

December 8, 2003

Deeana Jang
Office of Civil Rights
Department of Health and Human Services
Room 506F
200 Independence Avenue, S.W.
Washington, DC 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 for Civil Rights of the Department of Health and Human Services ("OCR") in the Federal Register on August 8, 2003.

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. OCR's endeavor is critically important to ensure that limited English proficient ("LEP") persons have fair and equal access to the health care and social services. The HHS LEP Guidance, historic Executive Order No. 13166, and the Department of Justice Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (DOJ LEP Guidance), confirm 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 has served 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 State Children's Health Insurance (SCHIP) programs.

While we support the LEP Guidance, we are deeply concerned that in many places the revised guidance of August 8, 2003, does not conform to the template that was established by DOJ. In a memorandum from Ralph Boyd on July 8, 2002, DOJ required each federal agency to re-issue its guidance and to conform to DOJ's template and meet the minimum requirements as stated in the DOJ LEP Guidance. The goal was to ensure minimum standards of consistency across the federal government. Yet in numerous situations throughout its reissued guidance, HHS has failed to conform to the DOJ template. And, it is widely recognized that the reissuance represents a weakening of the standards from their previous iterations by OCR. For example, an AMA News Editorial on November 10, 2003, states "Since the guidance was issued, the AMA and other physician groups have steadfastly argued for modifications. It seems as if the federal government got some of the message." While HHS may state in its trainings that its guidance conforms to the DOJ template, the actual text "and its interpretation by some who are looking for the ways to sidestep their nondiscrimination obligations" gives significant latitude to providers and weakens expectations that all recipients of federal funds must undertake at least some action to provide language services. As a result, rather than providing clearer guidance to health care providers and social service agencies, it has created greater confusion as to Title VI requirements and conflicts with DOJ's LEP Guidance. In section C. of our comments we have outlined "minimum recommendations" which are necessary to bring HHS guidance into conformance with DOJ's template.

We encourage OCR to adopt the recommendations which are attached. At a minimum, we urge OCR to conform its guidance to the DOJ template and ensure that when LEP persons access healthcare and other social services that they can expect meaningful access. We appreciate the opportunity to submit these comments and look forward to working with OCR to implement the LEP Guidance.

Sincerely,

National Health Law Program

cc: Alex Acosta, Assistant Attorney General for Civil Rights Division, Department of Justice
643 Main Building, Tenth St. & Constitution Ave., N.W., Washington, DC 20530

The undersigned organizations support the comments submitted by NHeLP:

The Access Project (Boston, MA)
ACLU of Northern California (San Francisco, CA)
AIDS Voice of Palm Beach County
American Civil Liberties Union
Asian Law Alliance (San Jose, CA)
Asian Pacific American Legal Center (Los Angeles, CA)
Bay Area Legal Aid, Contra Costa Regional Office (Richmond, CA)
Bazelon Center for Mental Health Law
California Pan-Ethnic Health Network
Center for Civil Justice (Saginaw, MI)
Center for Reproductive Rights (New York, NY)
Children's Defense Fund-Ohio (Columbus, OH)
Chinese for Affirmative Action (San Francisco, CA)
Chinese Progressive Association (Boston, MA)
Community Health Access Network (Raymond, NH)
Community Legal Services, Inc. (Philadelphia, PA)
Cross-Cultural Communications (Ellicott City, MD)
East Bay Community Law Center (Berkeley, CA)
Endowment for Health (Concord, NH)
The Emory Clinic (Atlanta, GA)
Families USA
Florida Legal Services, Inc. (Tallahassee, FL)
Health Care for All (Boston, MA)
Health Consumer Alliance (Los Angeles, CA)
Health Consumer Center, Legal Aid Society of San Mateo County
Health Consumer Center, Neighborhood Legal Services of Los Angeles County
Health Rights Hotline (Sacramento, CA)
Healthy House Within a MATCH Coalition (Merced, CA)
Institute for Reproductive Health Access (New York, NY)
Law Center for Families (Oakland, CA)
Legal Aid Foundation of Los Angeles
Legal Services of Southern Piedmont (Charlotte, NC)
The Legal Aid Society - Employment Law Center (San Francisco, CA)
League of United Latin American Citizens (Northeast Region)
Massachusetts Medical Interpreters Association
Maternal and Child Health Access (Los Angeles, CA)
Mercy Medical Center (Des Moines, IA)
Mid-Iowa Health Foundation (Des Moines, IA)
Migrant Legal Action Program
Multicultural Association of Medical Interpreters of Central New York, Inc. (Oneida, NY)
National Council on Interpreting in Health Care
National LEP Task Force
National Partnership for Women & Families

National Senior Citizens Law Center
National Women's Law Center
Neighborhood Legal Services (Los Angeles, CA)
New Hampshire Minority Health Coalition (Manchester, NH)
New York Immigration Coalition
New York Lawyers for the Public Interest
North Carolina Justice and Community Development Center (Raleigh, NC)
Northwest Health Law Advocates (Seattle, WA)
PALS for Health Program & ALAS para Tu Salud Project
Physicians for Human Rights
Santa Clara County Citizenship and Immigrant Programs (San Jose, CA)
Spoken Translation (Berkeley, CA)
Summit Health Institute for Research and Education, Inc.
Texas Breast Cancer Coalition (Carrollton, TX)
Universal Health Care Action Network of Ohio (UHCAN Ohio)
Virginia Poverty Law Center
Western Center on Law and Poverty

A. GENERAL COMMENTS

We appreciate the opportunity to provide comments to the revised OCR guidance that was published in the Federal Register in August 2003. Our comments are divided into three basic parts. The first section sets forth general, overall comments to the guidance. Part two contains more detailed comments on a section by section basis. Finally, the last section includes recommendations to bring HHS' guidance into conformance with the DOJ template.

Ensuring access to health care for people with limited English proficiency is more important than ever, because America is more diverse than ever. Surging immigration is transforming both urban and rural America, and has fueled the bulk of the population growth in rural and urban America. Large cities such as Los Angeles, New York and Chicago continue to be remarkably diverse. In addition, immigrants have now settled in smaller cities such as Des Moines, Iowa and La Crosse, Wisconsin. In percentage terms over the past ten years, Georgia and North Carolina saw the largest increases in their LEP populations – 243%. Thirteen additional states experienced over 100% growth in their LEP populations. The health care system throughout America must be in a position to respond to the often unique needs of immigrants, including but not limited to their cultural and linguistic needs. Health care providers must adjust to the new American landscape, and the OCR LEP Policy Guidance must also acknowledge this exciting yet challenging transformation.

The Bush administration has made a number of critical pronouncements about the need for health care and human service providers to ensure meaningful access for people with limited English proficiency. On a number of occasions, this administration has reaffirmed its commitment to Executive Order 13166, and we applaud your continuing support of this Executive Order. In 2002, the Department of Justice issued revised Title VI LEP Guidance, and set forth a standard for federal agencies to follow in crafting or revising their Title VI LEP Guidances.

We are seriously concerned that the OCR LEP guidance deviates from the DOJ requirements in a number of material respects. Equally importantly, the 2003 revised OCR guidance represents a troubling departure from the carefully crafted guidance issued by OCR in 2000, which was substantially unchanged from its revised guidance issued in February 2002. The 2000 guidance was the model for other federal agencies, and established OCR as the leader among federal agencies and throughout the country in providing a flexible compliance roadmap under Title VI. HHS federal fund recipients throughout the country have relied on the 2000 OCR guidance in crafting effective programs and policies to ensure that people with limited English skills can meaningfully access health care and human services.

The revised guidance sends a muddled, confusing message to providers and consumers, and stands in stark contrast to OCR's prior leadership on this issue. In so many instances throughout the revised guidance, "shall" has become "may" or "should." Equally troubling, the guidance, through its statement in section V that providers may conclude in "certain circumstances" that "language assistance services are not necessary," invites providers to disregard altogether their obligations under Title VI. Such guidance is legally incorrect under Title VI, reflects a shocking departure from OCR's prior interpretation of Title VI, and is unsound public policy and unsound health care policy.

Upon reviewing the revised OCR guidance, we have four general categories of concerns that are outlined below. Although we address specific concerns in the context of our section by section analysis, these four concerns repeatedly surfaced throughout the guidance as a whole.

1. The Current OCR Guidance Misinterprets the Obligations of Health Care and Social Services Providers under Title VI to Ensure Meaningful Access

It is well settled that a recipient of federal financial assistance has an obligation under Title VI to ensure that persons with limited English proficiency can meaningfully access the program or service. While the revised OCR guidance acknowledges this tenet in general, it often belies it with particulars. For instance, in section V, the guidance acknowledges a recipient's legal obligation to ensure meaningful access, but then notes that a recipient may conclude "in certain circumstances [that] recipient-provided language services are not necessary." This statement misconstrues Title VI, and invites all too many providers to do nothing for persons with limited English proficiency. The examples that were used presumably to clarify this statement actually complicate and confuse matters further.

The frequency with which optional wording "such as" "may" or "likely" "has replaced mandatory wording from DOJ's guidance demonstrates how HHS' guidance undermines Title VI of the Civil Rights Act. Interpretation and enforcement of Title VI, spanning almost four decades, cannot be overlooked. The current language in the Guidance has dramatically changed where DOJ's Guidance stated "must" to OCR's use of "may" or "should." Additionally, many of the examples within OCR's Guidance, used to clarify the suggestions, actually complicate matters, will further confuse providers, and do not give a clear guideline for providing quality care to LEP populations.

2. The Guidance is Inconsistent in a Number of Material Respects with the Directives Set Forth in the DOJ Policy Guidance on Title VI.

The Department of Justice coordinates the enforcement of Title VI across federal agencies. In 2002, DOJ issued its revised LEP guidance for recipients of DOJ financial assistance, and also sent a memorandum to federal agencies that provided a template for agencies to follow in preparing their LEP guidance. Creation of this template was due in part to a finding by the Office of Management and Budget of a need for consistency in the application of Title VI across federal agencies. The revised OCR guidance is inconsistent with the DOJ directive in a host of areas. For example, in a section on "Competency of Interpreters", DOJ's guidance states that "recipients should ensure" while HHS states "Recipients should take reasonable steps, given the circumstances"; in discussing the competency of family members as interpreters, DOJ states "in many circumstances" family members are not competent while HHS says "in some circumstances." The revised OCR LEP guidance must be modified to ensure compliance with this DOJ directive. Otherwise, the goal of consistency across federal agency LEP guidance documents will be thwarted.

3. The Guidance is Inconsistent with OCR's Longstanding Interpretations and History of

Enforcing Title VI

OCR has been enforcing Title VI for decades. During this period, OCR has entered into hundreds of compliance agreements with providers, and has provided technical assistance to thousands of recipients. We are unaware of any compliance agreement, consent decree or other document issued by OCR in which OCR agreed that a recipient could determine that it had *no obligation to provide any assistance to an LEP person*. Rather, these complaint resolutions correctly recognize that Title VI runs to and protects the *individual who is being discriminated against on the basis of race, color, or national origin*. Yet the provision in Section V that addresses this reflects a troubling turnabout in policy and a new interpretation of Title VI. If OCR indeed wishes to change its longstanding interpretation of Title VI in the LEP context, it must do so through notice and comment rulemaking. OCR lacks the authority to make such a critical change through this non-regulatory guidance process. To put it differently, OCR is no longer simply restating legal principles that were incorporated into prior compliance agreements and other related activities. The guidance proposes to move OCR in a new legal direction, and it must comply with the notice and comment rulemaking provisions before attempting to do so.

4. In a host of areas, the Guidance Reflects Unsound Public Policy that Runs Counter to Numerous HHS Initiatives, Including the Initiative to Eliminate Racial and Ethnic Disparities in Health Status, Numerous Quality Improvement Initiatives, and HHS Efforts to Reduce Medical Errors.

In addition to running counter to Title VI, the OCR Guidance is not good public policy as it is likely to foster bad health policies. The guidance invites providers to engage in unsound practices, such as allowing family members to serve as interpreters or failing to ensure the competency of the language service provider. Such practices are dangerous, and can have serious adverse consequences. In reviewing its guidance, OCR should consider the broader Departmental initiatives to improve quality of care, eliminate racial and ethnic disparities, and reduce medical errors. It is difficult to imagine how inviting providers to conclude that no language assistance services are necessary, or allowing family members or untrained staff to serve as interpreters, will assist in making progress on these initiatives.

B. SECTION BY SECTION COMMENTS

I. Background and Legal History

OCR has been enforcing Title VI for over 30 years, has investigated hundreds of complaints, and has negotiated dozens of voluntary resolution agreements. It issued an internal guidance memorandum on LEP issues in January 1998 to instruct its regional offices on enforcement of Title VI and "to ensure consistency in OCR's investigation of LEP cases." The current LEP Guidance should be consistent with those prior guidances to clarify for all federal fund recipients, as well as the general public, the recipients' legal obligations under Title VI.

