

December 28, 2001

Brenda Aguilar
Office of Information and Regulatory Affairs
Office of Management and Budget
Washington, DC 20503

RE: Request for Information: Assessment of Cost and Benefits Associated with Implementation of Executive Order 13166

Dear Ms. Aguilar,

The National Health Law Program (NHeLP) submits these comments on behalf of NHeLP and the undersigned organizations in response to OMB's Request for Information published in the [Federal Register on November 30, 2001](#)

. As organizations advocating and educating on health issues, we have tailored our responses to address the health care arena. These organizations represent a large and diverse group of Medicaid beneficiaries, including children, people with disabilities, immigrants and refugees, limited English proficient individuals, and others.

The resolve of President Bush to put "a priority on access to health care," and the Administration's commitment to Executive Order (EO 13166) and its implementing guidances offer a bright beacon of light for individuals currently consigned to the shadows of our health care system due to linguistic barriers. We applaud the Administration for recognizing the importance of ensuring the access of limited English proficient ("LEP") individuals to all government services, especially health care. We strongly support EO 13166 and the subsequent guidances issued by the Departments of Justice, Health and Human Services' Office for Civil Rights (OCR), and other Departments. The EO and subsequent guidances provide much needed clarification for health care and social service providers regarding their role in upholding Title VI of the Civil Rights Act of 1964. The federal government's endeavor to implement the EO is critically important to ensure that LEP persons have fair and equal access to the health care and social services to which they are entitled. The EO and subsequent guidances establish the key principle that all federal services

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whether by a federal agency or a federal fund recipient

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must be accessible to every LEP person, yet they recognize the pivotal role of flexibility in determining the provision of services by federal fund recipients.

We have organized our comments to follow the questions/issues raised by OMB in its Request for Information.

1. Determining how best to quantify the numbers of LEP individuals and which languages they speak.

A number of different methods exist to quantify the numbers of LEP individuals and which languages they speak. The 1990 Census provides the most comprehensive data on these two issues. (The 2000 Census data on language use will be available in the summer of 2002.) The 1990 Census asked respondents to answer the following questions: (1) Does this person speak a language other than English at home?; (2) What is this language?; and, for those who speak another language at home, (3) How well does this person speak English?

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very well, well, not well, not at all. This data is available by state and region, providing a baseline for the number of LEP individuals and their languages. Yet there are concerns about the completeness of the Census data due to the recognized undercount of minorities, particularly recent immigrants and non-citizen residents. To provide a more accurate quantification of the numbers and languages of LEP individuals, we would suggest that any use of Census data be adjusted in the manner that demographers or other expert deem appropriate to reconcile any possible undercount.

Decennial Census data should also be supplemented by reliable data which more clearly reflect the LEP population within a particular community. For example, additional census data B such as the Supplementary Survey

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may provide more specific data on the municipal level. And a forthcoming nationwide expansion of the American Community Survey beginning in 2003 will allow for the collection of language proficiency and other long-form data on a yearly basis. specific federal regulations provide a method of quantifying the numbers and languages of LEP individuals served by health programs.

In addition to Census data, data from other sources may be available. Pursuant to recently proposed Medicaid managed care regulations, states must establish a methodology (e.g. geographic composition, population density, enrolled population) for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the state. Proposed 42 C.F.R. ' 438.10(c), 66 Fed. Reg. at 43662. The regulations define "prevalent" as a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the state.

In addition to establishing a methodology, each state's quality assessment strategy must include procedures to identify the primary language of each Medicaid enrollee and notify the managed care organization or prepaid in-patient health plan at the time of enrollment. Proposed 42 C.F.R.

438.204(b)(2), 66 Fed. Reg. at 43668. Both of these provisions require states

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independent of EO 13166

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to collect the primary language of enrollees and determine the prevalent languages so that the state and managed care entities can ensure access by LEP individuals to the Medicaid program.

Some health care providers have also used information on school enrollment and from refugee re-settlement programs to further refine their data.

2. Understanding the number of different languages spoken by LEP individuals, and their geographic distribution.

As noted in our answer to Q. 1, the available 1990 Census data and forthcoming 2000 Census data will provide the most relevant information to understand the number of different languages spoken by LEP individuals and their geographic distribution. Once the Medicaid managed care regulation is finalized and states begin collecting data, another source of information specifically related to health care will be available.

Another source of data to understand the number of different languages and their geographic distribution are community health centers (CHC) which collect data on linguistic preference. The CHC's Uniform Data Set (UDS) reports the percentage of users needing interpretation, bilingual or Sign Language services.

3. Characterizing the interactions of LEP individuals with both federal and federally

funded entities. For example, how frequently do LEP individuals interact with government at all levels? What types of government services do LEP individuals typically access? Are there types of services that LEP individuals access more or less frequently than non-LEP individuals?

While the interaction of LEP individuals with federal and federally-funded programs is widespread including schools, refugee resettlement, INS, health care services, and transportation B current program policies, especially in health care, dramatically hinder the ability to characterize the interaction of LEP individuals with federal and federally funded programs. We wish to raise two concerns: 1. the lack of data collection by federal and federally-funded programs precludes an accurate assessment of those LEP individuals who do access these programs ; and 2. language barriers have hindered LEP individual's access to these programs.

Government agencies and recipients of federal financial assistance currently fail to collect primary language data of individuals utilizing federal and federally-funded services. If collected, this data would provide concrete evidence of the types of services LEP individuals typically access, whether some services are used more or less frequently and what types of linguistic and cultural competency services should be implemented to assist in this access. For example, as suggested in the Office of Minority Health's *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care*

, health care organizations should include a patient's race, ethnicity and spoken and written language in health records and the organization's management information systems. The routine collection of this data would provide accurate information for evaluations like those being undertaken here by OMB, and would also allow providers to tailor their services to address the needs of LEP individuals. On the other hand, no amount of improvement in utilization data will capture information on LEP individuals who should be benefitting from a given program but never even try to do so because of a perceived or actual inability of the agency to communicate with them.

4. Determining the costs and benefits of improving English language proficiency among LEP individuals .

Increasing English language proficiency among LEP individuals would decrease their need for interpreter and translation services. Toward that end, fostering completion of English as a Second Language (ESL) classes would improve English language proficiency among LEP individuals. Yet programs providing English as a Second Language (ESL) classes are

chronically underfunded. In many major metropolitan areas, the waiting list for entry into ESL classes extends to months or years. In New York City, for example, the wait is currently as long as two years. If additional funding were provided, more individuals could learn English. The initial cost outlay to subsidize ESL classes would be offset by the eventual benefit of needing fewer interpreters or translations for these individuals.

We do not suggest, however, that fully funding ESL classes will obviate the need for medical interpreters. Many LEP individuals who achieve some level of English proficiency will nonetheless not understand medical terminology. Trained medical interpreters provide the knowledge of complex terminology essential to ensuring a patient's understanding of a medical diagnosis and treatment, as well as bringing cultural sensitivity to the provider-patient interaction.

