Straight Talk

Model Hospital Policies and Procedures on Language Access

California Health Care
Safety Net Institute

Straight Talk: Model Hospital Policies and Procedures on Language Access

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Written by:
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[1] Appendix from the Los Angeles County Department of Health Services Cultural and Linguistic Competency Standards (2003), (available at http://ladhs.org/odp/docs/dhsculturalstds.pdf).

[2] Appendix from *Providing Linguistic Access to Limited English Proficient Individuals: Findings and Recommendations for Improving, Monitoring, and Maintaining Language Assistance Services.* Contra Costa Health Services (Dec. 2003).

[3] Appendix from *Providing Linguistic Access to Limited English Proficient Individuals: Findings and Recommendations for Improving, Monitoring, and Maintaining Language Assistance Services.* Contra Costa Health Services (Dec. 2003).

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Straight Talk: Model Hospital Policies and Procedures on Language Access

Introduction

As the United States becomes increasingly diverse, American hospital systems face an enormous challenge in providing quality health services to limited English speaking patients. Increasing attention to quality improvement and medical error reduction initiatives cannot overlook the critical element of effective communication between physicians and patients in ensuring successful health outcomes.

The dilemma of ensuring effective communication between medical providers and the Limited English Proficient (LEP) population and the deaf and hearing impaired is pervasive, facing not only large, urban public hospital systems in states such as California and New York, but also suburban and rural systems. The need for clear policy and detailed operational procedures, both to ensure quality health care services and to meet legal and regulatory requirements for language access, is the dilemma of virtually every health care provider in America.

California's public hospitals share a common mission to serve all in need regardless of ability to pay, immigration status or insurance, a unique challenge in a state of incredible diversity. According to the 2000 Census, 39.5% of Californians over the age of five speak a language other than English at home and 20% of this population speaks English less than very well. Immigrants now constitute over 26% of California's population, or almost 9 million people.[4] California's public hospitals and health systems serve a patient population made up of more than 76%[5] people of color and more than half of public hospi-

[4] 2000 United States Census (available at http://www.census.gov/main/www/cen2000.html).

[5] *On the Brink: How the Crisis in California's Public Hospitals Threatens Access to Care for Millions.* California Association of Public Hospitals and Health Systems (2003): 3 (available at http://www.caph.org).

tals' patients are Limited English Proficient.[6] As a result, public hospitals encounter a significant challenge in the volume and complexity of their provision of language services. This diversity, along with a high level of administrative and physician leadership and innovation, uniquely positions California's public hospitals and health systems to address the issue of language access. For example, these public hospital systems use a unique combination of medical interpreters, bilingual staff, remote interpreter services and most recently, a Remote Video/Voice Medical Interpreter bank, to stretch very limited resources to minimize language barriers within their systems.

Straight Talk: Model Hospital Policies and Procedures on Language Access is the result of the joint efforts of the California Health Care Safety Net Institute (SNI), which serves as the educational and research affiliate of the California Association of Public Hospitals and Health Systems (CAPH), and Melinda Paras, Principal at Paras and Associates. The adoption of hospital policies and procedures is the essential mechanism to making a significant change in the operational actions of the U.S. hospital industry, and has been used throughout the history of this industry as a mechanism to change practice and establish expectations on a challenging issue. For example, the creation and widespread distribution of model policies on issues ranging from sexual assault to organ donation have created universal standards through which the hospital industry navigates such issues of social importance. This document is designed to offer American hospitals a set of tools to utilize in updating their own internal Policy and Procedure Manuals. (*Language Access Policies and Procedures* are typically found in the Administrative Manuals required in every accredited U.S. hospital.)

Drawing on the expertise and generosity of "Best Practice" hospitals from around the nation, a multidisciplinary Advisory Committee and four California hospital systems that each conducted an extensive review of a draft of the Model, this document also incorporates some new and innovative operational procedures. For example, while many hospital systems have policies affirming access of LEP patients to interpreters, the ability of staff to actually access those services is often impeded by outdated procedural mechanisms. These Model Policies

[6] *Helping Public Hospitals Improve the Health of Patients and Communities.* California Health Care Safety Net Institute (2004): 10 (available at http://www.safetynetinstitute.org).

and Procedures address this issue by ensuring that access to interpreter services is readily available to frontline practitioners.