We agree with OCR's discussion and conclusions in Section I. We are concerned, however, that OCR has omitted any discussion of legal history except for *Lau v. Nichols*. In the guidance published in August 2000, OCR provided a fuller legal history which was helpful in explaining the scope and breadth of expectations under Title VI for recipients of federal funds. We urge OCR to incorporate cases in addition to

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Lau

is the seminal case in this area, the inclusion of other cases is helpful to provide additional guidance to recipients who often are unfamiliar with Title VI.

We also recommend that OCR include examples of recently decided cases from its own investigations, such as the Los Angeles County welfare department settlement finalized this month, the Rancho Los Amigos settlement against LA County DHS [OCR Docket No. 09-00-3014], the Fresno settlement agreement with Fresno County Adult Services [OCR Docket Nos. 09-00-3007, 09-00-3300 & 09-003338] and Maine Medicaid Center [OCR Docket No. 01-98-3025] consent decrees. Providing further examples of effective language access and steps recipients have undertaken to provide meaningful access can only further OCR's objectives in providing comprehensive uniform guidance to recipients of their obligations under Title VI.

With regard to the omitted Introductory section which was included in the DOJ LEP Guidance, we recommend that a similar section be included in the final OCR LEP guidance. For example, the DOJ LEP Guidance provides useful background information and statistics to illustrate the critical need to provide language assistance services and describes the barriers to access of important benefits and services by LEP persons.

RECOMMENDATION: Amend Section I to include an Introduction as well as additional legal history and selected OCR decisions and consent decrees.

II. Revised HHS LEP Guidance

We appreciate the discussion of the timeline from HHS's first republication of its guidance to the present. We believe this is helpful to explain to recipients, consumers and advocates of the development of this current guidance.

As HHS recognizes, it has decided that the DOJ template is an appropriate model for HHS to adopt. As DOJ recognized in its guidance, and as quoted in HHS's guidance, "Consistency among Departments of the federal government is particularly important."

We are therefore concerned when, throughout its guidance, HHS has deviated from the DOJ template and adopted less mandatory language. While HHS noted that it made "certain modifications for the purposes of clarity and organization", we believe that many of the changes actually hinder clarity by creating different standards and expectations for recipients of HHS funds compared to recipients of DOJ funds. For example, changing mandatory language as used in DOJ's template to voluntary language in HHS's such as changing "must" to "likely" or "may" does not clarify the guidance but rather obfuscates the situation and fails to ensure consistency. While we recognize that certain examples need to be changed because of the different nature of programs involved, we do not believe that HHS should change basic language used throughout and should not add examples that serve to confuse rather than clarify. We believe that as HHS has adopted DOJ's guidance as its template, and stated its intent to abide by that template to ensure consistency among the federal departments, that HHS must ensure that its guidance does indeed track DOJ's in substance as well as form.

In Section C. we have pointed out concerns about language changes that we believe fail to adhere to the DOJ template and create more confusion rather than clarity. We have provided "Minimum Recommendations" which we urge HHS to adopt to bring its guidance in line with

the DOJ template.

III. Who is Covered?

In general, we agree with the substance of this section and urge OCR to maintain it as is at a minimum. According to OCR, all programs operated by any recipient that receives any federal funding will be covered, regardless of whether federal funds are actually used to operate a specific program. This explicit interpretation makes it clear that any subcontractor or vendor to the recipient would be covered by Title VI.

RECOMMENDATION: Amend Section III, paragraph 1 to read as follows:

Department of Health and Human Services ... require all recipients of federal financial assistance from HHS, *either directly or indirectly*, to provide meaningful access to LEP persons.

IV. Who is a Limited English Proficient Individual?

We agree with the contents of this section. We would suggest that OCR add clarification specifically addressing health care issues. While an individual may have sufficient English skills to interact in many day-to-day situations, interactions in the health care arena often requires a higher level of English ability. One explanation is that health care interactions actually require knowledge of four languages – English, medical terminology in English, the target language, and medical terminology in the target language. The very complexity of medical terms, some of which do not have corresponding terms in other languages, further illustrates a heightened need for language services. Both the importance of comprehension as it directly impacts diagnosis, treatment and outcomes as well as the complicated terminology used in health care often results in a greater need for language services by LEP persons than in other day-to-day encounters.

RECOMMENDATION: Amend Section IV, paragraph 1 to read as follows:

Individuals who do not speak English as their primary language and *or* who have a limited ability to read, write, speak or understand English
at a level that permits him/her to interact effectively with health and social service agencies and providers
may
can
be limited English proficient. . .

V. How does a Recipient Determine the Extent of Its Obligation to Provide LEP Services?

(i) Introduction (68 Fed. Reg. 47314)

OCR sets out four key factors in its introductory comments to ensure meaningful access to LEP individuals, but does not state that they are mandatory minimum requirements. HHS guidance states that, after conducting the four factor test, "a recipient may conclude that different language measures are sufficient for the different types of programs or activities in which it engages, **or, in fact, that in certain circumstances, recipient-provided language services are not necessary**". (emphasis added) This position goes beyond what the DOJ template sets forth and is alarming because if a provider has made the affirmative choice to accept federal dollars, then Title VI requires that it do at least *something* to insure that it is not ever refusing service, or offering a different type or quality of service, based on a person's national origin. Title VI does not allow a recipient of federal funds to discriminate by refusing to serve LEP individuals as long it does so only rarely.

It is not exactly clear what HHS is trying to say by stating that "in certain circumstances," language services are not necessary. Is it that the provider need not serve LEP individuals if encounters with them are rare? Or is HHS saying that the provider must serve the individual, but may attempt to do so without being able to communicate with her? Or is HHS suggesting that the provider does not have to do anything, and the LEP individual has to make her own arrangements for interpretation if she wishes to be served? Whatever its intent, HHS position has confused the *extent* to which an entity may have to offer language services with *whether* any language services must be provided at all. Title VI does not allow a recipient of federal funds

to discriminate by refusing to serve LEP individuals, even on a rare basis. Nor is it a permissible option to attempt to serve such a person without knowing what it is the person actually wants or needs. In the example given by HHS, one must ask how the dentist, confronted with a Hmong speaking client and without language services of any kind, can even determine that what the person seeks is to have her teeth cleaned. It is inappropriate to tell an LEP individual to come back later with her own interpreter. At best, this results in delayed service, which will sometimes cause unnecessary suffering. At worst, the person will not be able to arrange for an interpreter on her own and will be denied the service

altogether

, no matter how routine it may be considered by HHS. Certainly Title VI does not envision or allow this,

but

the guidance

suggests

just that.

The extent to which *covered entities* provide language services is certain to differ based on the four factors. But something must be done in each case. For example all healthcare providers should have, at a minimum, a plan for using a telephonic interpreter line to access interpreters for those cases, no matter how rare, when the provider encounters an LEP individual. While we recognize that cost is

a consideration in determining the *ty*

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of language services to use, it cannot be legitimately considered in evaluating

whether

to provide such services at all. Otherwise, the clear message is that it is permissible to discriminate on the basis of national origin every now and again if doing otherwise would cost anything more than a nominal amount.

We *strongly* recommend HHS amend its guidance to delete the qualification underlined above, so that its current policy conforms to Title VI and to the DOJ LEP guidance.

RECOMMENDATION: Amend V, paragraph 2, sentence 1 to read as follows:

After applying the above four-factor analysis, a recipient may conclude that different language assistance measures are sufficient for the different types of programs or activities in which it engages. or, in fact, that, in certain circumstances, recipient-provided language services are not necessary.

Ensuring effective communication between the provider and the LEP person is critical to increasing access to the recipient's services, especially when there may be adverse consequences in the area of professional services such as health care. We are concerned that the current guidance, as well as the DOJ template, result in confusion rather than clarification because of the contradictory language in the guidances. For example, in Section III of the DOJ and OCR LEP Guidances, it states that the regulations "require all recipients .. to provide meaningful access to LEP persons." This is in contrast to Section V, which claims that "[r]ecipients are required to take *reasonable* steps to ensure meaningful access to their programs and activities by LEP persons (emphasis added)." The DOJ standard provides inconsistent and conflicting guidance to the recipients. Moreover, ensuring effective communication between the provider and the LEP person is critical to increasing access to the recipient's services, especially when there may be adverse consequences in the area of professional services such as health care.

RECOMMENDATION: Amend III and V, paragraphs 1, sentence 1 to read as follows:

HHS regulations require all recipients of Federal financial assistance of HHS to provide meaningful access to LEP persons at no cost to the LEP person. The most important step in meeting the Title VI obligation is for the recipients of Federal Financial assistance to provide the language assistance services necessary to ensure meaningful access at no cost to the LEP person. The key to meaningful access to benefits and services to LEP persons is to ensure that the language assistance provided results in accurate and effective communication between the provider and LEP applicant/client about the types of services and/or benefits available and about the applicant's or client's circumstances.

(1) *The Number or Proportion of LEP Persons Served or Encountered in the Eligible Service Population*

Individuals *Eligible to be Served*: OCR's first factor, as the heading reads, focuses on "the number or proportion of LEP persons *served or encountered* in the eligible service population." (emphasis added) Yet, as noted in the text below the heading, a recipient should consider not only those LEP patients it *is* serving, but also those who are *eligible*

to be served but may be underserved because of existing language barriers. The failure of many recipients to provide language services causes LEP patients to forego care or seek it from other sources. By not acknowledging in the title and then confirming in mandatory language in the text that a recipient must consider persons

eligible

to be served, the guidance implicitly allows a recipient to continue discriminating by not providing language services. Thus, language services should be available based on the LEP population of the service area — those

eligible

to be served — regardless of the population that is presently encountered by the recipient.

Furthermore,

not

providing such service perpetuates discrimination because LEP individuals seeking care by the recipient cannot benefit from their services and any recipient receiving federal funding has to abide by Title VI.

A standard that looks only to encounters with an eligible service population of LEP patients is rife with the potential to perpetuate past or ongoing discrimination. The current OCR language allows a recipient to choose when they serve LEP persons because recipients are anticipated to provide services *only if* there is a population to serve. This is worrisome because it allows recipients to simply argue that their current LEP population is too small to require them to provide any language assistance or to claim that they do not have the resources to provide adequate language assistance to its LEP clients. It also fails to recognize that not having LEP persons in their current patient population is often not based on a lack of LEP persons in the service area but rather a lack of language services which turns patients away. The covered entity must consider those eligible to be served, not those *actually* served, because the latter measure may well be a function of current inadequate or discriminatory practices. It also ignores the need for the entity to continuously assess its ever-changing service population which, as the most recent census has shown, can change dramatically in a relatively short period of time. Again, while we recognize that cost is a consideration in determining the

type

of language services to use, it cannot be legitimately considered in evaluating

whether

to provide such services at all. Additionally, it is imperative to identify and maintain a record of the preferred languages needs of each LEP patient/client and ensure that the appropriate language services are provided. The whole purpose here is to improve the status quo, not to perpetuate it.

RECOMMENDATION: Amend (V) (1) Factor 1 page 68 Fed. Reg. 47314 to read as follows:

The Number or Proportion of LEP Persons *Eligible to be Served or Likely to be Affected by Encountered*
the
Program or Recipient.

RECOMMENDATION: Amend (V) (1), second paragraph, second sentence, 68 Fed. Reg. 47314 to read as follows:

In certain circumstances, it is important in conducting this analysis to include language minority populations that are eligible for their programs or activities but may be underserved because of existing language barriers.

Service Area: The guidance states that a service area includes persons who are in the geographic area that has been approved by a federal agency. Where no service area has been previously approved, the guidance recognizes that a service area may be approved by state or local authorities or *designated by the recipient itself*, provided that these designations do not themselves discriminatorily exclude certain populations. We believe, however, that in assessing and determining what language services recipients should provide to the LEP population encountered in the eligible service population, it is important for the approval to come from a central source, whether that is state and/or local authorities and/or an objective, third party. If an entity has the latitude to determine its own service area, inconsistencies between hospitals, within the area and in the state, may result in inadequate services for LEP patients. It may also pose a conflict of interest for the recipient who may choose to limit its service area by excluding the eligible LEP population to avoid the costs of providing language assistance services. If self-designation is allowed, at a minimum an entity must be required to document how the determination was made and what data was considered in determining what types of language services must be provided. Mechanisms must be in place to ensure consistency across similar entities and to preclude discrimination. While the guidance does state that a self-designation does not discriminatorily exclude certain populations, the long history of redlining and discrimination throughout this country illuminates the need for more than this statement. We urge OCR to preclude self-identification of a service area or, at a minimum, provide necessary guidelines for consideration if a provider is allowed to self-identify a service area and require state or local approval of the self-identification. While we are not undermining the recipient's abilities in deciding what language services are ultimately needed, the recognition of existing federal, state and local standards for defining service areas should be adopted by those who will self-define.