5. Understanding and quantifying the level of services provided by the government or government funded organizations to address the special needs of LEP individuals prior to Executive Order 13166 and to what extent changes will be necessary to achieve full compliance with Executive Order 13166 and related agency guidance.

The requirement that recipients of federal financial assistance provide access to LEP individuals in assisted programs and activities is not new. In 1964, Congress enacted Title VI of the Civil Rights Act which prohibits discrimination on the basis of national origin and ensures LEP individuals access to federal and federally-funded programs.

In ensuring access for LEP individuals in the health care arena, OCR has had the responsibility to enforce Title VI for over 30 years, has investigated hundreds of complaints, and has negotiated dozens of voluntary resolution agreements. For example, in 1998 it issued an internal guidance memorandum on LEP instructing its regional offices on enforcement of Title VI "to ensure consistency in OCR's investigation of LEP cases." The EO and OCR's current LEP Guidance merely clarify, for all federal fund recipients as well as the general public, the recipients' *existing* legal obligations under Title VI. Thus, as the EO and implementing guidance recognize, no new requirements or mandates have been effectuated by the EO.

Indeed, as many existing regulations demonstrate, agencies have long-standing policies which require providing language assistance or cultural competency as a condition of receiving funding. These regulations include:

\$ HHS generally B 45 C.F.R. ' 80.4(a) requires every application for federal financial assistance, as a condition of approval, to include an assurance that the program will be conducted or the facility operated in compliance with all requirements of Title VI. States must adopt methods of administration for the program that give reasonable assurance that the applicant and all recipients of federal financial assistance under the program will comply with all the requirements imposed by Title VI;

\$ Medicaid generally B 42 C.F.R. ' 435.901 requires a state Medicaid agency's standards for determining eligibility be consistent with the rights of individuals under Title VI;

\$ Medicaid managed care B

Proposed 42 C.F.R. ' 438.10(c) would require: (1) states to develop a methodology for identifying LEP individuals and provide written information in each prevalent non-English language, and to require each managed care entity to make its written information available in the prevalent non-English languages in its particular service area; (2) the state and managed care entities to make oral interpretation available free of charge to each potential enrollee and enrollee; and (3) the state and all managed care entities to notify enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent language and how to access those services;

Proposed 42 C.F.R. " 438.6(f)(1), .8(a)(1) would require all Medicaid managed care contracts to comply with Title VI;

Proposed 42 C.F.R. ' 438.206 would require states to ensure that managed care organizations and prepaid in-patient health plans participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including LEP individuals and those with diverse cultural and ethnic backgrounds;

Proposed 42 C.F.R. ' 438.100 would require states to ensure that each managed care entity complies with Title VI;

\$ **State Children's Health Insurance Program (SCHIP)** B 42 C.F.R. ' 457.130 requires the State plan to include assurances of compliance with Title VI ;

\$ **Medicare** B 42 C.F.R. ' 489.10(b)(1) requires that all providers must meet the applicable civil rights requirements of Title VI;

\$ **Medicare Plus Choice (M+C)** B 42 C.F.R. ' 422.112(a)(9) requires all M+C organizations to ensure services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency;

\$ **Hill-Burton supported programs** B 42 U.S.C. 300s(6), 300s-6 and 42 C.F.R.124.9, 124.603 outline the community service assurance requirement which mandates that recipients of Hill-Burton funds make services available to persons residing in the facility's service area without discrimination on the basis of race, color, national origin, creed, or any other ground unrelated to the individual's need for the service or the availability of the needed service in the facility;

\$ **Community health centers** B 42 U.S.C. ' 254b(j)(3)(K) requires that centers that serve a substantial proportion of individuals of limited English-speaking ability must, to the extent practicable, make arrangements to provide services in the most appropriate language and cultural context;

\$ **Maternal and Child Health block grant** B 42 C.F.R. ' 51a.7 requires grantees to abide by Title VI;

\$ **Department of Defense** B 32 C.F.R. Part 195 requires each applicant for federal financial assistance to include assurances of compliance with Title VI ; and

\$ **Department of Veterans Affairs** B 38 C.F.R. ' 18.4 requires applicants for federal financial assistance to provide assurances of compliance with Title VI.

6. Quantifying and describing the costs to the Federal Government or recipients of federal funds of providing oral and written translation services.

The Costs of Providing Language Assistance Which Should Be Excluded from the Costs of Implementing EO 13166

While we recognize that, pursuant to P.L. 107-67, OMB must issue a report assessing the total costs and benefits of implementing EO 13166, we believe that the initial threshold OMB must address is what costs are *directly associated with implementing the EO* as opposed to the expected and ongoing costs of implementing Title VI of the Civil Rights Act of 1964.

Thus, as discussed in our answer to Q. 5 and as the EO and implementing guidance recognize, no new requirements or mandates have been effectuated by the EO. Rather, the EO merely clarifies the existing responsibilities of recipients of federal financial assistance. *Since recipients have been mandated to provide access to LEP individuals for over thirty-five years, OMB need not include any costs that recipients of federal financial assistance were already required to undertake in the costs of implementing EO 13166.*

In addition to excluding the costs associated with ongoing compliance with Title VI, OMB should also exclude the costs of linguistic access required by other laws and/or policies. These include costs to comply with:

\$ state and local laws/ordinances regarding language assistance and/or cultural competency;

\$ federal and/or state contract requirements to provide language assistance and/or cultural competency; and

\$ the requirements of accrediting organizations.

State Laws and Local Ordinances

A number of states and localities have applicable laws and ordinances which require providing language assistance and/or culturally competent care. For localities where such requirements exist independent of Title VI, OMB should not include these costs in the implementation of EO 13166.

In a 1998 study, NHeLP identified 151 state laws that require language services in health care, many tied to specific health services or providers. Six state laws set forth a general responsibility for health care facilities to ensure proper communication with non-English speaking providers. BC, CA, FL, IL, NJ, NY, and VT. Since 1998, at least one state enacted a new law. Massachusetts now requires emergency rooms and acute-care psychiatric facilities to provide interpreters to LEP individuals. A listing of state law requirements addressing language and cultural needs in health care is attached as Appendix A.

Contractual Requirements

In addition to state laws and local ordinances requiring linguistic access, many states have addressed linguistic access in their contracts with health care providers. For example, states often require managed care organizations (MCOs) to provide translation services and address cultural competence, and presumably take these requirements into consideration in developing capitation rates. According to George Washington University's Center for Health Services Research and Policy, the majority of Medicaid managed care contracts or requests for proposals require MCOs to provide materials in other languages (38 states), require services for persons whose primary language is not English (31 states) or include a cultural competence requirement (27 states).

Accreditation Requirements

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

Costs of Non-Compliance

In addition to excluding pre-existing costs for providing linguistic access under Title VI, state laws, local ordinances, contracts, and accreditation, OMB should also consider reducing any estimated costs of implementing EO 13166 by the costs of non-compliance with Title VI and the EO. Any estimation of the costs of non-compliance is complex and must include costs inherent in delays in seeking care, additional emergency room visits, malpractice claims, mis-diagnosis, unnecessary tests, and lost work days and productivity.

