, California's Dymally-Alatorre bilingual Services Act requires that interpreters and translation services be provided to language groups that comprise 5% or more of the people served by any local office or facility of a state agency. Cal. Govt. Code § 7290 et seq. In addition, California requires both translation and interpretation for state agencies. Specifically addressing health care facilities, acute care hospitals must ensure availability of interpreter services to patients who are part of a language group that comprises at least 5% of the population of the geographic area served by the hospital, "to the extent possible". Cal. Health & Safety Code § 1259. According to Illinois Language Assistance Services Act, "... it is the intent of the General Assembly that where language or communication barriers exist between patients and the staff of a health facility, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff." 210 Ill. Comp. Stat. 87/5. New Jersey's Bill of Rights for Hospital Patients states that every person shall have the right "[t]o expect that within its capacity, the hospital will make reasonable response to his request for services, including the services of an interpreter in a language other than English if 10% or more of the population in the hospital's service area speaks that language." N.J. Stat. 26:2H-12.8(h). New York's Patients' Rights law requires that hospitals "manage a resource of skilled interpreters. ...and shall provide translations/transcriptions of significant hospital forms, instructions and information in order to provide effective visual, oral and written communication with all persons receiving treatment in the hospital regardless of a patient's language." Interpreter services and translation/transcriptions must be available to non-English speaking groups comprising more than 1% of the total hospital service area population. 10 N.Y.C.R.R. § 405.7. Vermont's Bill of Rights for Hospital Patients states "A patient who does not speak or understand the predominant language of the community has a right to an interpreter if the language barrier presents a continuing problem to patient understanding of the care and treatment being provided." 18 V.S.A. § 1852.

See The George Washington University Medical Center, Center for Health Services Research and Policy, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, Fourth Edition, Volume 2, Part 3, Table 3.6 (June 1999) available at <http://www.gwu.edu/~chsnp/>.

This was based on the total number and average cost of ER visits, inpatient hospital visits, outpatient physician visits, and dental visits. Office of Management and Budget, *Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No.13166: Improving Access to Services for Persons with Limited English Proficiency*, (March 14, 2002) available at <http://www.whitehouse.gov/omb/infoereg/regpol.html> .

*Id.*

This was a national survey of over 10,000 respondents, 4,161 of whom took the survey in Spanish and provided information on their experiences at twenty-three urban and suburban hospitals located in 15 cities. For additional information, contact Mark Rukavina, The Access Project, (617) 654-9911, ext. 229, [rukavina@accessproject.org](mailto:rukavina@accessproject.org).

See, The Los Angeles Times (May 31, 1999); The Fresno Bee, *Woman jailed for TB will get \$1.2m* (April 5, 2001).

Requirements to collect and report primary language data are currently underutilized. Under a proposed rule for Medicaid managed care, states would have to notify managed care organizations of the primary language of enrollees but there is no requirement to report this data to CMS. Under a revised SCHIP final rule issued by the current administration, a provision that would have required states to report the primary language of enrollees was deleted. For a further discussion of the need for data collection, see Perot, Ruth and Youdelman, *Maria, Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices*, The Commonwealth Fund (Sept. 2001).

Office of Minority Health, DHHS, "Assuring Cultural Competence in Health Care: Recommendations for National Standards and An Outcomes-Focused Research Agenda, Part One ("CLAS"), 64 Federal Register 75042-44 (Dec.15, 1999), CLAS final standards, 65 Fed. Reg. 88865 (Dec. 22, 2000).

There are currently various efforts throughout the country to create culturally and linguistically appropriate standards in health care, such as the recent issuance of OMB's "CLAS" standards. Office of Minority Health, OHHS, 45 Fed. Reg. 8085 (December 22, 2000) In Los Angeles, the Department of Health Services and other county agencies and community advocates are finalizing standards on cultural and linguistic standards in health care. The National Council on Interpretation in

Health Care and the California Health Interpreters Association have developed competency and

training standards for health care interpreters.

This was based on the total number and average cost of ER visits, inpatient hospital visits, outpatient physician visits, and dental visits. Office of Management and Budget, Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency. (March 14, 2002) available at <http://www.whitehouse.gov/omb/inforeg/egopd.html> .