For example, language services may be provided for an LEP individual in one clinical setting,

but not another in the same service area. A primary care physician and a specialist both practicing in the same community would generally be acknowledged to have similar service areas. But allowing the providers to self-define their service area without reliance on the same types of data (such as Census or school enrollment) may result in different conclusions and thus discrepancies in language services should not be tolerated if the service area is substantially the same.

RECOMMENDATION: Amend V (1) to replace the first paragraph, second sentence, page 68 Fed. Reg. 47314, with the following:

Where no service area has been previously approved, the relevant service area must be approved by state and/or local authorities if designated by the recipient provided that these designations do not themselves discriminatorily exclude certain populations.

In addition to our concerns about the self-designation of a service area, we also want to applaud OCR for recognizing that in considering the number of persons eligible to be served, a recipient must not only consider the patients themselves but, in the case of minor children of the language needs of the parent/guardians. We would suggest, however, that this sentence be expanded to include consideration of incapacitated adults who have designated guardians who may be LEP. For example, an elderly person with Alzheimer's or dementia may be under the guardianship of his/her adult child who is LEP. Just as OCR is sensitive to the fact that communicating with the child is not sufficient when the parents speak another language, it should also recognize that adults with disabilities who have guardians must also be ensured that the guardian has language services as needed since it is only the parent/guardian who has the legal authority to give informed consent for a particular treatment. Further, it will be the guardian who will have to understand instructions for follow-up care, prescription medication dosages and schedules, monitoring and other necessary treatment. Thus, if the guardian is a LEP individual, the provider must ensure language services for the guardian regardless of the patient's English skills.

RECOMMENDATION: Amend V (1) to replace the first paragraph, seventh sentence, page 68 Fed. Reg. 47314, with the following:

When considering the number or proportion of LEP individuals in a service area, recipients should consider whether the minor children *or incapacitated adults* their programs serve have LEP parent(s) or guardian(s) with whom the recipient may need to interact, thus

requiring

language services to better assist the minor children

, *incapacitated adults,*

and their parents,

guardians and other who make decisions on behalf of the child or incapacitated adult

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(2) The Frequency With Which LEP Individuals Come in Contact With the Recipient's Program, Activity or Service

Under Title VI, a recipient of federal funds must do something to provide meaningful access to all persons it services, regardless of their national origin. Assessment is a key factor to ensure meaningful access to LEP individuals. If a recipient does not assess the needs of the LEP population eligible for its services, it will be unable to provide meaningful access. In addition to assessing the eligible population to be served (as discussed above), the guidance also expects an evaluation of the frequency with which LEP individuals access a recipient's program, activity or service. Combined with information on the eligible population, this information is essential to accurately assess how a provider will meet the needs of the pertinent LEP populations. The guidance appropriately emphasizes a greater need to provide language access services for those recipients who frequently encounter LEP individuals. This greater need, however, does not obviate the responsibility of recipients with less frequent LEP contacts to periodically engage in an objective assessment to accurately verify the extent of need — both of those currently in contact with the recipient but also those who would be in contact if language services were provided. As stated above, all recipients must offer some type of language services. and have a contingency plan to provide language assistance services to any LEP patient, especially in emergency situations. The frequency of contact with LEP persons may assist in determining what method(s) to employ. For example, we would expect that a provider who frequently sees LEP patients of a particular language group should consider language capabilities in hiring decisions — having a bilingual staff person who is trained and competent to interpret is often more efficient than relying on a telephone language line which may be staffed by individuals with no knowledge or understanding of medical concepts. But while the frequency of contact is helpful in identifying language needs and developing an effective language access plan, it must be combined with the information on those eligible to be served to determine whether providing language services will influence the frequency of contact.

We are particularly concerned, however, that the HHS guidance does not conform to the DOJ guidance. The DOJ guidance states the following at the end of V (2): — certain recipients should take care to consider whether appropriate outreach to LEP persons could increase the frequency of contact with LEP language groups. [67 Fed. Reg. 41460] OCR's guidance copies DOJ's language, but then adds an example that specifies that some providers may not

have to undertake outreach. The effect of inserting this example in its current form is a weakened expectation that smaller providers will conduct outreach to surrounding LEP populations, as well as the creation of a disincentive to do so. It seems disingenuous to have a provider assess the population eligible to be served and then not have to at least notify LEP individuals of the availability of language services. Further, relying on the frequency of contact while not considering whether frequency may change depending on assessing those eligible to be served. While the methods of outreach may vary based on the frequency of contact and resources of the provider, we would then expect that all providers would, at a minimum, notify callers to their office and post notices that language services are available. And to the extent that a provider does conduct general outreach, this outreach should include information about language services. By stating that most individual physicians and dentists do not need to perform outreach, OCR invites a situation where LEP individuals in small communities, who may only have access to individual physicians, will not have the benefit of any community outreach.

By exempting certain providers from outreach, HHS's guidance does not conform to the DOJ template and we thus recommend that OCR delete the additional language which relieves small providers of any responsibility to perform outreach.

RECOMMENDATION: Delete V (2), paragraph two, sentences two and three, page 68 Fed. Reg. 47314:

For example, in areas where a community health care center serves a large LEP population, outreach may be appropriate. On the other hand, for most individual physicians or dentists, outreach may not be necessary.

(3) The Nature and Importance of the Recipient's Program, Activity or Service

Health care services are always important, and often are of an urgent or critical nature. In medical settings, denials or delays of treatment can result in dire consequences. Moreover, delays in service may turn routine, chronic problems into serious conditions requiring immediate treatment and elective surgeries can easily become emergency surgeries. We urge OCR to recognize that guidelines for federally funded health care providers must be more specific and stringent than those set forth in the DOJ LEP guidance, which applies to a broader range of service programs. It is imperative, therefore, that OCR amend the examples set forth in V (3) of the guidance.

The OCR guidance has created three levels of care – 1. important and urgent; 2. important but not urgent; and 3. neither important nor urgent. We believe that in making these distinctions OCR is suggesting – or at least implying – hard and fast distinctions where the reality is not so clear. It would be difficult for a provider, without conducting an actual physical examination, to accurately evaluate whether something is important and urgent or important but not urgent. And if a provider or his/her staff cannot communicate with a patient, a provider would be unable to even evaluate a telephone request to make an appointment to determine if it is important or urgent. Oftentimes, the patient is unaware of the urgency of the needed health care and may not initially understand the implications of his/her symptoms unless asked by the provider. For example, an LEP patient might request a cholesterol test, due to a fear of heart problems. If there is no family history of high cholesterol, his doctor may initially decide the test as important, but not urgent and the guidance would imply a delay in providing the test would be justified. But for how long would a delay be allowed and where would the line be crossed? Is a day, a week, a month or some other time acceptable as a delay? Perhaps the individual's test results would indicate a high cholesterol level and suggest the need for further tests. If another provider could again delay, what would the potential adverse consequences be to the patient? This – important but not urgent – test might in hindsight be viewed as – important and urgent – because the patient needed to make immediate changes in diet and medication and even consent to surgical interventions such as angioplasty or bypass. Perhaps a series of delays could lead to the patient suffering a heart attack or stroke because a condition treatable by cholesterol-lowering drugs or even minimally invasive angioplasty is worsened due to the delays.

Further, this distinction is not included in the DOJ guidance and thus does not conform to its template. Thus, we recommend that it be deleted.

RECOMMENDATION: Amend V (3) to delete sentences 3-6 and insert the following:

Health care services are always important, and often are of an urgent or critical nature. In medical settings, denials or delays of treatment can result in dire consequences. Moreover, delays in service may turn routine, chronic problems into serious conditions requiring immediate treatment and elective surgeries can easily become emergency surgeries.

We recognize that OCR may wish to include some distinction between types of services and when language services are immediately available. Rather than evaluate based on a perceived level of urgency and importance without any actual evaluation by a health care provider, OCR should distinguish not between – important and urgent – and – important but not urgent – but

rather between clinical and non-clinical care. Regardless of whether treatment is an emergency, all clinical care should require immediate language services or the de facto result is discrimination against LEP persons in violation of Title VI. In contrast, non-clinical care, such as administrative matters, billing and tours of the facility, may be subject to a less stringent standard.

RECOMMENDATION: Amend V (3) as follows:

If the activity is *clinical*, immediate language services are needed. Finally, if an activity is *non-clinical* such as a general public tour of a facility it is more likely that language services would not be needed immediately.

(4) The Resources Available to the Recipient and Costs and the Text that Follows

We are concerned that OCR's attempt at defining *the contours of* when recipients need to provide language services of some sort to LEP patients demonstrates a lack of understanding of the LEP individual's contact with the health care setting. In the guidance, OCR provides an example that a dentist in an almost exclusively English-speaking neighborhood who has rarely encountered a patient who did not speak English and has never encountered a Hmong-speaking patient may not need, solely pursuant to Title VI, to provide language services for a LEP Hmong individual who comes in for a dental cleaning. But the guidance fails to recognize that in many areas of the country, particularly rural areas with dwindling access to health care providers, there may only be one available dentist in the neighborhood, community or even county, particularly a dentist accepting Medicaid. If the dentist accepts federal funds, and can effectively provide language services by utilizing a language line for his one LEP patient (and thus amortize the cost over all his patients, resulting in a minimal additional cost), why should the dentist be allowed to send the patient away? If this dentist does not serve the LEP person, where should he go? What if every dentist in a particular county decided not to offer services to LEP patients because they would only see a handful of LEP patients a year? Preparing for such scenarios is crucial to prevent detrimental consequences in seemingly benign health care settings.

We are concerned that the guidance's examples within V (4) for recipients in this area would openly permit discrimination against LEP individuals by allowing individual providers to forego

treating LEP patients because they serve a predominantly English-speaking community. When the recipient decided to accept federal dollars, the application of Title VI cannot be ignored. Title VI requires the recipient to do at least *something* to insure that is not refusing service or providing a different quality of service because of person's national origin. Title VI does not allow a recipient of federal funds to discriminate by refusing to serve LEP individuals as long it does so only rarely.

RECOMMENDATION: V (4) paragraph four, delete sentence eight, page 68 Fed. Reg. 47316:

In contrast, a dentist in an almost exclusively English-speaking neighborhood who has rarely encountered a patient who did not speak English and has never encountered a Hmong-speaking patient may not need, pursuant solely to Title VI, to provide language services for a LEP Hmong individual who comes in for a dental cleaning.

We are also concerned about another misleading example which would allow one provider to transfer a patient to another to achieve language concordance. This example effectively shows recipients what could be permitted under the guidance and is not an option even contemplated by the DOJ LEP Guidance. The example seems to accept shuttling LEP patients to different doctors or healthcare workers, solely based on the provider's decision not to provide services because of the recipient's language skills or contact with "similar LEP patients." Allowing such actions informs the recipient that "one time discrimination" is allowed. But the question is: once allowed, where would it stop?

The example would allow recipients to rely on other providers to provide language access, and discourages providers from finding a way to improve access within their own facility/practice. Allowing a provider to refer LEP patients solely on the basis of which language they speak fails to take into account other important considerations in the patient-provider relationship. People choose their doctors based on a variety of factors that are important to them and make them feel comfortable with that particular provider. While language may be one of those factors, or even an important one, the OCR guidance effectively assumes that it is the *only* factor of importance to an LEP person. In the alternative, which would be even more troubling, the example assumes that it is legal, and even acceptable, to ignore all the other preferences of LEP people and refer them elsewhere under the guise of "helping" them, simply because the provider of choice has not seen fit to take the steps necessary to communicate with them. This is in our view discrimination per se, and OCR's suggestion that it is an acceptable practice represents nothing short of an abdication of its responsibilities in this area.

Furthermore, the end result of this example would be to allow the recipient to never provide language services if it could refer patients out – it would never have to train staff or be prepared for *any* LEP patients. In addition, as this example does not conform to the DOJ template, it must be deleted.

RECOMMENDATION: text following V (4) paragraph one, delete sentences six and seven, page 68 Fed. Reg. 47315:

In certain circumstances, pursuant to an arrangement, where there is no discriminatory intent, the purpose is beneficial and will result in better access for LEP persons, it may be appropriate for a recipient to refer the LEP beneficiary to another recipient. For example, if two physicians in the same field, one with a Spanish-speaking assistant and one with a Vietnamese assistant, practice in the same geographic area and have a custom/practice of referring patients between each other, it may be appropriate for the first doctor to refer LEP Vietnamese patients to the second doctor and for the second doctor to refer LEP Spanish patients to the first doctor.