Lack of Interpreters Increases the Costs of Care

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

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

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

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

For individuals whose language barriers create an inability to understand their diagnosis or treatment, serious health consequences can result. For example, a Russian speaking patient profiled by the PBS program *Healthweek* was diagnosed with diabetes. Because the doctor did not ensure the patient understood his diagnosis and treatment, the patient left without knowing he had to change his diet to avoid further complications. A few months later, with his blood sugar levels dangerously high, and suffering bouts of dizziness and weakness, the patient returned to the doctor. With family members interpreting, he was finally able to understand his diagnosis. If he had not received treatment, he faced life-threatening complications

diabetes is the leading cause of new cases of blindness in adults age 20-74, of end-stage chronic irreversible kidney disease, and of lower-extremity amputations (not related to injury). According to the Centers for Disease Control and Prevention (CDC), many of the complications from diabetes can be prevented with early detection, improved delivery of care, and better education on diabetes self-management. The CDC estimates that at least half of the new cases of diabetes-related kidney failure, half of all lower extremity amputations and 90% of blindness could be prevented each year with early detection and treatment.

The LEP patient's risk of complications is easily remedied

and further costs avoided

if interpretation is provided to explain the diagnosis and treatment.

Many other examples exist regarding diseases that require early treatment to alleviate further complications and costs. By providing interpreters to LEP individuals diagnosed with these diseases, the result can be a better quality of life as well as decreased health care costs. For example, early detection of cancer is crucial to obtaining life-saving treatment. Treatment of late-stage cancers yields a lower rate of remission and recovery than early intervention. And the costs of terminal care significantly exceed initial diagnosis and treatment costs. For individuals diagnosed with end-stage renal disease, dialysis treatments can enable them to maintain normal functioning and hold most symptoms at bay. Without dialysis, they will suffer recurrences of renal failure, or develop hypertension, which can lead to strokes or cerebral bleeding. Strokes or cerebral bleeding in turn induce a deterioration of health status, including the possibility of paralysis or loss of functional ability

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conditions which would not have resulted had an individual received sufficient interpretation to explain the need for ongoing utilization of preventive care. In the absence of such interpretation, the costs of treating the complications often outweigh the costs of providing an interpreter.

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

Additional information on the quality of care is provided in our answer to Q.7.

Lost Productivity

If an individual is unable to obtain appropriate access to needed care, the individual may miss unnecessary work days and endure decreased productivity. Further, an individual who does not access needed care, especially one with a chronic or potentially debilitating condition, may ultimately be unable to work to support his or her family, thus increasing the strain on the social welfare system. Thus, the lost productivity and work days of LEP individuals due to lack of

access because of language barriers should also be factored in to offset costs associated with implementing the EO.

Legal Claims

The costs of non-compliance also include those associated with legal suits and malpractice claims brought against providers and others who fail to ensure a patient understands necessary treatment. For example, in a striking California case, a 51-year old mother of seven came to America as a refugee from Laos. She was diagnosed with tuberculosis. Her disease, which was not contagious at the time, was determined to be a drug-resistant form that required long-term therapy. But Mrs. Souvannarath ceased taking the medication because the side effects led her to believe the drugs were going to kill her. County health officials B one Hmong worker and one Thai, neither of whom spoke her language

B could not explain the need for treatment and a Lao interpreter was never provided. County health authorities jailed Mrs. Souvannarath for failing to take her medications. At the jail, a Hmong officer who spoke no Lao misinterpreted for her. She thought he asked if she was afraid of dying so she said "yes". The actual question was if she was thinking of killing herself, and her "yes" answer led the jail to put her on a suicide watch. She was jailed for ten months without a proper court order. Attorneys representing Mrs. Souvannarath subsequently filed a federal complaint for damages and equitable relief that was ultimately settled for \$1.2 million. Both the trauma to Mrs. Souvannarath and her family, as well as the resulting payment to her of \$1.2 million, could have been easily avoided had an interpreter been provided.

Cost-Effective Methods of Providing Language Assistance

As noted above, many states already require linguistic access for LEP individuals in health care settings. While these costs should not be included in any estimates of implementing EO 13166 because they pre-existed the EO, the costs indicate that effective linguistic access is affordable and effective and ultimately results in cost savings on health care outlays.

In Washington state, state law requires language assistance. The state estimates that it will spend \$24 million over two years for oral interpretation. With an estimated 26,000 encounters per month (or 624,000 encounters in 2 years), the average cost of providing oral interpretation is \$38.46 per encounter. Massachusetts, which requires hospitals to provide interpreters in their emergency rooms and in-patient psychiatric facilities, has appropriated \$1.1 million to

implement the program next year.

In addition to state budgetary funding, federal funding is already available for providing linguistic access. Five states have availed themselves of the opportunity highlighted by the Centers for Medicare and Medicaid Services to obtain reimbursement for language assistance provided to Medicaid and SCHIP enrollees. Hawaii, Maine, Minnesota, Utah and Washington all ensure linguistic access and reimburse the costs of interpreters (either by directly paying interpreters or by reimbursing providers for the costs of hiring interpreters).

Some health plans, recognizing the business benefits and ultimate cost savings of ensuring linguistic access, have spent up-front budgetary funds to pay for interpreters. L.A. Care Health Plan recently implemented a training program for its providers and staff to certify them in medical interpretation. And the Alameda Alliance for Health has proposed incentives to providers for the appropriate use of interpreters B \$30 per visit using an in-person interpreter and \$20 per visit using a telephone interpreter on top of payments of the interpreter's fee.

7. Quantifying and describing the benefits to LEP individuals and society as a result of having oral and written translation services available, in accordance with Executive Order 13166.

First and foremost, the major benefit of having oral and written translation services available Bth rough Title VI as reemphasized by EO 13166

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is the quality of care that results. LEP individuals who can communicate effectively and accurately with their health care provider will reap the benefits of accessing preventive care, understanding their diagnosis and condition, making informed decisions about treatment options, recognizing the importance of monitoring a chronic condition and following through with recommended treatments.

In addition to the benefits directly ascribed to LEP individuals, providers will also garner benefits. Providers who ensure linguistic access insulate themselves from claims of malpractice and/or negligence. Providers will ensure their patients have given "informed consent" for needed tests, procedures and surgery. They will avoid complaints that the patient did not understand the doctor's diagnosis or recommended treatment. Further, a "business case" exists for ensuring linguistic access B providers can market themselves on their ability to

ensure linguistic access and achieve a strong word-of-mouth reputation that will result in other LEP individuals seeking care from that provider. These steps can only help the economic viability of their practices. Thus, more than imposing costs, the EO serves a public awareness function by focusing on the need for linguistic access and highlighting the existing responsibilities of providers.