While the study, review and creation of these Model Policies and Procedures was based primarily on California public hospitals, this Model is applicable and adaptable to the entire U.S. hospital industry. The only significant distinguishing feature required in the adoption of these procedures in a state other than California is to ensure that state specific laws and regulations regarding language access in health care settings have been incorporated and referenced. In addition, local counties and cities may have additional ordinances which should be considered. Every hospital system will want to incorporate additional specifics in the procedural sections addressing the details of departments to contact and steps to follow in accessing language services.

Electronic copies of *Straight Talk: Model Hospital Policies and Procedures on Language Access* are available on the Safety Net Institute website (http://www.safetynetinstitute.org) in both Microsoft Word and PDF formatting so that this document can easily be adapted and incorporated into existing hospital policies and procedures.

Background

These Model Policies and Procedures address issues of language access related to immigrants and visitors to the United States who are protected under civil rights law from discrimination based on national origin. They do not address access issues related to disability (i.e. communication issues of the deaf and hearing-impaired). While some individual hospitals have policies and procedures on language access that jointly address these subjects, initial review of these issues indicates significantly differing legal requirements and mechanisms for addressing disability access. An active review and establishment of appropriate policies and procedures for language access for the deaf and hearing impaired is in need and strongly encouraged.

Barriers faced by immigrant patients accessing health care in the United States are extensively documented. Popular literature, such as the non-fiction book, *When the Spirit Catches You and You Fall Down* by Anne

Fadiman, has drawn national attention to the challenges of LEP patients accessing the American health care system. Documentation of the impact of language access on the delivery of quality care can be found in major governmental reports which include: the Office of Management and Budget (OMB) Report To Congress, *Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency;*[7] and, the Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health.*[8]

The most significant legal statute regarding language access in hospital settings lies in Federal civil rights law, specifically Title VI of the Civil Rights Act of 1964.[9] Under Title VI, no program or activity receiving Federal financial assistance may discriminate on the basis of national origin, including language and therefore applies to LEP immigrants. To further ensure compliance with Title VI, Executive Order 13166, mentioned above, was issued by President Clinton in 2000. This Executive Order was reaffirmed in 2002 by the Bush Administration in a memorandum by Assistant Attorney General Ralph F. Boyd, Jr. communicated to the Heads of Federal Agencies, General Counsels and Civil Rights Directors.[10]

Title VI has been interpreted to include coverage of linguistic services for the LEP population and requires compliance by all recipients of federal funds, including hospitals receiving Medicare and/or Medicaid funding and participating in the State Children's Health Insurance Program (SCHIP). The Office of Civil Rights (OCR) of the Department of Health and Human Services (HHS) is responsible for overseeing health care facility adherence to Title VI of the U.S. Civil Rights Act. The resolution of OCR investigations regarding health care provider compliance to Title VI requirements regarding language access typically

[7] *Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency* (available at http://www.whitehouse.gov/omb/inforeg/lepfinal314.pdf).

[8] *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* (available at http://www.iom.edu/report.asp?id=4475).

[9] Title VI of the 1964 U.S. Civil Rights Act, 42 U.S.C. § 2000d (available at http://www.usdoj.gov/crt/cor/coord/titlevi.htm).

[10] Memorandum available at http://www.usdoj.gov/crt/cor/lep/BoydJul82002.htm.

concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes."[16]

In addition, HHS recipients that would like to ensure with greater certainty that they comply with their Title VI obligations to provide written translations in languages other than English can follow the following Safe Harbor[17] suggestions: "1) The HHS recipient provides written translations of vital documents for each eligible LEP language group that constitutes 5% 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; or, 2) If there are fewer than 50 persons in a language group that reaches the 5% percent trigger in 1), the recipient does not translate vital written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost."[18]

California hospitals may face possible tort liability if a LEP patient files a malpractice claim in an instance "where [a] lack of communication creates a damaging barrier to adequate care," for example, in the case of a lack of informed consent.[19] The maximum amount of damages for noneconomic losses in medical malpractice actions is $250,000[20]

[16]MRMIB/HFP, Health Plan Model Contract, Agreement #05MHF000, Exhibit A, Exhibit A, Attachment 9, § 13(C) at 8-9 (June 2003).