Types of Oral Interpretation: Additionally, the guidance identifies a number of methods of providing oral interpretation. We recommend that these methods be listed in order of preference, with a designation that an in-person or on-site interpreter is preferred to a telephonic interpreter. The primary difficulty with telephone language lines is that they may not always have readily available medical interpreters who are familiar with the terminology essential to health care. The same type of competency and training requirements expected from on-site interpreters should be required of telephone interpreters. Moreover, we believe that a recipient should not offer this as the only language service except when other language assistance options are unavailable, such as in a rural clinic visited by an LEP patient who speaks a language that is not usually encountered in the area.

We also request that OCR set a minimum requirement that an interpreter hotline number be available 24 hours a day, seven days a week as a back-up for existing language services and to cover situations where immediate interpretation is critical. While we recognize that DOJ and HHS have identified cost as a factor in a recipient's determination of what language services to provide, the costs of maintaining access to a telephone language line are minimal compared to the ultimate benefit offered by having instant access, reducing language barriers, and protecting the health care provider from liability for malpractice or negligence and other indirect costs that can result from misdiagnosis and mistreatment. While the costs of language line contracts vary depending on language and usage, the NetworkOmni Multilingual Communication group provides language services via phone for a one-time set up fee for \$150. with monthly service fees *only costing* \$50.; the monthly fee is credited towards usage which costs \$1.60/minute for

Spanish and \$1.70/min for other languages. Further, the monthly fee is charged only once per entity, even if multiple departments access the services. For example, the Alzheimer's Association recently contracted with NetworkOmni to provide language services to each of its state and local chapters. If OCR, state agencies, or health care provider associations were to assist health care providers in contracting with telephone language lines such as this, we believe the costs could be reduced even further with a bulk purchasing agreement.

RECOMMENDATION: Add to text following V (4) paragraph two, sentence 4, page 68 Fed. Reg. 47315

A recipient/covered entity must provide language assistance through the use of trained and competent bilingual staff or staff interpreters. When these options are unavailable, preference should be given to provide language assistance in the following order: trained and competent outside interpreters; trained and competent voluntary community interpreters and, only when all other options are unavailable, trained and competent telephone interpreters.

VI. Selecting Language Assistance Services (68 Fed. Reg. 47316)

In selecting language assistance services, providers must ensure the competency of interpreters and translators, as well as providing the best mode of communication for the specific situation, taking into account many factors. Although it may not be possible to have linguistically and culturally competent bilingual staff to communicate with patients in every instance, OCR must amend the guidance to ensure effective communication with all LEP patients. It is unacceptable, because of the danger to LEP patients, that the guidance allows indefinite delays in treatment based solely on language issues. It is also unacceptable that the guidance allows family members, friends and even minors to interpret in situations, such as domestic abuse, which clearly involve a conflict of interest.

Not having *any* interpreters can have serious detrimental results to patients as well as providers, who may be liable for actions undertaken without obtaining informed consent. For instance, a Hmong patient received *no interpretation* prior to having an operation where one potential outcome was the amputation of his foot and lower leg, which in fact occurred. The patient could not give informed consent because of language barriers and was not aware that he lost his leg until after the surgery when his son said, in Hmong, "Where is your leg, Dad?"

A. Considerations Relating to Competency of Interpreters and Translators

1. Competence of Interpreters

We appreciate OCR's recognition that all interpreters must be competent. An inadequate interpreter may do more harm than good by providing a false sense of security that the patient fully understands the provider when he or she may not. Unfortunately, only one state, Washington, offers certification for medical interpreters. There are currently several efforts to develop interpreter standards in California, Massachusetts, Minnesota, and New York, and nationally by the National Council of Interpreters in Health Care (NCIHC).

Minimum Training: The areas of competency outlined in the Guidance – demonstration of proficiency in English and target language, knowledge of specialized terms/concepts, recognition of confidentiality and impartiality issues, and understanding of role of interpreter – are generally consistent with NCIHC and other professional medical interpreter associations. However, we would recommend that a training program offer a minimum of 40 hours training, which is the minimum length of programs well-regarded by professionals and medical interpreters. While there is no hard-and-fast rule for a minimum number of training hours, the most widely recognized training program – Bridging the Gap, developed by Resources in Cross-Cultural Health Care Program – employs forty hours of training. In addition to requiring a minimum amount of training, interpreters should be assessed for their knowledge and skills before they are allowed to interpret in a medical setting. As the guidance recognizes, it cannot be assumed that a nurse, medical staff, physician or other staff who speaks two languages will be sufficiently familiar with medical terms and concepts in both languages. Typically, bilingual individuals may only have conversational skills, which would result in similar interpretation errors as encountered with using untrained family and friends. Too often, recipients rely heavily on bilingual staff who are untested and may not afford true language access, leaving the health care provider at risk of misdiagnosis or medical errors which can lead to legal liability for the provider. Hiring competent and trained interpreters is also crucial in serving LEP patients. For instance, a Spanish interpreter for the Department of Health in Florida told numerous LEP patients referred to specialists that they must bring an interpreter with them to the appointment. The interpreter would also tell patients that services were not available unless the patient brought an interpreter, in turn making parents and patients frantic when they did not know anyone who could interpret even though the provider, pursuant to Title VI, should have provided an interpreter free of charge. The lack of training of the interpreter resulted in many patients not understanding their rights and foregoing or delaying care.

In addition to assessing bilingual abilities, the need for adequate training of interpreters cannot be underestimated. For example, Cuban refugees in Lansing reported that a County Health Department interpreter used extremely inappropriate language when interpreting for a nurse during a gynecological examination. When the women went for health screenings and had to give urine samples, the interpreter would use vulgar words to convey the nurse's description. All of the women were of the opinion that the interpreter was fully aware of how inappropriate his language was, but that he enjoyed making them uncomfortable. The lack of training of the role of the interpreter to conduct complete interpretation, as well as oversight of the interpreter by the facility's management, resulted in many women feeling uncomfortable with the care they received. This type of interaction discourages follow-up care, further interaction with the healthcare system, delayed care, discourages women from seeking care for their families.

RECOMMENDATION: Add to VI (A), paragraph two, after sentence one, page 68 Fed. Reg. 47316:

A recipient must ensure that those persons that it provides as interpreters are trained and demonstrate competency as interpreters. It is recommended that medical interpreters undergo training of a minimum of forty hours and that interpreters are assessed for their competency in the specific subject areas they will be interpreting.

Timeliness: Finally, oral language assistance must be timely and readily available during all hours of operation. As OCR recognizes, language assistance should be provided at a time and place that avoids the effective denial of the service. It is noteworthy that the DOJ LEP Guidance identifies health and safety services provided DOJ recipients as those types of activities for which timeliness of services is important. (67 Fed. Reg. 41461.) Some additional guidance regarding the definition of "timely" would be helpful because people may differ as to what they consider timely, much in the same way that providers may differently determine whether a service is "important" or "urgent" (see above). For example, in New York State's Patient Bill of Rights, the statute requires interpreters for sign language be provided within 20 minutes for in and out-patient settings and 10 minutes in emergency rooms. (10 N.Y. Comp. Codes R. and Regs. § 405.7(a)(7)). Maine's Medicaid managed care contract requires managed care plans to maintain a list of interpreters who are able to provide services within 30 minutes. (Maine Managed Care Contract, pg. 16-17, see Sara Rosenbaum, et.al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*,

Tables 1.5 & 3.6 (2001),

http://www.gwhealthpolicy.org/managed_care.htm

. Many additional Medicaid and SCHIP managed care contracts require access to customer service with bilingual language assistance (e.g. Colorado, Massachusetts, Ohio, and Texas).

We have gathered numerous examples of unnecessary delays in obtaining treatment when appropriate language services are not in place and/or communicated to staff. For example, a member of *Make the Road by Walking* (a New York City based organization) related his experience going to the emergency room by ambulance with an infection in his leg and being in a lot of pain. The physician attempting to treat him did not speak the LEP patient's language, Spanish. The patient did not want to accept medical treatment from someone with whom he could not communicate and an interpreter was not provided in a timely manner. The physician immediately left the patient who was led back to the waiting room, remaining in pain. There should be no excuse for a patient to wait more than 20-30 minutes, since, at a minimum, access to telephonic interpreters should be immediately available. In this situation, a telephonic interpreter could have been used for an initial assessment prior to the availability of an in-person interpreter. In exigent situations, telephone interpreters can be used until an in-person interpreter can be found.

RECOMMENDATION: Add to VI (A), paragraph nine, after sentence two, page 68 Fed. Reg. 47316:

The term, "in a timely manner," means that the LEP patient/client should wait no more than 20-30 minutes for an interpreter, since at a minimum, a telephone interpreter should always be available until an in-person interpreter can be located.

RECOMMENDATION: Delete VI (A), paragraph nine, sentence five, page 68 Fed. Reg. 47316:

Conversely, where access to or exercise of a service, benefit, or right is not effectively precluded by a reasonable delay, language assistance can likely be delayed for a reasonable period.

RECOMMENDATION: Amend VI (A), paragraph ten, sentence one, page 68 Fed. Reg. 47316:

For example, language assistance could not likely be delayed in a medical emergency, or when the time period in which an individual has to exercise certain rights is shortly to expire.

If LEP patients are forced to schedule appointments only at a time during which an interpreter is available, and this results in a delay in obtaining care due to limited interpreters, there is no question that the LEP patient is receiving a lesser standard of care than an English proficient patient who can schedule an appointment whenever she chooses. Mandating appointments at a certain time may preclude LEP patients from accessing care because of conflicts due to work, school or child care obligations. Further, as the DOJ guidance notes, a recipient would likely not be providing meaningful access if it had one bilingual staffer available only one day a week to provide the service. "Such conduct would likely result in delays for LEP persons that would be significantly greater than those for English proficient persons." DOJ LEP guidance, 67 Fed. Reg. at 41461. It cannot be the standard that LEP patients must constantly wait for interpreters before they can access routine visits.

In addition, how would a provider know that an individual was seeking a routine examination if he could not communicate with the patient? It is likely that a provider could delay care in order to wait for an interpreter because the doctor thought the issue was a routine examination, when in reality the LEP patient's health problem needed immediate care, and the misunderstanding arose from lack of adequate communication.

We are also concerned that the text allows for a delay in applying for benefits if a person has an "ample time to apply". In many situations, the actual timeframe for applying may be indefinite but certain rights attach once an application is made. For example, once a Medicaid application is filed, the state must determine eligibility within 45 days. If OCR allows a state benefit agency to delay assisting an LEP patient in completing an application because language services are not provided, the result is a delay in the availability of medical care because the 45 day period to determine eligibility will not start until the application is complete. Thus, the state becomes complicit in denying care to the applicant by delaying the application. This also can have serious financial consequences for an individual since Medicaid will reimburse an individual for medical expenses incurred for up to three months prior to the date of application. If the state delays the individual's application because of language barriers, the individual would be denied retroactive payments. For example, an LEP individual incurs medical expenses on December 8th

and goes to a state benefit office to apply for Medicaid on March 1st

. If the application was made on March 1st

, the LEP person's medical expenses from December 8th

would be eligible for reimbursement (as long as the individual meets the eligibility requirements). But if the state can delay the application because an interpreter is not available, and the delays last past March 8

th

, the individual would be barred from receiving reimbursement for the December 8

th

medical expenses because the application was not made within three months of the expense. The financial consequences to the LEP person would arise because OCR has given the state permission to discriminate against an LEP person as compared to an English speaking person who seeks to apply for benefits.

RECOMMENDATION: Delete VI (A), paragraph ten, sentence two, page 68 Fed. Reg. 47316:

On the other hand, when an LEP person is seeking a routine medical examination or seeks to apply for those benefits and has an ample period of time to apply for those benefits, a recipient could likely delay the provision of language services by requesting the LEP person to schedule an appointment at a time during which the recipient would be able to have an appropriate interpreter available.

2. *Competence of Translators* (68 Fed. Reg. 47316)

We appreciate that OCR recognizes that translators of materials, just as oral interpreters, must be competent. The major benefit of having translated materials available is the quality of care that results, specifically for the LEP population being served, arising from an understanding of treatment regimens, follow-up care, discharge instructions and the like. Securing adequate translation services, whether it is in prepared brochures or handouts specific to each medical area for LEP patients and informing the patient about their medical condition in proper and accurate terminology is essential to ensure the quality of health care services for LEP patients.