Quality of Care

Improvements in the quality of care LEP individuals receive will also be bolstered by full implementation of EO 13166. Preliminary findings from a study sponsored by the Robert Wood Johnson Foundation, *How Language Barriers Hinder Access and Delivery of Quality Care*, demonstrate the negative consequences created by language barriers. Twenty percent of Spanish-speaking Latinos surveyed reported not seeking medical treatment due to language barriers. Furthermore, the study documented that both patients and providers believe that language barriers present immense obstacles to achieving positive health outcomes. Among the results:

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

According to a recent study by L.A. Care Health Plan, 51% of doctors surveyed said that their patients do not adhere to medical treatments because of culture and language barriers. When asked whether they considered language and cultural issues important in the delivery of care to patients, 71% said that it was very important and another 21% said it was important. Overcoming language barriers can have a dramatic impact on patients' adherence to medical treatments, with an expected rise in positive outcomes.

Business Case for Ensuring Linguistic Access

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

And as mentioned in our answer to Q. 6, both L.A. Care Health Plan and Alameda Alliance for Health have made business decisions that ensuring linguistic access will bolster their organizations' financial stability.

Public Awareness

While the requirements to ensure linguistic access have existed since 1964, many doctors remain unaware of them. For example, in a study conducted by L.A. Care Health Plan, less than 24% of physicians surveyed said they were familiar with existing laws. Thus, while EO 13166 does not result in any direct costs of implementation itself (see answer to Q. 6 above), it serves a significant public awareness function by bringing increased attention to the issue, including the statutory requirements to provide language assistance. For example, L.A. Care found that, of the physicians it surveyed:

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

8. Identifying any existing studies of the costs and benefits of improving the quality of communications and interactions between LEP individuals and the federal government or federally funded services. We are also interested in studies of similar language or translation issues internationally, (e.g. Canada, European Union, United Nations and OEDC).

We have provided the relevant information in our answer to Q. 10 below.

9. Identifying "real-world" case studies that illustrate the costs and benefits of providing translation services to LEP individuals, as envisioned by Executive Order 13166, and related agency guidance. We are seeking examples from multiple perspectives, including LEP individuals, federal agencies/recipients of federal funds, and the international context.

NHeLP has collected a number of "real-world" cases that illustrate the dramatic and sometimes life-threatening consequences to individuals' health and lives when linguistic access does not exist. We have included a sample of these cases below and attached additional ones as Appendix B.

The Dire Consequences of Care without Linguistic Access

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

\$ a pregnant woman lost her baby when her doctor, using an untrained interpreter, failed to communicate adequately that she needed an immediate Caesarian section, and the woman returned home. Her child was ultimately stillborn.

\$ despite statements that it used a language line when interpreters were unavailable, one hospital asked a Spanish-speaking nurse to interpret for a Bosnian patient.

\$ a patient underwent a battery of expensive tests for angina after an emergency room physician misunderstood his complaints of "urgina" B Russian for sore throat.

\$ a child being treated at a hospital had a feeding tube inserted without anyone explaining the procedure to his Spanish-speaking mother or obtaining her consent. When the child was sent home with an oxygen tank, no one explained to his mother how to operate it.

\$ a bilingual Spanish-speaking patient in a hospital's ICU was asked by medical staff to interpret for another ICU patient.

For additional case studies, see Appendix B.

Using Family Members and Friends as Interpreters Is Not a Solution

In addition to the direct consequences an individual may suffer because language barriers hinder understanding a diagnosis or treatment, myriad direct and indirect costs arise when a family member and/or a friend attempts to interpret for a patient. Research and anecdotal information reveal many problems that result from this practice. These costs should also be discounted from any costs incurred by implementing EO 13166.

Adult family members and/or friends who serve as interpreters often do not accurately interpret, which can limit communication between a provider and patient. Untrained interpreters are prone to omissions, additions, substitutions, volunteered answers and other problematic practices.

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

The implementing guidance from HHS' Office for Civil Rights recognizes the drawbacks of using family members/friends and encourages the use of trained interpreters whenever possible. Thus the EO and implementing guidance educate providers about the need for heightened awareness of the problems that can arise from the use of family members/friends and of the benefits of using trained interpreters.

While many problems exist with the use of adult family members/friends as interpreters, when the interpreter is a minor, additional concerns arise, including:

\$ requiring children to take on additional burdens, decision-making and responsibilities;

\$ causing friction and a role reversal within the family structure, which can even lead to child abuse situations; and

\$ violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services.

Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information. Children who act as language brokers often influence the content of the messages they translate, which in turn affects the ultimate decisions of their parents.

A Los Angeles Times article about children who translate for their parents illustrates the potential for harm: a 13-year-old boy described feeling tongue-tied on a recent visit to a health clinic with his mother when the doctor asked him to explain the medicine that the doctor was prescribing to the child's mother. The potential for harm is exacerbated when providers

use children to translate in gynecological or reproductive health settings, as in this situation: a provider performing an ultrasound on a pregnant LEP patient instructed the patient's seven-year-old daughter to tell her mother that the baby was stillborn. Only when the daughter became upset and refused to interpret the message was a professional medical interpreter called.

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

four problems were:

\$ the child translated incorrectly;

\$ the child left out information;

\$ the information was too technical for the child; and

\$ the child was unable to properly translate due to limited English skills.

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

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

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

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

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

"Then he said it B despite her radiation treatment, my mother's cancer would require surgery. I looked at my mom, searching for the words in Cantonese that could communicate what the doctor had explained to me. I didn't know the Cantonese terms for the organ parts he described. I didn't know how to say "chemotherapy." I didn't know how even to say "surgery." So instead, I had to resort to a crude description of what would happen. I had to tell her that there would be needles, and knives, and incisions into her body. My mother began to weep and kept asking me if she was going to be okay. And I didn't know how to console her.

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

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

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

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

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

10. Identifying existing academic research and "real?world" case studies from the following sectors: health, social services/income maintenance, education, transportation, law enforcement and trade, as well as recommendations of additional sectors or perspectives from which to address this issue.

A forthcoming study from The Access Project surveyed uninsured individuals who had received care in the previous year. Analysis compared those who did not need an interpreter, those who needed and received an interpreter and those who needed but did not receive an interpreter. A higher proportion of individuals needing and receiving an interpreter rated their experiences with medical staff and support staff as "satisfactory" or "very satisfactory" than individuals needing but not receiving interpreters and individuals not needing interpreters. Further, individuals needing but unable to receive interpreter assistance were more likely to find their encounters with medical staff moderately but significantly more unsatisfactory than those not needing interpreters and those needing and receiving an interpreter. Additionally, over 25% of those needing but not receiving an interpreter did not understand their medication instructions, compared with about 2% for each of the other groups.

The California Primary Care Association (CPCA) recently released *Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices*.

This report outlines steps that members of CPCA

B

primarily community health centers

B

have taken to ensure linguistic access of LEP individuals.