Office of Management and Budget, Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency. (March 14, 2002) at 45, available at <http://www.whitehouse.gov/omb/inforeg/egopd.html> .

In Washington state, state law requires language assistance. The state estimates that it will spend \$4 million over two years for oral interpretation. With an estimated 25,000 encounters per month (or 304,000 encounters in 2 years), the average cost of providing oral interpretation is \$38.46 per encounter.

This report is available from CPIC, 918-448-8170, [www.cpic.org](http://www.cpic.org)

This was based on the total number and average cost of ER visits, inpatient hospital visits, outpatient physician visits, and dental visits. Office of Management and Budget, Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency. (March 14, 2002) available at <http://www.whitehouse.gov/omb/inforeg/egopd.html> .

See, e.g., Robert Wood Johnson, *How Language Barriers Hinder Access and Delivery of Quality Care*, forthcoming, January 2002.

Leighton Ku & Sheetal Maitani, Urban Institute, *Immigrants Access to Health Care and Insurance on the Cusp of Welfare Reform*, No. 00-03, at 9, citing Lachner, et al., 1994, analysis of the National Health Interview Study at 17.

Numerous medical studies point to the ability of regular care to lessen overall health care costs. One such study documents the reduced costs, and hospital readmissions, that result from providing comprehensive discharge planning and home care intervention for at-risk hospitalized elders. Naylor, M., et al., *Comprehensive Discharge Planning and Home Follow-Up of Hospitalized Elders*, *Journal of the American Medical Association*, Vol. 281, No. 7, 613, 617 (February 17, 1999).

Post-discharge assistance has also been documented to reduce unplanned admissions, days of hospitalization upon admission, and poor long-term outcomes in patients with high-risk congestive heart failure. Simon Stewart,

et al.

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*Prolonged Beneficial Effects of a Home-Based Intervention on Unplanned Readmissions and Mortality Among Patients with Congestive Heart Failure*

, *Arch. Intern Med.*, Vol. 159, 257 (February 8, 1999).

The Institute for Health and Aging, University of California, San Francisco, on behalf of the Robert Wood Johnson Foundation, *Chronic Care in America: A 21st Century Challenge* , [www.ihaging.ucsf.edu/news/05nov07.htm](http://www.ihaging.ucsf.edu/news/05nov07.htm) at 1 (November 1996).

John Holahan et al., Urban Institute, Health Policy for Low-Income People in New York, <http://www.urbaninstitute.org/html/nyhealth.html> at 7 (November, 1998).

Hoffman, Catherine & Schkaboehn, Alan, The Kaiser Family Foundation Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book*, 2nd Edition (May 2000) at 56.

See PBS Healthweek, Program No. 506, Medical Interpreters, [http://www.pbs.org/healthweek/feature1\\_506.htm](http://www.pbs.org/healthweek/feature1_506.htm).

National Center for Chronic Disease Prevention and Health Promotion, Diabetes: A Serious Public Health Problem, A-4-Glance 2000, <http://www.cdc.gov/diabetes/basics/glance.htm> at 3-4.

Herbert Schvartz, et al., *The Costs of Cancer Care in the United States: Implications for Action*, Oncology, Vol. 9, No. 11, <http://link.springer.com/journal/10902/ep1195a.htm> at 6, (November 1995).

Bernstein, J. et al., *The Use of Trained Interpreters Affects Emergency Department Services, Reduces Charges, and Improves Follow-Up*, Boston Medical Center, Boston University School of Medicine and School of Public Health.

Id.

See e.g., Maine Medical Center, *OCR v. Los Angeles County Department of Health Services (Rancho Los Amigos)*, Resolution Agreement, Docket No. 09-00-301-4, and *OCR v. Fresno County Adult Services*, Resolution Agreement, Docket Nos. 09-00-3007, 3300, and 3338.

67 Fed. Reg. at 4975.

67 Fed. Reg. at 4977.

The Supreme Court's recent decision in *Alexander v. Sandoval*, precluding a private right of action to enforce the Title VI regulations, merely underscores the importance of agency guidance to ensure that the rights, and more importantly the health, of LEP individuals are protected. See *Alexander v. Sandoval*, 532 U.S. (2001).

It is widely expected that this number will increase once the 2000 Census data is tabulated.