RECOMMENDATION: Add to the beginning of VI (A) under *Competency of Translators* paragraph one, sentence one, page 68 Fed. Reg. 47316 with the following:

The provisions in this section only apply to the provision of written translated materials and oral assistance of translated materials, and do not apply to the provision of oral interpretation services, which must be provided for any LEP person.

We appreciate that OCR has distinguished that translated materials and translators are different from interpreting. Often the terms may be interchanged and making the distinction from the beginning would absolve any confusion. We support OCR's recognition of the importance of using competent, and preferably certified, interpreters, using back translation techniques, and targeting the materials to the appropriate literacy level of its audience.

Yet despite the need for accurate translated materials, the guidance allows providers to use less skilled translators to translate "nonvital documents." We strongly disagree with this statement and believe there is no rational reason to allow for different standards for translation. As written materials are often the first materials an LEP person will receive from a provider or health care entity, accuracy is crucial to developing trust. If an outreach brochure is translated inaccurately, it would be unlikely that an LEP person would feel comfortable accessing health care with that provider because the written translation could be viewed as indicative of the importance the provider places on accuracy in other areas, such as treatment and diagnosis. De-emphasizing the need for accurate translation done by competent and qualified translators with non-vital materials is counter-productive. Further, providers are given little guidance in what is vital and non-vital information. The guidance says that less skilled translators may be used for documents that have "no legal or other consequence." It is difficult to imagine that a document will ever have "no other consequence." OCR lists examples of vital and non-vital documents in Section C. but leaves most of the determination up to the health care provider. This leaves wide latitude for a recipient to determine when less skilled translators are available. For example, a common mistake in translations from English to Spanish involves the English word "health." In one translation recently obtained from Dr. Tango, a Spanish translation service, the word "health care services" was translated as "medico" rather than "salud" – an Spanish-speaking LEP patient would likely believe only true *medical* ("medico") services were available rather than a wider array of health services ("salud") such as prevention services, counseling, etc. An individual would have received erroneous information about available services. The result is the LEP individual would have effectively been denied services because a less skilled translator was used. Providing accurate and competent information to LEP individuals has to be consistently done in providing quality care. This cannot be accomplished when providers are given options between providing LEP populations "some translated documents" while others are not provided for.

RECOMENDATION: Amend paragraph four, sentence 2, page 68 Fed. Reg. 47317:

For instance, to translate nonvital documents that have no legal or other consequence for LEP persons who rely on them, a recipient may use translators that are less skilled than the translators it uses to translate vital documents with legal or other information upon which reliance has important consequences. Providers must ensure the translator should have knowledge of the subject area for which they are translating.

B. Oral Language Services (Interpretation) (68 Fed. Reg. 47317)

1. Hiring Bilingual Staff

We appreciate that OCR provides clear guidance related to the appropriate use of various interpreter services. In explaining the circumstances when different types of oral assistance should be used, however, we recommend that OCR include an explicit statement in the Guidance regarding the order of preference. We believe that the use of bilingual, professionally and culturally competent, language-concordant staff in patient/client contact positions is the ideal way to ensure meaningful access to health and social services. This would ensure that each patient had access to a provider who understands the cultural issues that may affect treatment and outcomes. However, although we realize that this may not always be possible, we still believe that it is important that OCR recognize this “gold standard” to emphasize what we all should strive to work towards. To the extent that bilingual bicultural providers are unavailable, we suggest OCR specify that its preference for the best alternative option available. We believe telephone language lines should only be used as a last resort. The primary difficulty with telephone language lines is that they may not always have readily available interpreters who are familiar with the terminology essential to healthcare. We believe that a recipient should not offer this as the only language services except when other language assistance options are unavailable, such as in a rural clinic visited by an LEP patient who speaks a language that is not usually encountered in the area.

We recommend that OCR include an explicit statement in the Guidance regarding the order of preference, which should be similar to the order of the interpreter services listed in the Guidance.

RECOMMENDATION: Add to VI (B) after paragraph one, sentence two, page 68 Fed. Reg. 47317:

Whenever possible, a recipient/covered entity should provide language assistance through the use of trained and competent bilingual staff or interpreters. When these options are unavailable, preference should be given to provide language assistance in the following order: trained and competent outside interpreters; trained and competent voluntary community interpreters and, only when all other options are unavailable, trained and competent telephone interpreters.

2. Hiring Staff Interpreters

In many situations, the most cost-effective and efficient way to provide language services is to hire full- or part-time staff interpreters to ensure meaningful access for LEP persons, particularly in situations where a recipient serves a large LEP population, or multiple LEP populations. We urge OCR to recognize that hiring staff interpreters is not only reasonable, but may be required if the four factor analysis points to a high percentage or number of LEP patients who access the facility on a regular basis. OCR should encourage recipients to understand and expect that it is not a rarity if they should need to hire staff interpreters.

RECOMMENDATION: Amend VI (B), paragraph three, sentence two, page 68 Fed. Reg. 47317:

Depending on the facts, sometimes it *will* may be necessary and reasonable to provide on-site interpreters to provide accurate and meaningful communication with an LEP person.

3. Using Telephone Interpreter Lines

We believe that certain options, such as the use of outside interpreter services, especially telephonic interpreter services, should only be used as a supplemental system and not as the sole language option. There are many disadvantages to the use of telephone interpreter services, such as its limited use due to higher costs, awkward and/or inadequate interactions, the use of untrained medical interpreters, inability to convey body language and visual cues, and confidentiality concerns. And as we stated above, one difficulty with telephone language lines is that they may not always have readily available interpreters who are familiar with the terminology essential to healthcare. We believe that a recipient should not offer this as the only language services except when other language assistance options are unavailable, such as in a rural clinic visited by an LEP patient who speaks a language that is not usually encountered in the area. The use of telephone interpreter services must be limited to situations where an in-person interpreter is unavailable.

RECOMMENDATION: Amend VI (B), paragraph five, sentence two, page 68 Fed. Reg. 47317:

Telephone language lines should supplement other preferable language assistance options and may not be used as a primary method of providing language services except when other language assistance options are unavailable. While telephone interpreters can be used in numerous situations, they may be particularly appropriate where the mode of communicating with an English proficient person would also be over the phone.

4. Use of Family Members or Friends as Interpreters

We are pleased that OCR is cognizant of the dangers of using untrained interpreters and has included language which discourages the use of friends, minors or family interpreters. We are concerned, however, that the language does not provides sufficient clarification. Researchers have identified a number of problems with the use of untrained interpreters, such as omissions, additions, substitutions, volunteered opinions, and semantic errors that can seriously distort care. The friend, family member or minor is likely to be untrained in medical terminology, uncomfortable discussing certain medical conditions, and untrained in interpreter ethics. Using a family member, friend or minor as an interpreter is more likely to lead to misdiagnosis and or medical errors. As documented in a study earlier this year in the journal *Pediatrics*, the use of untrained interpreters causes more errors in interpretation that can have serious adverse consequences. In pediatric emergency rooms, researchers evaluated usage of professionally-trained interpreters, ad hoc interpreters (e.g. friends, relatives, children, untrained staff or strangers from the waiting room) and no interpreter. Overall, eighteen percent of interpretation errors had potential adverse medical consequences for patients. For example, in one case a family thought they should give their child two

tablespoons

instead of two

teaspoons

of a medication and they failed to understand that a second medication was to be given. But the rate of errors of potential medical consequence was significantly lower for those encounters using a professional hospital interpreter – about 12 percent – as compared to those using an ad hoc interpreter – 22 percent – and those using no interpreter – 20 percent.

[\[1\]](#)

Another example of the problems caused by using family members as interpreters involved a female Mixtec Indian from Mexico who received pre-natal and birth services from two different medical centers. The husband was constantly asked by the providers to interpret to his wife, although the husband often could not understand what the doctors were saying. The doctors would speak Spanish to the husband, who would then try to interpret this into Mixtec despite his lack of knowledge of Spanish. Because of the failure to obtain a Mixtec interpreter, the medical centers placed themselves at risk of malpractice or negligence for care provided without

informed consent. In addition, the husband missed more than three weeks of work trying to interpret conversations with the hospital for his wife.

RECOMMENDATION: Amend VI (B), paragraph one, sentence four to the following, page 68 Fed. Reg. 47317:

However, a recipient may not require, *suggest, or encourage* an LEP person to use a family members, friends, *or minors* as a
n
interpreters.

Moreover, the distinction between the use of a family member or friend as an interpreter versus a minor is not discussed comprehensively in the Guidance. In fact, the Guidance allows the use of minors and merely notes that "extra caution should be exercised when the LEP person chooses to use a minor as the interpreter." Unfortunately, it is a common practice for children to act as interpreters for their parents in health care settings which causes them to miss classes and places them in untenable circumstances. The Guidance does not adequately acknowledge that many of the identified problems are exacerbated when the interpreter is a minor. In addition to the problems pointed out in the Guidance, the use of minors could upset familial relationships or hierarchies that are deeply rooted in the LEP person's culture, and is particularly problematic in the areas of gynecology, reproductive health, sexually transmitted diseases, and mental health treatment. We strongly urge OCR to amend the Guidance to prohibit the use of minors as interpreters regardless of the beneficiary's request, unless it is an emergency medical situation with no alternative means of providing language assistance. And given the near-immediate availability of telephonic interpretation through a language line, the use of minors should effectively never be necessary.

RECOMMENDATION: Amend VI (B) paragraph twelve to add the following after sentence three, page 68 Fed. Reg. 47318:

A recipient/covered entity may not use a minor to provide interpreter services, even if requested by a client, unless the client needs emergency care and no alternative language assistance is immediately available. Extra caution should be exercised when the LEP person chooses to use a minor as the interpreter. While the LEP person's decision should be respected,
There
may be additional issues of competency, confidentiality, or conflicts of interest when the choice

involves using minor children as interpreters

The recipient should also be especially careful about relying on the English speaking spouse or partner of an LEP individual who may be in an abusive relationship. The use of the word "may" in the example included in the guidance would allow a provider to, in some cases, ask a batterer-parent or spouse to interpret in a situation that involves abuse or neglect. This scenario is unacceptable because of the serious safety issues and conflicts of interest.

RECOMMENDATION: Amend VI (B), paragraph fourteen, sentences one, two, three, page 68 Fed. Reg. 47318:

A woman or child is brought to an emergency room and is seen by an emergency room doctor. The doctor notices the patient's injuries and determines that they are consistent with those seen with victims of abuse or neglect. In such a case, use of the spouse or a parent to interpret for the patient may raise serious issues of conflict of interest and may, thus, be inappropriate.

C. Written Language Services (Translation) (68 Fed. Reg. 47318)

Again, we urge OCR to emphasize the need for providers' recognition in supplying written language services because it is an effective and efficient way to provide quality care. Because language barriers are frequently cited by immigrants, including LEP populations, as a major problem in obtaining healthcare, the need for providing translated materials or services where competent translators have completed the job is important.

1. What Documents Should be Translated?

We urge OCR to emphasize the need for providing translation services for documents that are imperative in the health care setting. OCR states that "whether or not a document (or the information it solicits) is "vital" may depend upon the importance of the program, information, encounter, or service involved, and the consequences to the LEP person if the information in question is not provided accurately or in a timely manner." While determining vitality based on

encountering a population, it is crucial that the provider is aware of the community's potentially changing population. A provider often cannot accurately determine who they serve because the existing LEP population may not be attending the provider's hospital or clinic *because of the lack of* translated or interpreter services. Additionally, in relation to classifying a document as vital or non-vital, it is far more cost-effective to be over inclusive with translation services because a brochure, prepared document or materials, at times, they are far more accessible and easier to obtain than an interpreter.

Collaboration with Community Organizations: Emphasizing the need to work with community organizations cannot be overlooked because they are an invaluable source of information in providing complete and accurate care for LEP populations in the healthcare setting. Without input from the community, many providers may incorrectly determine which documents should be translated. Providers with limited interactions with LEP or immigrant communities may not understand language or cultural influences that impact how consumers read and understand materials. Community organizations can also be helpful in informing a provider about other issues affecting the community so that, for example, materials can be targeted to appropriate literacy levels when translated or pictures can be used for communities with low literacy levels. For example, a provider may believe that a general outreach pamphlet should be translated to notify about general access when a LEP population from a particular country may not understand how the U.S. health system works and thus general information will be unhelpful. Or community members may prefer specific disease-related information prevalent in their communities, such as diabetes or cancer, to identify which providers can offer services needed by that community. With the input from the community, the provider can work to ensure the most effective use of what may be limited resources for translation.

RECOMENDATION: Amend VI (C) paragraph three, sentence five, page 68 Fed. Reg. 47318 as follows:

In determining what outreach materials may be most useful to translate, such recipients may want to *should* consider consulting with appropriate community organizations.