11. Identifying any other information or resources that the public believes will assist us

in our efforts to assess the benefits and costs of Executive Order 13166.

The Center for Immigrant Health at New York University is collaborating with Gouverneur Hospital in New York City to expand a pilot simultaneous translation program, Technology/Team Enhanced Medical Interpretation System (TEMIS)

. A preliminary analysis from a cost-effectiveness (time-motion) study should be available in January. The contacts are Javier Gonzalez, Director, Language Initiatives Center for Immigrant Health, New York University School of Medicine, 212-263-8242 and the Medical Director for the Program, Dr. Francesca Gany, 212-263-8242.

The full results from the Robert Wood Johnson Foundation's study (see Q. 7) on "How Language Barriers Hinder Access and Delivery of Quality Care" will be available in early 2002. The contact persons are Paul Tarini and Pamela Dickson at 609-452-8701, www.rwjf.org.

Conclusion

We appreciate the opportunity to submit these comments to OMB and look forward to working with OMB to implement EO 13166 and the Department's LEP guidances to guarantee full and equal health care access to all LEP individuals. If the National Health Law Program can provide any additional assistance, please contact us at 202-289-7661.

Sincerely,

Mara Youdelman
Staff Attorney
National Health Law Program

The undersigned organizations support the comments submitted by NHeLP:

Alliance for Children and Families

Asian & Pacific Islander American Health Forum
Asian Health Services
Asian Pacific American Legal Center
Association of Asian Pacific Community Health Organizations
Bay Area Legal Aid
California Healthcare Interpreters Association
California Pan/Ethnic Health Network
California Women's Law Center
Center for Civil Justice (Saginaw, MI)
Chinese for Affirmative Action
Consumer Subcommittee, Pennsylvania Medical Assistance Advisory Committee
Families USA
Florida Legal Services
Greater Hartford Legal Assistance
Health Care Organizing Project (RI)
The Legal Aid Society, NYC
Maryland Disability Law Center
Mental Health Legal Advisors Committee (Boston, MA)
Michigan Legal Services
National Abortion and Reproductive Rights Action League
National Association of Protection and Advocacy Systems
National Center for Youth Law
National Council on Interpreting in Health Care
National Immigration Law Center
National Minority AIDS Council
National LEP Advocacy Task Force
National Senior Citizens Law Center
National Women's Law Center
New York Immigration Coalition
New York Lawyers for the Public Interest
Northwest Health Law Advocates
Ocean State Action (Cranston, RI)
PALS for Health (Los Angeles, CA)
Protection & Advocacy, Inc. (California)
Public Justice Center (Baltimore, MD)
Senior Citizens Law Project of Vermont Legal Aid, Inc.
Southern Poverty Law Center
Summit Health Institute for Research and Education
Tennessee Justice Center
University Legal Services (Washington, DC)
Virginia Poverty Law Center

Appendix A:

Summary of State Laws/Local Ordinances Requiring

Language Assistance and/or Cultural Competency

This Appendix includes two documents: a summary of state laws from NHeLP's 1998 report, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (Kaiser Family Foundation, January 1998); and a chart with selected state laws and local ordinances enacted since publication of NHeLP

=
s report.

Both charts demonstrate that the obligation to provide linguistic access and cultural competency is widespread and existed long before EO 13166.

Summary of State Law Requirements Addressing

Language and Cultural Needs in Health Care (Appendix G)

from

NHeLP

State

Provision

Requirements

AL

Alaska Stat. " 47.30.735, 745

During 30 and 90 day involuntary commitment hearings, patients have the right to an interpreter.

Alaska Stat. ' 47.30.860

When practicable, notices and documents served on mental patients must be explained in a language u

Alaska Stat. ' 47.30.855

Patient rights must be explained in languages understood by mental patients.

Alaska Stat. ' 47.30.675

All applicants for voluntary treatment must receive an explanation of rights in languages that they unders

AK

25 Ark. Code. Ann. ' 15-101

Non-English speaking persons are entitled to the assistance of interpreters in administrative proceedings

AZ

Ariz. Admin. Code ' R9-21-305(B)(9)

Case management services employed by the Department of Health Services must assess communicatio

CA

22 Cal. Code Regs. ' 98211(c)

Recipients of state funds may not discriminate against ethnic minorities by failing to provide alternative c

Cal. Health and Safety Code 1259

General acute care hospitals must provide language assistance services for language groups that comp

Cal. Welfare and Institution§ Code 5804, 5868

County mental health demonstration programs and children's mental health programs must make provis

22 Cal. Code of Regs. ' 73501

Intermediate Care Facilities must use interpreters and other methods to ensure adequate communicatio

Cal. Welf. and Inst. Code ' 14552(e)

An adult day care provider serving a "substantial number" of participants of a particular racial group, mu

22 Cal. Code of Regs.. ' 54401

Adult day care centers must include ethnic and linguistic staff as indicated by participant characteristics.

Cal. Gov = t Code '

States must make available certified interpreters to non-English speaking individuals upon request to int

Cal. Welf. and Inst. Code ' 7290 et seq.

State and local agencies must provide bilingual services to non-English speaking persons. Local agenc

9 Cal. Code of Regs. ' 862, 22 Cal. Code of Regs."

Mental health treatment facilities must post notice of patients' rights in English and Spanish.

22 Cal. Code of Regs. " 79111, 79113

Chemical dependence recovery hospitals must post notice of patients rights in English or the predomina

Cal. Welf. and Inst. Code ' 4503

State hospitals and community care facilities must post notice of the rights of developmentally disabled p

Cal. Health and Safety Code 1599.74

Department of Health Licensing is directed to translate enumerated patient rights into Spanish, Chinese,

Cal. Health and Safety Code 124300

Local health departments are directed to make family planning pamphlets and circulars available in lang

16 Cal. Code of Regs. ' 1003

Dental health experimental programs must post notices describing the nature and intent of the program

22 Cal. Code of Regs. ' 79799

Correctional facilities must post notice of rights of inmate-patients in English and Spanish.

Cal. Welf. and Inst. Code ' 14191, 22 Cal. Code of Regs.

Physicians and hospitals performing voluntary, non-emergency sterilizations on Medi-Cal beneficiaries n

Cal. Welf. and Inst. Code ' 5325

Individuals subjected to involuntary mental health treatment must receive an explanation of their rights in

Cal. Health and Safety Code 1568.02(c)(4)

Residential care facilities for persons with chronic, life-threatening illness must demonstrate ability to pro

22 Cal. Code of Regs. " 72528, 73524

Nursing facilities must obtain informed consent from non-English speaking patients through use of an int

Cal. Welf. and Inst. Code ' 10746

Informational materials about state administration of public assistance must be produced in both English

17 Cal. Code of Regs. ' 6824(b)(3)(B)

Medicaid beneficiaries who cannot understand English must be informed "appropriately" of the Early Per

Cal. Welf. and Inst. Code ' 14007.5(j)

Local offices must explain Medicaid alien eligibility rules to aliens who are not fluent in English in a language they understand.