Vital Documents: In providing quality care for LEP populations, OCR recognizes that certain documents should be provided in languages other than English. Yet OCR does not mandate translation of vital documents or mandate a minimum list of certain documents as vital. Providing this basic information to providers will help clarify minimum expectations and improve

access for LEP individuals. Without at least minimum standards, providers are left with little guidance from OCR and more room for errors. Providers must recognize the need and requirement under Title VI to provide vital documents in the LEP patient's language. Not doing so compromises patients' understanding and their legal consent to the procedure, surgery or recommendations from the provider.

RECOMMENDATION: Amend VI (C) paragraph five, sentence one page 68 Fed. Reg. 47319 as follows:

Given the foregoing considerations, vital written materials could *must* include *but are not limited to*

Hospital Menus: OCR has included "hospital menus" as non-vital documents, but moving this bullet under "vital written materials" is essential to allow recognition of possible dietary restrictions, potential food allergies and specific meats or other food items that cannot be consumed by some LEP patients because of medical, religious or cultural considerations. Ensuring and respecting various restrictions and needs of LEP patients will further ensure quality of care and providers will be conveying a strong message of respect, and quality of care to LEP patients.

RECOMENDATION: Move bullet one, under "non-vital written materials" to "vital written materials" in page 68 Fed. Reg. 47319:

- *Hospital Menus*

3. *Safe harbor* (page 68 Fed. Reg. 47319)

We strongly support the inclusion of the "safe harbor" provisions to offer providers ways to ensure compliance with Title VI. The "safe harbor" gives specific information that providers can follow to ensure compliance with Title VI. With regard to the precise nature of the recipient's responsibility to provide written materials in non-English languages, we suggest a slight alteration of the provision dealing with the requirement to better reflect what we believe to be the intent of the Guidance. We believe that this provision will prove more serviceable, and

better balance the competing interests involved.

RECOMMENDATION: Amend (a) and (b) to read as follows, page 68 Fed. Reg. 47319:

The following actions will be considered strong evidence of compliance with the recipient's written translation obligations:

(a) The HHS recipient provides written translations of vital document for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed can be provided orally; *and*

(b) *For language groups that do not fall within paragraph (a) above, or constitute fewer than 50 persons in a language group eligible to be served*
that reaches the five percent trigger in (a), the recipient does not translate vital written materials but provides written notice in the primary language group of the right to receive competent oral interpretation of those written materials, free of cost.

VII. Elements of Effective Plan on Language Assistance for LEP Persons

We are very concerned that the guidance does not mandate that a recipient develop a written language access plan. DOJ has mandated this in its guidance which says that recipients "should" rather than HHS "may" develop an implementation plan. The lack of stronger language regarding development of a plan means that many providers will not take the time necessary to determine how to meet the needs of LEP patients, nor will they likely adequately train staff regarding language access, or provide adequate notice to LEP patients about the availability of language services. It is difficult to imagine how training can take place without a written policy or plan to teach the staff how to provide appropriate language assistance services and comply with Title VI.

By accepting federal funds, providers make a commitment to provide some type of language

services. Having a written implementation plan is a way for a provider to also protect him/herself when questions arise about how the provider was complying with Title VI. A written plan promotes consistency and uniformity among employees, and solidifies the provider's commitment to an equal quality of care for all patients. Developing a written plan need not be labor intensive or expensive and the type of written plan can vary according to the size of the recipient. For example, for a smaller provider, the written plan could simply constitute an outline of its policy for treating LEP patients and how to access interpreters, and be distributed to all staff members.

We recommend that OCR require federal fund recipients to develop a written plan in order to provide meaningful access for LEP persons in compliance with Title VI. This amendment is further required to bring HHS's guidance in conformance with DOJ's template which states that recipients "should" develop an implementation plan.

RECOMMENDATION: Amend VII (introduction), paragraph one, sentence one, page 68 Fed. Reg. 47319:

If After completing the four-factor analysis *and deciding what*, a recipient determines that it should provide language assistance services *are appropriate*, a recipient may *should* develop a written implementation plan to address the identified needs of the LEP populations it serves.

We believe determining the necessary language assistance services before contact with LEP patients is appropriate and important. Implementation of the plan is needed in order for recipients' staff and persons coming into contact with LEP individuals to be prepared on the to offer appropriate assistance so that LEP individuals experience the same welcoming environment when they arrive as do English speaking patients.

RECOMMENDATION: Amend VII (introduction), paragraph one, sentence three, page 68 Fed. Reg. 47319

The development and maintenance of a periodically updated written plan on language assistance for LEP persons ("LEP plan") for use by a recipient's employees who serve or interact with the public *is an* could be an appropriate and cost-effective means of documenting compliance with Title VI and providing a framework for the provision of timely and reasonable language assistance.

In addition, we are concerned that this section has misstated a covered entity's obligation to do *something* with the question of *how much* that entity must do. A recipient of federal funds may *never* discriminate against a person because of the language she speaks, and therefore every provider should have a written LEP plan of some sort. What may vary according to the circumstances is the content of that plan, but at a minimum it should inform staff of the need to accommodate LEP individuals and provide the procedure for accessing the translation language line with which the provider has chosen to contract.

RECOMMENDATION: Delete VII (introduction), paragraph one, sentences six and seven, page 68 Fed. Reg. 47320:

Despite these benefits, certain HHS recipients, such as recipients serving very few LEP persons and recipients with limited resources, may chose not to develop a written LEP plan. However, the absence of a written LEP plan does not obviate the underlying Title VI obligation to ensure meaningful access by LEP persons to a recipient's program or activities.

Finally, we also believe that OCR should encourage recipients to consider alternative ways to articulate how it is providing meaningful access, *in addition* to a written LEP plan. Thus, we recommend that recipients consider additional methods " such as data collection of patients' race, ethnicity and primary language, documentation of language services provided, and/or monitoring complaints " to demonstrate compliance with Title VI. While having an implementation plan is obviously an important step, it is only the first step " after having a plan in place, providers should take steps to ensure that the plan is appropriately implemented by staff and that the services outlined in the plan are available in practice.

RECOMMENDATION: Amend VII (introduction), paragraph one, sentence eight, page 68 Fed. Reg. 47320:

Accordingly, in the event that A recipient elects not to develop a written plan, it may want to consider alternative and additional reasonable ways to articulate how it is providing meaningful access in compliance with Title VI.

(1) Identifying LEP Individuals Who Need Language Assistance (68 Fed. Reg. 47320)

Data Collection: We are concerned that the guidance does not recognize the benefits of data collection to assist providers in identifying LEP individuals who need language assistance. It also does not provide any specific recommendations on how to assess the number, proportion, or needs of LEP persons, such as reviewing census data, client utilization data, data from client files, data from schools and community groups, and state and local projections. A provider/recipient would not be able to accurately determine the need for language assistance without knowing which patients are LEP and require language services. Thus, it is imperative to implement effective strategies for accurately identifying the LEP patient's language and need for assistance via translation or interpretation in an efficient manner. Additionally, informing LEP individuals of the desire and need to collect language assistance information/data by the recipient is important. Ensuring that data on the LEP individuals' race, ethnicity, spoken and written language, and the need for a translator/interpreter are collected and placed in their health records and periodically updated will assist the doctor/provider in the ongoing provision of language services and advance planning. The purpose of collecting such information will help to identify population groups within a service area; ensure appropriate monitoring of patient needs, utilization, quality of care and outcome patterns, prioritize allocation of organizational resources and improve service planning to enhance access and coordination of care. Additionally, collecting such data will be helpful when an LEP patient schedules an appointment because the provider will understand her/his needs and schedule an interpreter rather than make last minute plans. HHS has already expressed its support for this data collection, as evidenced by its inclusion in the CLAS (Culturally and Linguistically Appropriate Services) Standards, published by the Office of Minority Health. In addition, to encourage patients to provide the data, it is essential that recipients explain the purpose for collecting the data to the LEP patient. If the reasons are not made clear that such information is collected to assist the LEP patient, they may have privacy concerns about disclosing the information. We urge OCR to recognize that recipients cannot forego engaging in outreach activities to gather needed information about the local LEP population, as well as alert LEP individuals about the services they can provide.

RECOMMENDATION: At the end of VII (1), add the following, page 68 Fed. Reg. 47320:

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

(2) *Language Assistance Measures* (68 Fed. Reg. 47320)

We urge OCR to reinforce the importance of communicating the language assistance measures to LEP populations. If providers do not communicate or bring awareness of such measures to the LEP community, the need for such services will be greatly underestimated because the use of such language assistance services will not be substantial. OCR's guidance leaves the impression that providing interpreters, collecting data on patients' backgrounds for future use and better understanding on serving the patient are *completely irrelevant*, because it uses the voluntary language of "would likely" which means recipients have the option of never fully assisting an LEP patient in the healthcare setting.

RECOMMENDATION: Amend VII (2) paragraph one, first sentence, page 68 Fed. Reg. 47320, as follows:

An effective LEP plan *should* would likely include information about the way in which language assistance will be provided.

OCR's language does not sufficiently emphasize the need and requirement for language access. Without guidance on methods of language assistance that should be provided, entities, recipients, staffs, providers, and LEP patients cannot be aware of what to expect in the healthcare setting regarding language assistance. Even where a hospital has a plan, if the line staff are not aware of the plan, they cannot provide the linguistically appropriate health care services to the LEP patients. Not only will LEP patients suffer needlessly, but it would/could also result in legal suits and malpractice claims brought against the providers and others who fail to ensure a patient understands necessary treatment can be very costly. Lack of awareness regarding the steps for treating an LEP patient can thus

have unnecessary but serious consequences.

RECOMMENDATION: Amend VII (2) paragraph one, second sentence, page 68 Fed. Reg. 47320, as follows:

For instance, recipients *must* may want to include information on at least the following:

- Types of language services available.
- How staff can obtain those services.
- How to respond to LEP callers.
- How to respond to written communications from LEP persons.
- How to respond to LEP individuals who have in-person contact with recipient staff.

All of the bulleted points, listed above are necessary for ensuring staff know what to do when a LEP patient comes into the facility. When gathering data for the LEP patient's files, it is important to set minimum guidelines on what kind of information recipients must include. Allowing important information needed to assist LEP patients in the healthcare setting to be *optional*

greatly hinders efforts to insure greater medical access for LEP patients. Such an approach is also likely to result in providers believing medical access for LEP patients does not apply to them because their records will not indicate that they serve a large LEP population, or possibly any at all.

One way that OCR could assist recipients in understanding ways to conduct outreach and gather information from the LEP communities would be to provide examples for each bullet point. For example, to explain the bullet point "how to respond to LEP individuals who have in-person contact with recipient staff", OCR could highlight the University of Massachusetts Medical Center in Worcester "the staff at the main information kiosk direct incoming LEP patients to a sign on the wall that has tear-off identification cards in many different languages " a patient can tear off a card and bring it to the desk to request language services. We would suggest that OCR add additional relevant examples to provide further guidance to recipients.

RECOMMENDATION: Amend VII (2) paragraph one, second sentence, page 68 Fed. Reg. 47320, as follows:

For instance, recipients may want to *must* include information on at least the following:

- Types of language services available *□ e.g. oral interpretation, written translations; methods for providing services □ in-person, telephonic, video-conferencing; language available.*
- How staff can obtain those services *□ e.g. provide telephone number for the interpreter department or language line to call when an interpreter is needed*
- .
- How to respond to LEP callers *□ e.g. if an LEP person calls to schedule an appointment and the staff answering the phone does not speak the person's language, outline the procedures to transfer the call to another staff person who speaks that language or conference an interpreter in to the line.*
- How to respond to written communications from LEP persons *□ e.g. designate one staff person to coordinate responses to communications in various languages*
- How to respond to LEP individuals who have in-person contact with recipient staff *□ e.g. post tear-off identification cards in many different languages in the main lobby to allow a patient to bring a card to the staff to request language services*
- How to ensure competency of interpreters and translation services *□ e.g. assess, train, monitor and evaluate interpreters and translators .*

(3) Training Staff (68 Fed. Reg. 47320)

We strongly urge OCR to change the language in the guidance addressing training staff who work with LEP persons and to mandate such training. Training staff about the recipient's language assistance policies and procedures is a critical element of an effective language assistance program. Without training of staff, any LEP plan will be meaningless if LEP patients cannot access the language assistance services allegedly offered by the entity. Thus, implementing a required training program for all new employees is well advised, particularly in areas where frequent contact with LEP persons does or may, because of the size of the LEP population served or eligible to be served, occur. This can easily be done during the employee's orientation. Additionally, follow-up annual training for all employees should not be

overlooked, to inform them of any changes in the recipient's policies. Finally, the value of ensuring that management knows and supports the standards and procedures cannot be overestimated.

If staff are not fully aware of what they are expected to do, when contact with LEP persons occurs, seemingly benign situations may quickly turn harmful, particularly in the healthcare setting. Specifically, staff should be trained on whom to contact if interpretation is needed, where to obtain informed consent forms in the language of the LEP persons before undertaking care, and how to work with the interpreter. For instance, a certified court interpreter in Michigan was giving an ethics seminar to bilingual workers of the local Refugee Services, on which Lansing health care facilities rely heavily for interpreter services. One bilingual worker asked what she should do when a provider is trying to relate that a patient has terminal illness. She stated in the past, she had refrained from interpreting this piece of information because she did not consider the patient needed to know. The role of the interpreter, however, is not to make judgment calls on what information to relay for a patient but to ensure complete and accurate interpretation of everything said by both the patient and provider. Additionally, attempting to withhold information from a patient *simply because the patient is LEP* is not appropriate.

Training of physicians and support staff who come into contact with LEP persons cannot be underestimated. In another example, an interpreter for King County Public Health was working for a private agency and interpreting at a hospital for a patient going through a long and arduous labor. At one point, the anesthesiologist came in and informed the interpreter that he spoke Spanish and instructed her not to interfere unless he asked for help. The doctor then went on to explain in very simple, grammatically incorrect Spanish that the patient was going to "get a shot in the back," and that "it wouldn't hurt." He *never* asked the patient if she wanted an epidural or if she understood her anesthesia options. The interpreter felt that "no Anglo-American would have put up with such skimpy information." Training should not begin only after a substantial LEP population has accumulated in the area, but should be addressed in the ongoing staff training and orientation provided for new employees.

At minimum, OCR must conform its policy to the DOJ LEP guidance, outlined below, under the "minimum recommendation" section.

RECOMMENDATION: Amend VII (3) to replace the first paragraph, second sentence, page 68 Fed. Reg. 47320 as follows:

Staff working or coming into contact with LEP persons must be given training on their obligations to provide meaningful access to information and services.

Further, we are also concerned that the guidance does not specifically address ongoing training. From our experience, continuous reinforcement of the language assistance policy ensures continued compliance with VI, especially if the demographics of the service area are constantly changing. This can be achieved through regularly scheduled trainings. For example, the Northern Virginia AHEC program offers one-hour training programs on the appropriate use of medical interpreters and cultural competency at health care provider's offices. The providers often schedule these language access trainings as part of ongoing lunchtime trainings provided for its staff. Because of its importance in ensuring equal access and care to people of all ethnic backgrounds, we suggest that OCR state its expectation that all staff, including management, attend periodic trainings in culturally and linguistically competent health care and social services delivery.

RECOMMENDATION: Amend VII (3) to replace the second paragraph, sixth sentence, page 68 Fed. Reg. 47320, with the following:

A recipient/covered entity must provide an ongoing training process for its staff, including management, with refresher training occurring at least annually to reiterate, and highlight any changes in, the recipient/covered entity's language assistance policy.

RECOMMENDATION: Amend VII (3) to add after second paragraph, sixth sentence, page 68 Fed. Reg. 47320, the following:

A recipient/covered entity shall also include training on cultural competency as part of its overall training on the recipient/covered entity's language assistance policy. Having written policies on language assistance may be ineffective without reinforcing the need of staff members to be sensitive to an LEP individual's cultural beliefs, practices and preferences.

We appreciate that OCR has recognized the importance of ensuring that management staff is fully aware of and understanding a recipient's language access plan to reinforce its importance and ensure implementation. We also believe that management participate in the training, both to send a strong message that the recipient regards cultural and linguistic access as a priority,

and so that supervisors and managers can implement, evaluate, monitor, and enforce its language access policies and procedure.

RECOMMENDATION: Amend VII (3) to add at the end of the second paragraph, page 68 Fed. Reg. 47320, with:

All management staff of a recipient/covered entity must be knowledgeable of the standards and procedures of the entity's language assistance plan so they can reinforce its importance and ensure its implementation by staff.

(4) Providing Notice to LEP Persons (68 Fed. Reg. 47320)

We appreciate OCR's recognition that a vital part of a well-functioning program includes having effective methods for notifying LEP persons regarding their right to language assistance and the availability of such assistance free of charge. In its current form, however, the reissued guidance fails to *require* such notification. Without effective notification, LEP patients may be denied care or fail to seek care because they are unaware of available resources. [insert example] Similar to staff ignorance of the availability of language assistance services for LEP patients due to lack of training makes the recipient's language access plan useless, offering to provide language assistance services but not informing the appropriate patients of such services defeats the purpose of the plan. One instance where this problem is likely to arise is if a provider institutes new language services, such as translating forms into an additional language or adding a staff person who is bilingual and can assist in interpretation, but has no method for informing LEP patients of the change. In such a case, LEP patients who are aware that in the past the provider was unable to accommodate their language needs will have no reason to think nor any reasonable chance of learning that they can now access that care. At the very least, if a provider implements new language services, LEP persons who could benefit from those services should be informed upon calling or presenting at the recipient. Finally, in order to determine whether there is an underutilization of a recipient's services among persons in a particular ethnic or LEP community an effective plan should be developed for outreach to those communities to notify them of the availability of the recipient's services.

Notification addressed in Language Access Plan: As currently written, OCR's guidance does not mandate that an LEP plan include information on how a provider will notify LEP

individuals of the available services. We suggest that OCR amend its language to address this issue. OCR would recognize the necessity of notification to providing meaningful access.

If our suggested change is not adopted, we recommend deleting the sentence altogether. This sentence is not included in the DOJ LEP guidance. In its current form, this sentence does not comply with the standard set forth by DOJ, which unequivocally emphasizes the importance of notification to LEP persons. [VII (4), paragraph one, sentence one, 67 Fed. Reg. 41465]

RECOMMENDATION: Amend VII (4), paragraph one, sentence one, page 68 Fed. Reg. 47320 as follows:

An effective LEP plan *should* would likely include a description of the process by which *the recipient will*
to
provide notice of the services that are available to the LEP persons it serves or, to the extent that a service area exists, that reside in its service area and are eligible for services.

or

An effective LEP plan would likely include a description of the process by which to provide notice of the services that are available to the LEP persons it serves or, to the extent that a service area exists, that reside in its service area and are eligible for services.

In recognition of the importance of posting notices in the intake areas and other entry points in order to inform LEP patients of their right to language assistance services, OCR should be consistent in its guidance and require that such notices state the availability of free language assistance.

RECOMMENDATION: Amend VII (4), paragraph two, sentence five, to the following, page 68 Fed. Reg. 47320:

For instance, signs in intake offices *should* could state that free language assistance is available.

Outreach: As part of identifying LEP individuals who need language assistance, it is important that providers not only include information on notification in their language access plan but also actively conduct outreach to ensure practical notification to LEP persons. Outreach is not only important to ensure meaningful access to the recipient's services but also will offer a provider the means to accurately assess individuals eligible to be served and thus appropriately select methods for providing language assistance. We thus suggest that OCR provide additional language in this section specific to conducting outreach. Without effective outreach, even the most developed implementation plan will fall short of improving access for LEP persons because they will not know of the availability of services.

RECOMMENDATION: At the end of VII (4), add the following, page 68 Fed. Reg. 47320:

In addition to developing effective notice, a recipient/covered entity should engage in outreach activities, including working with community based organizations, to inform LEP individuals of the availability of language assistance services and develop an outreach plan.

(5) Monitoring and Updating the LEP Plan (68 Fed. Reg. 47311)

We appreciate that OCR recognizes the need for regular monitoring which is an essential component of any effective language assistance program. Due to changes in demographics, the availability of resources, and staff, it is necessary for recipients to monitor their programs in order to adequately meet language access needs. We are concerned, however, that OCR does not mandate a monitoring process, unlike the DOJ guidance. Without a requirement for monitoring, OCR allows for, and perhaps invites, outdated and inadequate plans that may well fail to serve the needs of LEP patients. For example, as documented by the last Census, we have seen tremendous changes in the location of LEP populations. States that previously had minimal interactions with LEP populations have seen increases of hundreds of percentages in their LEP populations. Both Georgia and North Carolina saw increases of 243% in their LEP populations over ten years. If a provider developed a plan and did not continually update it, a

provider may decide, based on one year's data, that he does not have a significant LEP population that requires certain language services. But the changing demographics of the community can lead to significant increases in short periods of time. The provider should continually monitor changes in the population eligible to be served and adapt the language services plan accordingly. We also recommend that OCR include a requirement for community input into the assessment and monitoring process, perhaps provided by a community advisory committee or board.

Finally, we recommend that OCR require that recipients notify employees and LEP individuals of any changes in LEP services. We suggest that OCR take additional measures to ensure meaningful community input by providing that the results of the required annual assessment be made available to clients/patients, both to help identify problems and to seek assistance from the community in implementing a successful limited English proficiency program.

RECOMMENDATION: Amend VII (5), paragraph one, sentence two, page 68 Fed. Reg. 47231:

For example, Recipients must should have a process for determining, on an ongoing basis, whether new documents, programs, services, or andactiv ities need to be made accessible for LEP individuals may be appropriate , and recipients must should provide notice of any changes in services to the LEP public and to the recipient's employees.

RECOMMENDATION: Replace VII (5) paragraph three, sentence two, page 68 Fed. Reg. 47321 with the following:

Some recipients may also want to consider whether they should provide opportunities for community input and planning throughout the process. *A recipient/covered entity must attempt to secure meaningful community input. For some recipients/covered entities, this should include establishing a community advisory committee or board to provide regular feedback on the recipient/covered entity's policies regarding meaningful LEP access.*

VIII. Voluntary Compliance Effort

The Guidance makes it clear that there is much flexibility in meeting a recipient's Title VI legal requirements, especially for smaller recipients. We are concerned, however that there is a critical lack of any requirement for recordkeeping and data collection in the Guidance, which will make monitoring compliance difficult, if not impossible. We therefore urge OCR to recommend that the recipient maintain a centralized recordkeeping system that assures the ready availability of data that includes race, ethnicity, and national origin of patients/clients served at its facilities and the primary language of such LEP persons. One source for guidance on the collection of race and ethnicity data can be found in the revised Office of Management and Budget (OMB) standards for Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity, at 65 Fed. Reg. 58782, 58788 (October 30, 1997). ^[2] Such data should include the number of LEP complaints and their resolution, any census data, census sampling data, or census estimates which the recipient has based its determination to provide written translations of documents, the number of LEP persons, by language group and ethnicity, who received the recipient's services in each department during the year, the number of LEP patients for whom interpreter services were used by language group, and within each language group by source of interpreter used and the name of the interpreter, the recipient's expenditures for interpreter services, by language group, and a report on staff training, including the date of the training, the name of the trainer, and the names and categories of the individuals in attendance. By recommending uniform data collection by recipients, racial disparities in health care could be more adequately addressed.

RECOMMENDATION: Add the following the fifth paragraph (before the last paragraph in this section), page 68 Fed. Reg. at 47321.

Monitoring compliance requires uniform recordkeeping and data collection. OCR recommends that the recipient/covered entity maintain a centralized recordkeeping system that assures the ready availability of data that includes race, ethnicity, and national origin of patients/clients served at its facilities and the primary language of such LEP persons. The recipient/covered entity should also collect data and maintain records on the number of LEP complaints and their resolution, any census data or sampling data which the recipient has based its determination to provide language services including oral interpretation and written translations of documents, the number of LEP persons, by language group and ethnicity, who received the recipient's services in each department during the year, the number of LEP patients for whom interpreter services were used by language group, and within each language group by source of interpreter used and the name of the interpreter, the recipient's expenditures for interpreter services, by language group, and a report on staff training, including the date of the training, the name of the trainer, and the names and categories of the individuals in attendance.

C. MINIMUM RECOMMENDATIONS

In publishing its final guidance in June 2002, DOJ established a template guidance to ensure consistency among all federal agencies issuing LEP guidances. In a memorandum to all agencies from Ralph Boyd on July 8, 2002, DOJ stated that all agencies must use this template and any variations from it must be explained in written justifications.

There are numerous instances in HHS's guidance where it does not conform to the DOJ template and no written justifications were provided in its reissuance. Especially because of the life-or-death consequences that errors in health care may create, we believe that HHS's guidance

should at least conform to DOJ's template and that indeed HHS has strong justifications for strengthening its guidance rather than deviating below DOJ's standards.