Cal. Welf. and Inst. Code " 4710.8(d), 4712(k)

State or service delivery agency must provide non-English speaking claimants with interpreters at fair hearing.

CO

Colo. Rev. Stat. ' 26-4-703(d)(3)

Directing the Department of Health Services to consider the special cultural and linguistic needs of patients.

CT

Conn. Agencies Regs. ' 17-134d-41

Coordinating, Assessment and Monitoring Agencies that provide assessment and case management services.

Conn. Gen. Stat. ' 19a-490g

Requiring Department of Public Health to develop a bilingual consumer guide on home health services.

DE

16 Del. Code ' 5161

Mental health hospitals and residential centers must display patient rights in English and Spanish and m

DC

D.C. Code ' 31-2711(a)

Establishing the Office of Interpreter Services to facilitate the use of interpreters in administrative, judicia

FL

Fla. Stat. ' 381.026(4)(b)(7)

A patient in a health care facility who does not speak English has the right to be provided an interpreter v

Fla. Admin. Code ' 59A-3.207

Each hospital offering emergency services must post notices in English and Spanish clearly stating patient

Fla. Code " 636.015, 641.305 and 641.421

Prepaid limited health service organizations, health maintenance organizations, and prepaid health clinics

HI

Haw. Rev. Stat. Ann. ' 321-301

Establishing state sponsored bilingual health education aide program to assist in the provision of health

Haw. Rev. Stat. Ann. ' 334-13

Establishing a bilingual mental health division within the Department of Health to provide outreach, education

IL

210 Ill. Comp. Stat. 87/5 et seq., 77 Ill. Admin. Code 250.265

Because access to information regarding basic health care services is an essential right, communication

405 Ill. Comp. Stat. 75/1

State-operated mental health and developmental facilities must provide qualified Spanish speaking inter

405 Ill. Comp. Stat. 5/3-204

Patients admitted to mental health facilities must who do not understand English must receive an explan

405 Ill. Comp. Stat. 5/3-205

Patients admitted to mental health facilities who do not understand English must receive an explanation

59	Ill. Admin. Code	'	112.20
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Mental health and developmental disability facilities must notify non-English speaking patients and their

20	Ill. Comp. Stat.	2310/55.66
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The Department of Public Health is required to publish and distribute pamphlets to women on reproducti

89 III. Admin. Code " 302.30(c) and 308.30

In delivering social services to children and their families, the Department of Children and Family Service

89 III. Admin. Code ' 140.461

Federally qualified health centers must comply with federal and state laws and regulations governing the

89 III. Admin. Code ' 716.200(d)(2)

Providers contracting with the Department of Rehabilitative Services to provide case management service

89 III. Admin. Code ' 1200.10(d)(1)

Information, forms, and applications distributed by the Division of Specialized Care for Children shall be

KS

Kan. Admin. Regs. ' 28-4-550(h)(1)(A) and (w)

Informed consent for services under part H of the Individuals With Disabilities Education Act (IDEA) must

LA

40 La. Rev. Stat. ' 1299.35.6.B(2)(4)

Specified oral information and written materials about abortion and abortion alternatives must be provided

ME

5 Me. Rev. Stat. ' 51

State must provide qualified interpreters or utilize a professional telephone-based interpretation service

MA

114.3 Mass. Regs. Code " 3.02 and 3.06

Home health agencies may apply for adjustment in rates for provision of interpreters to non-English speaking

102 Mass. Regs. Code " 3.03(6)(a)(1)(a.), 6.05(6)(a)(1)(a)

Group care facilities for children must maintain records of the primary language of children in their care.

105 Mass. Regs. Code ' 127.021

As a condition of licensing, mammography facilities must provide specified information to patients. The

105 Mass. Regs. Code " 150.001 and 150.004(H)

Skilled nursing facilities for AIDS patients must provide access to sufficient bilingual services to meet the

105 Mass. Regs. Code " 160.303(B)(1)

Substance abuse treatment facilities must keep data listing primary language spoken by patients if other

105 Mass. Regs. Code ' 130.615(C) and (E)

Maternal-newborn service must make available health education materials and activities in languages s

117 Mass. Regs. Code " 8.08(d)

Community health centers must post notice of the availability of free care in any language spoken by 10

MI

Mich. Stat. Ann. ' 14.15(b) and (c)

Consequences of abortion must be explained in language understood by patient and consent forms must

MN

Minn. Stat. " 144.651(4)

Health care facilities must make reasonable accommodations to inform non-English speaking patients o

Minn. Stat. ' 148B71(1)

Mental health facilities must make reasonable accommodations to inform non-English speaking patients

Minn. Stat. ' 256.01 (13)

Mandating pilot projects for language assistance for individuals applying for or receiving aid through cou

NE

40 Nev. Rev. Stat. ' 442.253 (1) and (3)

Consequences of abortion must be explained in language understood by patient and consent forms must

NJ

8 N.J. Admin. Code " 31B-4.37(a)(1), 31B-4.41C

Hospitals must post notices regarding availability of charity care in Spanish, English and any other language

8 N.J. Admin. Code " 33-4.10(a)(8), 33A-1.29(b)(3)(ii)-4.10(a)(8)

For approval of certificate of need, hospital must show how the project will promote access for racial and ethnic

26 N.J. Rev. Stat. ' 2-168

Department of Health must disseminate informational brochure on breast cancer in English and Spanish

26 N.J. Rev. Stat. ' 2H-12.8.h.

Patients have the right to expect that within their capacity, hospitals will make reasonable response to re

8 New Jersey Administrative Code 33E-1.5a

For approval of certificate of need for intensive cardiac care units, hospitals should have bilingual clinica

30 N.J. Rev. Stat. ' 4-27.11

Patients admitted to psychiatric facilities have the right to have examinations and services provided thro

8 N.J. Admin. Code " 42A-6.10, 42B-6.6(e)

Drug and alcohol treatment facilities must provide interpreter services if their patient population is non-E

8 N.J. Admin. Code " 43H-6.1(a)(14)

Rehabilitation hospitals must provide interpreter services if their patient population is non-English speak

8 N.J. Admin. Code " 43F-6.6

Adult day care centers must provide interpreter services if their patient population is non-English speaking

30 N.J. Stat. ' 1-1.1

Requiring the Department of Human Services to establish a comprehensive social services information

10 N.J. Admin. Code ' 74-1.3

To meet requirements for bilingual services, Medicaid managed care plans must be able to provide serv

NY

10 N.Y. Comp. Codes R. & 'Reg. 405.7 (a)(7)

Hospitals must provide skilled interpreters and translations of all significant forms to ensure effective ora

N.Y. Consolidated Laws Service, Mental Hygiene 41.47(f)(3)

Directing the Office of Mental Health and local mental health agencies to consider the availability of serv

N.Y. Consolidated Law Service, Mental Hygiene 7.09(h)(i) and 13.09(e) (1995)

Directing the Office of Mental Health and Office of Mental Retardation and Developmental Disabilities to

New York Consolidated Laws Service, Mental Hygiene 81.07(b)

Orders to show cause in proceedings for appointment of a guardian must be translated into languages of

14 New York Consolidated Law Service, Mental Hygiene 21.7

Non-English speaking mental patients must be provided with qualified translation services to facilitate with

New York Consolidated Law Service, Social Services 473-a.4.(c)(vii) (1995)

Petition for involuntary commitment must state that if a patient is non-English speaking, reasonable effort

NC

10 N.C. Admin. Code ' 50B.0203(c)(5)

Requiring the county department of social services to verify eligibility information when an applicant is un

OH

Ohio Admin. Code ' 5124-2-01(D)(4)

Hospitals and mental health clinical facilities must ensure that all non-English speaking patients meet with

Ohio Admin. Code, Chapter 3793, 2-1-12(G)

Licensed referral and information services for drug and alcohol addiction must provide access to patients

Ohio Admin. Code, Chapter 5101, Section 3-2-0717(D)(3)

Hospitals receiving state payments for indigent must post notice of patient rights to free care.

PA

55 Pa. Admin. Code ' 1140.41(12)

Providers that contract with state's Healthy Beginnings Plus program must ensure use of qualified interpreters

35 Pa. Stat. ' 449.36

Health care practitioners that treat non-English speaking Medicare beneficiaries must post translated sign

28 Pa. Admin. Code " 201.29(k) and 201.30(h)

Nursing homes must make arrangements to communicate patient rights to non-English speaking patients

28 Pa. Admin. Code ' 553.12

Ambulatory surgery patients who do not speak English shall have access to an interpreter where possible

28 Pa. Admin. Code ' 201.29(x)

Hospitals must translate notices of patient rights for non-English speaking patients.

35 Pa. Stat. ' 449.36(c)

Hospitals must post translated notices of patient rights for non-English speaking Medicare beneficiaries.

RI

23 R.I. Gen. Laws ' 17.5-18(3)

Nursing homes serving non-English speaking patients must attempt to find interpreters to allow patients

TX

25 Tex. Admin. Code ' 29.609(c)(3)

Disproportionate share hospitals must post notices of right to charity care in English and Spanish.

25 Tex. Admin. Code ' 405.88

Facilities for the mentally retarded must make necessary provisions to assess non-English speaking ind

40 Tex. Admin. Code 25 " 147.35(10), 153.36(13)

Alcohol and drug abuse education programs and drug offender education programs must make provisio

Tex. Health and Safety Code 161.132(e), 161.134(j), 161.135(h), 321.002(h), 2

Facilities and hospitals offering mental health, rehabilitation and alcohol and chemical dependency services

Tex. Health & Safety Code ' 161.136(a)

State health care regulatory agencies are empowered to require mental health services providers to furnish

25 Tex. Admin. Code " 404.161(f), 404.162(d)

Mental health facilities must provide patient rights brochures to teens and children in English and Spanish

UT

Utah Admin. Code ' R501-2-9(J)

Human service programs that contract with the state must employ staff as necessary to communicate with

VT

18 Vt. Stat. Ann. ' 1852

Hospital patients who do not understand English have a right to an interpreter "if the language barrier prevents

33 Vt. Stat. Ann. ' 7301

Nursing homes must make reasonable accommodations to communicate patients rights to non-English

WA

Wash. Admin. Code " 440-22-160 and 440-22-310(b)

Chemical dependency service providers must make available certified interpreters or other acceptable a

Wash. Rev. Code ' 74.04.025(1)

The Department of Social and Health Services and the Office of Administrative Hearings shall insure tha

Wash. Admin. Code ' 246-452-010

Written explanations about charity care must be provided in any language spoken by more than ten per

Wash. Rev. Code " 2.43.010 and 2.43.020, Wash. Admin. Code

Interpreters must be provided to non-English speaking persons in legal proceedings, including administrative

WI

Wis. Admin. Code, Chapter HSS, 102.01(b)(4)

In administering state Medicaid program, agencies that serve substantial non-English speaking or limited

Wis. Stat. Ann. 253.10(3)(d)

Written information about abortion alternatives must be provided to patients in English, Spanish and language

Wis. Dep. of Health and Social Services Administrative Disposition

DHSS divisions must translate program information into languages spoken by at least 5% or 1,000 individuals

Selected State Laws and Local Ordinances

Enacted Since 1998

State/

Locality

Provision

Requirements

State Laws

FL

Fla. Stat. ' 641.54

Each health maintenance organization shall provide to subscribers, upon request, policies and procedures

MA

Emergency Room Interpreter Law, 105 Mass. Regs. Code 18.1100 et Seq.

The state must compensate hospitals for interpreting costs in emergency rooms and inpatient psychiatric

State Dept. of Public Health website on Hospital-Based Interpreter Services (with best practices, resources

MN

Minn. Stat. ' 62Q.07

All health plan companies that issue or renew a health plan (defined in

MT

Mont. Code Ann. ' 33-36-201

Each managed care plan in the state must submit an access plan including the health carrier

Administrative Codes

ID

Id. Code 16.03.09.090

When obtaining consent for sterilization in the Medical Assistance Program, an interpreter must be provi

NM

13 N.M. Admin. Code 10.13.29

The managed health care plan must ensure that information and services are available in languages other than English.

Each managed health care plan must submit a plan which shall address: how it will identify the language needs of its members.

OR

Or. Admin. R. 410-141-0760

Primary Care Case Managers (PCCMs) are expected to have a plan to access qualified interpreters who can provide services in the member's language.

PCCMs shall provide education on the use of services, including Urgent Care Services and Emergency Services, to members in their language.

TX

25 Tex. Admin. Code ' 30.27

Managed Care Organizations (MCOs) shall develop a written cultural competency plan describing how to provide services to members in their language.

Local Ordinances

CA (San Francis-co)

Equal Access to Services

City Departments must offer information and services in each language spoken by a substantial number

A Concentrated number of limited English speaki

A Substantial number of limited English speaking

CA (Oak-land)

Equal Access to Services

City departments must offer bilingual services and materials if a substantial portion of the public utilizing

A Substantial number of limited English speaking

Appendix B:

The Consequences of Ineffective Language Assistance

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

1. A Korean woman appeared for a gynecology exam, but no interpreter or language line assistance was provided. The clinician used the 16-year-old son of a complete stranger to translate.
2. A woman requiring treatment for a uterine cyst was unable to receive treatment on two separate occasions because an interpreter was unavailable.
3. A man suffering from a skin condition requiring laser treatment underwent treatment for over a year. The man endured days of pain after each treatment, but was unable to communicate this because he was never provided with an interpreter. Only after a community organization intervened did the clinic understand the patient's pain and adjust the treatment.
4. A Russian-speaking woman experienced life-threatening complications from prescribed medications. Without an interpreter or use of a language line, doctors in the emergency room were unable to treat her. Only because a Russian-speaking young girl happened by and agreed to help were doctors able to save the woman's life.
5. An elderly Vietnamese-speaking man visited a dental clinic for treatment. Without an interpreter, the man was told to sign an English consent form asking if he agreed to the extraction of a large number of teeth. The man placed a mark in the signature space, was

placed under anaesthesia and, only after the procedure, found out what had been done.