Given the July 8th DOJ memo, and the desire to ensure consistency across federal agencies, we recommend that HHS make the following minimal changes to conform its guidance to HHS. We do not intend for these recommendations to substitute for the ones above; rather, these should be made regardless of what recommendations above are adopted. The subparts below correspond to the subparts in the HHS guidance.

IV. Who is a Limited English Proficient individual?

MINIMUM RECOMMENDATION: Amend II, paragraph 1, sentence 1 to read as follows:

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English *can* may be limited English proficient, or "LEP", and *can* may be eligible to receive entitled to language assistance with respect to a particular type of services, benefit, or encounter.

V. How does a Recipient Determine the Extent of its Obligation to Provide LEP Services?

HHS has added a clarification to DOJ's language that implies that some recipients of federal funds may not have to provide any language services. This contradicts not only DOJ's template but also the long history of HHS' enforcement of Title VI. Once an entity makes the affirmative choice to accept federal funds, that recipient must do *something* to provide meaningful access and doing *nothing* has never been "acceptable".

MINIMUM RECOMMENDATION: Amend V, paragraph 2, sentence 1 to read as follows:

After applying the above four-factor analysis, a recipient may conclude that different language assistance measures are sufficient for the different types of programs or activities in which it engages. or, in fact, that, in certain circumstances, recipient-provided language services are not necessary.

With regard to the discussion under (3), Nature and Importance of the Recipient's Program, Activity or Service, for the reasons mentioned in our comments to this section above, we believe OCR mistakenly makes distinctions between the types of health care services and should not classify some clinical care as non-urgent, thereby allowing a delay in language services. Foremost, the classification assumes that the provider can determine whether the needed care is urgent or not, even if the provider can't communicate with the patient when the patient initially requests to schedule a visit. OCR's "important and urgent" and "important but not urgent" classifications presume meaningful communication, at least at some earlier point, but never require the provider to allow for that. This particular example allows for delay, and possible denial, of important, although not urgent, services such as tests or elective surgery. The results of such delay are harmful, even if they are not life-threatening. It is unquestionable that if an LEP patient cannot access tests or surgical procedures that he/she deems necessary, or desires, in the same time frame as an English-speaking person that the LEP patient is receiving lower quality care than those who can access these services without delay. There is often stress and emotional anguish involving medical tests or procedures, regardless of whether these procedures are of life-saving nature. If OCR does not conform to the DOJ guidance template, it must provide written justifications to explain the difference. If OCR chooses to maintain its distinctions, despite the problems explained above, we recommend that, at a minimum, the following changes be made.

"Important and urgent" The use of the phrase "more likely" in the example provided is not clear. It is alarming if OCR is suggesting that there are situations in which information about emergency surgery need not be conveyed to an LEP person in a manner that she can

comprehend.

This position would represent a wholesale retreat from the position that OCR has always espoused, and enforced, in the past. If not, suggesting otherwise in this guidance can accomplish nothing other than misleading even well-meaning providers.

We urge OCR to set the standard that recipients must have immediate language services available in important and urgent situations, without any qualifications.

MINIMUM RECOMMENDATION: Amend V (3), paragraph one, sentence four, page 68 Fed. Reg. 47315:

If the activity is both important and urgent □ such as the communication of information concerning emergency surgery and the obtaining of informed consent prior to such surgery □ it is more likely that relatively immediate language services are needed.

Communicating Rights □ We urge OCR to avoid placing some clinical care in the same non-urgent category as non-clinical care such as recreational programming. First, this standard assumes that the provider can accurately assess what type of treatment the patient requires, whether it is routine or emergency, even though the provider cannot communicate with the patient. Without an examination, how will a provider be able to determine if an LEP patient is ill or healthy? We recognize that many individuals make appointments with health care providers because they suffer particular symptoms, such as a virus or sprained ankle. However, a provider should not automatically be able to decide that a request for an annual physical examination or a □ check-up □ to monitor of an ongoing condition such as diabetes be acceptable to delay because of language abilities. This is a dangerous assumption that OCR repeatedly makes throughout the guidance. Medical care, regardless of whether it is being provided to an ill patient, or a health patient, is of the utmost importance and should not be subject to delay simply because a patient cannot speak English. For example, many diabetic patients may believe that their disease is under control and thus only make appointments for an annual check-up with their doctor. It is these appointments, however, that often lead to the identification of early onset of additional symptoms (such as cataracts, foot problems, etc.) which, if left untreated even for a short period of time, may have adverse consequences and lead to blindness or amputation. How would a provider know if the diabetic patient were □ healthy □ and would not suffer adverse consequences from a delay in an appointment without an examination? An LEP person should have the same access to a health care provider as an English speaking patient □ this is the essence of non-discrimination.

MINIMUM RECOMMENDATION: Amend V (3), paragraph one, sentence seven, page 68 Fed. Reg. 47315:

The obligation to communicate rights to a person whose benefits are being terminated or to provide medical services to an LEP person who is ill differ, for example, from those to provide medical care for a healthy LEP person or to provide recreational programming.

VI. Selecting Language Assistance Services

At the very least, OCR should adopt the following recommendations to ensure that the LEP Guidance conforms to the template set forth by DOJ.

A. Oral Language Services

MINIMUM RECOMMENDATION: Amend VI (A) paragraph two to read as follows:

When using interpreters, recipients should *ensure that they* take reasonable steps, given the circumstances to assess whether the interpreters:

MINIMUM RECOMMENDATION: Add to VI (A) paragraph two, at the beginning before sentence one, page 68 Fed. Reg. 47316 to conform to DOJ LEP Guidance VI (A), page 67 Fed. Reg. 41461:

When providing oral assistance, recipients should ensure competency of the language service provider, no matter which of the strategies- outlined below is used.

MINIMUM RECOMMENDATION: Amend VI (A), paragraph four, sentence one, page 68 Fed. Reg. 47316 to conform to DOJ LEP guidance VI (A), paragraph five, sentence one, page 67 Fed. Reg. 41461:

To the extent necessary for communication between the recipient or its staff and the LEP person, have knowledge in both languages of any specialized terms or concepts peculiar to the recipient's program or activity and of any particularized vocabulary and phraseology used by the LEP person;

The DOJ guidance states that where the quality and accuracy of language services is critical, the quality of those services must be *extraordinarily high*. The example that the DOJ guidance provides of such a situation is a prison hospital emergency room. In contrast, the DOJ guidance notes that a class on bicycle safety need not meet the same high standard. The DOJ guidance explicitly requires extremely high quality of language services in contexts such as emergency room. We urge OCR to adopt this requirement as set forth by DOJ.

MINIMUM RECOMMENDATION: Amend VI (A), paragraph eight, sentence two, page 68 Fed. Reg. 47316 to conform to DOJ LEP guidance VI (A), paragraph seven, sentence two, page 67 Fed. Reg. 41461:

The quality and accuracy of language services in a hospital emergency room, for example, should be as high as possible, given the circumstances *must be extraordinarily high*, while the quality and accuracy of language services in *a hospital tour* other circumstances need not meet the same exacting standards.

MINIMUM RECOMMENDATION: Amend VI(A), last paragraph, last sentence to read as follows:

The permanent nature of written translations, however, imposes additional responsibility on the recipient *to ensure* to take reasonable steps to determine that the quality and accuracy of the translations permit meaningful access by LEP persons.

B. Oral Language Services

MINIMUM RECOMMENDATION: Amend VI (B), paragraph five, sentence two, page 68 Fed. Reg. 47317:

While telephone interpreters can be used in numerous situations, they *may be* *may be* particularly appropriate where the mode of communicating with an English proficient person would also be over the phone.

MINIMUM RECOMMENDATION: Amend VI (B), paragraph seven, to delete sentences one and two:

Some LEP persons may feel more comfortable when a trusted family member or friend acts as an interpreter. However, when a recipient encounters an LEP person attempting to access its services, the recipient should make the LEP person aware that he or she has a the option of having the recipient provide an interpreter for him/her without charge, or of using his/her own interpreter. However, When a recipient encounters ...

MINIMUM RECOMMENDATION: Amend VI(B), paragraph nine, sentence one to read as follows:

As with the use of other non-professional interpreters, the recipient *should take special care to ensure* may need to consider issues of competence. . .

MINIMUM RECOMMENDATION: Amend VI (B), paragraph eleven, sentence one, page 68 Fed. Reg. 47318 to conform to DOJ LEP guidance VI (A), paragraph sixteen, sentence two, page 67 Fed. Reg. 41462:

In some *many* circumstances, family members (especially children) or friends may not be competent to provide quality and accurate interpretations.

MINIMUM RECOMMENDATION: Amend VI (B), paragraph eleven, sentence seven, page 68 Fed. Reg. 47318 to conform to DOJ LEP guidance VI (A), paragraph eighteen, sentence two, page 67 Fed. Reg. 41463:

When precise, complete, and accurate interpretations or translations of information and/or testimony are critical, or where the competency of the LEP person's interpreter is not established, a recipient may want to consider providing *might decide to provide* its own independent interpreter, even if an LEP person wants to use his or her own interpreter as well.

VII. Elements of Effective Plan on Language Assistance for LEP Persons

MINIMUM RECOMMENDATION: Amend VII (introduction), paragraph one, sentence one as follows:

If, after completing the four-factor analysis *and deciding what language assistance services are appropriate*, a recipient determines that it should provide language assistance services,
a recipient
should
may
develop an implementation plan to address the identified needs of the LEP populations it serves.

MINIMUM RECOMMENDATION: Amend VII (introduction), paragraph one, sentence three, page 68 Fed. Reg. 47319

The development and maintenance of a periodically updated written plan on language assistance for LEP persons ("LEP plan") for use by a recipient's employees who serve or interact with the public *will likely be the most* could be an appropriate and cost-effective means of documenting compliance with Title VI and providing a framework for the provision of timely and reasonable language assistance.

MINIMUM RECOMMENDATION: Amend VII (3), paragraph one, third and fourth sentences, page 68 Fed. Reg. 47320 as follows to conform to the DOJ LEP guidance, paragraph one, second and third sentences, page 67 Fed. Reg. 41465

An effective LEP plan *would likely* may include training to ensure that:

- Staff know about LEP policies and procedures.
- Staff having contact with the public (*or those in a recipient's custody*) are trained to work effectively with in-person and telephone interpreters.

NOTE: While we assume DOJ's template applied the "recipient's custody" phrase primarily for instances involving individuals in jail or prison, this phrase should be incorporated by OCR because of its application to LEP persons who have been committed to psychiatric wards.

MINIMUM RECOMMENDATION: Amend VII (3), paragraph two, seventh sentence, page 68 Fed. Reg. 47320 as follows to conform to the DOJ LEP guidance, paragraph two, fifth sentence, page 67 Fed. Reg. 41465

It is important to ensure may be important to take reasonable steps to see to it that all employees in public contact positions (*or having contact with those in a recipient's custody*) are properly trained.

NOTE: While we assume DOJ's template applied the "recipient's custody" phrase primarily for instances involving individuals in jail or prison, this phrase should be incorporated by OCR because of its application to LEP persons who have been committed to psychiatric wards.

MINIMUM RECOMMENDATION: Amend VII (4), paragraph one, sentence two, page 68 Fed. Reg. 47320 as follows to conform to the DOJ LEP guidance, VII (4), paragraph one, sentence one, page 67 Fed. Reg. 41465:

Once a recipient has decided, based on the four factors, that *which* language access services *it will provide*, *it is* may be important for the recipient to let LEP persons know that those services are available and that they are free of charge.

The changes specified below are the minimum necessary to bring OCR's guidance into compliance with that of DOJ, which states that: (a) recipients should have an ongoing monitoring process and (b) an effective LEP plan includes community input.

MINIMUM RECOMMENDATION: Amend VII (5), paragraph one, sentences one and two, page 68 Fed. Reg. 47320 as follows to conform with DOJ LEP guidance VII (5), sentences one and two, paragraph one:

An effective LEP plan should include a process for a recipient to monitor its implementation of its plan and for updating its plan as necessary. Recipients should determine, on an ongoing basis, whether new documents, programs, services, and activities need to be made accessible for LEP individuals and, if so, recipients should provide notice of any changes in services to the LEP public and to employees.

MINIMUM RECOMMENDATION: Amend VII (5), paragraph three, sentences one and two, page 68 Fed. Reg. 47321 as follows to conform with DOJ LEP guidance VII (5) sentence one, paragraph three:

In addition to these five elements, effective plans set clear goals, establish management accountability and provide opportunities for community input and planning throughout the process.

Glen Flores, *et. al*, Errors in Medical Interpretation and their Potential Clinical Consequences in Pediatric Encounters, *Pediatr.* 111-6-14 (2003).

The revised OMB standards establish new race and ethnicity reporting categories replacing prior directives.