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

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

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

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

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

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

12. A Spanish-speaking patient suffered complications from treatment for a severe tooth infection. Because she was never told in Spanish that follow-up care was free, she did not return for assistance and the infection got worse, forcing her to miss work.

13. A Vietnamese-speaking patient with multiple chronic illnesses applied for disability and was told that if he did not bring his own interpreter, it would take longer to get a determination.

14. A Spanish-speaking patient seen in an emergency room was given instructions in English for a follow-up ultrasound. The patient took time off from work for the ultrasound, but then found that, because he did not understand the instructions, he had not prepared appropriately. He had to have the procedure rescheduled and therefore missed more work.

15. A Spanish-speaking patient was unable to reschedule her urgent gynecology appointment because the receptionist on the phone only spoke English.

16. A Spanish-speaking father with a severe seizure disorder needed brain surgery, and his 13 year old son was told to interpret to explain the surgery. The child was so traumatized that he refused to go back to the hospital.

17. A Vietnamese-speaking patient had abdominal surgery and was not informed how to care for his wound or how to get the staples removed because his discharge instructions were only in English.

18. A Vietnamese-speaking man had an appendectomy, and his 14 year old son had to spend several days with him in the hospital to interpret, thereby missing school.

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

Telephone conversation with Rosalind Bruno, Education and Social Stratification Branch, Population Division, Census Bureau, 301-457-2464 (December 18, 2001).

While we expressed concerns in our comments on the regulations regarding the limitations of the proposed regulations, they do offer one method of quantifying the numbers and languages of LEP individuals. For information about our specific recommendations, please contact NHeLP at 202-289-7661.

See Uniform Data Set Manual at 27. If the CHC does not maintain actual data in its management information system, linguistic preference data may be estimated but, wherever possible, the estimate should be based on a sample.

65 Fed. Reg. 80865, Standard 10.

Providers include hospitals; skilled nursing facilities; home health agencies; clinics, rehabilitation agencies, and public health agencies; comprehensive outpatient rehabilitation facilities; hospices; critical access hospitals; community mental health centers.

For example, California's Dymally-Alatorre bilingual Services Act requires that interpreters and translation services be provided to language groups that comprise 5% or more of the people served by any local office or facility of a state agency. Cal. Govt. Code 7290 et seq. In addition, California requires both translation and interpretation for state agencies. Specifically addressing health care facilities, acute care hospitals must ensure availability of interpreter services to patients who are part of a language group that comprises at least 5% of the population of the geographic area served by the hospital,

A
to the extent possible

@
. Cal. Health & Safety Code

1259. According to Illinois Language Assistance Services Act,

A
. . . it is the intent of the General Assembly that where language or communication barriers exist between patients and the staff of a health facility, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff.

@
210 Ill. Comp. Stat. 87/5. New Jersey
,
s Bill of Rights for Hospital Patients states that every person shall have the right
A
[t]o expect that within its capacity, the hospital will make reasonable response to his request for
services, including the services of an interpreter in a language other than English if 10% or more
of the population in the hospital's service area speaks that language.
@
N.J. Stat. 26:2H-12.8(h). New York
,
s Patients
,
Rights law requires that hospitals
A
manage a resource of skilled interpreters. . .and shall provide translations/transcriptions of
significant hospital forms, instructions and information in order to provide effective visual, oral
and written communication with all persons receiving treatment in the hospital regardless of a
patient
=
s language.
@
Interpreter services and translation/transcriptions must be available to non-English speaking
groups comprising more than 1% of the total hospital service area population. 10 N.Y.C.R.R.
,
405.7. Vermont
,
s Bill of Rights for Hospital Patients states
A
A patient who does not speak or understand the predominant language of the community has a
right to an interpreter if the language barrier presents a continuing problem to patient
understanding of the care and treatment being provided.
@
18 V.S.A.
,
1852.

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

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

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

Numerous medical studies point to the ability of regular care to lessen overall health care costs. One such study documents the reduced costs, and hospital readmissions, that result from providing comprehensive discharge planning and home care intervention for at-risk hospitalized elders. Naylor, M, *et al.*, *Comprehensive Discharge Planning and Home Follow-Up of Hospitalized Elders*, Journal of the American Medical Association, Vol. 281, No. 7, 613, 617 (February 17, 1999). Post-discharge assistance has also been documented to reduce unplanned admissions, days of hospitalization upon admission, and poor long-term outcomes in patients with high-risk congestive heart failure. Simon Stewart, *et al.*, *Prolonged Beneficial Effects of a Home-Based Intervention on Unplanned Readmissions and Mortality Among Patients with Congestive Heart Failure*, Arch. Intern Med., Vol. 159, 257 (February 8, 1999).

The Institute for Health and Aging, University of California, San Francisco, on behalf of the Robert Wood Johnson Foundation, *Chronic Care in America: A 21st Century Challenge*, www.rwjf.org/library/chrcare/p3pg27.htm at 1 (November 1996).

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

Hoffman, Catherine & Schlobohm, Alan, The Kaiser Family Foundation Commission on

Medicaid and the Uninsured, *Uninsured in America: A Chart Book*, 2nd Edition (May 2000) at 56.

See PBS Healthweek, Program No. 506, *Medical Interpreters*, http://www.pbs.org/healthweek/feature1_506.htm.

National Center for Chronic Disease Prevention and Health Promotion, *Diabetes: A Serious Public Health Problem, At-A-Glance 2000*

,
<http://www.cdc.gov/diabetes/pubs/glance.htm>
at 3-4.

Id. The CDC estimates that adequate care could prevent 6-12,000 cases of blindness each year, 16,500 cases of kidney failure, and 43,000 amputations.

Herbert Schuette, *et al.*, *The Costs of Cancer Care in the United States: Implications for Action*, *Oncology*, Vol. 9, No. 11,
<http://Intouch.CancerNetwork.com/journals/oncology/qol1195b.htm>
at 6, (November 1995).

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

Id.

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

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

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

Id. Five percent said they were not familiar with the laws and 51% said they were not sure.

Id.

See 65 Fed. Reg. at 52769-80 (August 30, 2000). While OCR is currently reviewing its guidance to comply with a Memorandum from the Department of Justice (October 26, 2001), we anticipate that the substance will remain the same. Although OCR will re-publish its guidance early in 2002, its existing guidance remains in effect.

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

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

This was a national survey of over 10,000 respondents, 4,161 of whom took the survey in

Spanish and provided information on their experiences at twenty-three urban and suburban hospitals located in 15 cities. For additional information, contact Mark Rukavina, The Access Project, (617) 654-9911, ext. 229, rukavina@accessproject.org.

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