[17]Following the OCR safe harbor suggestions is considered strong evidence of compliance with written-translation obligations. However, the failure to provide written translations under the outlined circumstances does *not* mean there is non-compliance. Rather, the safe harbor suggestions provide a common starting point and merely provide a guide. Additional information on the safe harbor suggestions for written translations can be found in *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities.* National Health Law Program. (2003): 2.19-2.21 (available at http://www.healthlaw.org/).

[18]Office of Civil Rights, U.S. Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* 68 Fed. Reg. 47311 (Aug. 8, 2003). (available at http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.html).

[19]E*nsuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities.* National Health Law Program. (2003): 3.20 (available at http://www.healthlaw.org/).

[20]Cal. Civil Code §3333.2 (available at http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=civ&codebody=&hits=20).

which does not include possible punitive damages in the case of an egregious error.[21]

A comprehensive review of the legal and regulatory requirements for providing language access can be found in the National Health Law Program (NHeLP) publication, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities.*[22] A California-specific NHeLP publication by Doreena Wong and Jane Perkins on the same topic will likely be published in the summer of 2005.[23]

Key Policy and Procedural Issues

A comprehensive set of policies and procedures addressing the provision of health care services to LEP patients covers a wide variety of elements, from the annual review of the changing needs of immigrant communities in a hospital service area to the procedures for hospital signage. The following, however, highlight and elaborate on some of the most important elements of these Model Hospital Policies and Procedures for Language Access:

1) Requirement that health care interpreter services be available and provided at no cost to the patient (Policy #1000)

The first major policy statement in this Model states that the hospital system shall provide for the communication needs of the LEP population at no cost to the patient. The Office of Civil Rights guidance and its resolution of complaints against hospital systems require both that interpreter services be provided free of charge, during all hours of services,

[21] Additional information on language access responsibilities and requirements under federal and state law can be found in *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* by the National Health Law Program (available at http://www.healthlaw.org/).

[22] *Ensuring Linguistic Access in Health Care Settings: Legal Rights & Responsibilities.* National Health Law Program (available at http://www.healthlaw.org/).

[23] *Ensuring Linguistic Access in Health Care Settings in California: Legal Rights and Responsibilities* available in the summer of 2005 on The California Endowment website at http://www.calendow.org/.

and that signage advising patients of these rights be posted in all appropriate languages.[24]

Please note that rights to language access in hospital settings are not exclusive to the patient, but also apply to the surrogate decision-maker. Adult parents, guardians for a minor and legal representatives of a patient also must be offered full access to necessary information in their language through an effective mechanism for communication.

2) Procedure requiring health care interpreting and who is qualified to provide these services (Policy # 1000.2 – 1000.3)

Perhaps the most significant programmatic element to these Model Policies and Procedures on Language Access resides in the1000.2 listing of examples of key medical and nursing procedures that require the provision of health care interpreting for LEP patients. These procedures include ensuring informed consent, obtaining a medical history and providing medication instructions; and, are recognized by regulatory and legal practices to require clear and accurate communication between providers and patients.

OCR guidance on compliance with Title VI requirements encourages recipients of Federal funds to evaluate the nature of the services they provide, and accordingly match assurance of appropriate and timely interpreter service to the importance and urgency of the service delivered. The listing of medical and nursing procedures that should receive qualified health care interpreter services is a cornerstone of appropriate hospital policy and procedure on language access because it targets the most significant and urgent communication needs between the provider and patient.

By establishing that these prioritized services must receive qualified health care interpreter services, hospitals can avoid practices such as the

[24]Office of Civil Rights, U.S. Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* 68 Fed. Reg. 47311 (Aug. 8, 2003). (available at http://www.usdoj.gov/crt/cor/ lep/hhsrevisedlepguidance.html).

utilization of children, strangers, ad hoc volunteers and housekeeping and other hospital staff who are not trained medical interpreters.

Under these policies and procedures, family members and bilingual staff whose bilingual qualifications have not been tested through hospital Human Resource processes may be utilized for the purposes of interpreting directions or for registration purposes, but they may ***not be utilized for the provision of "health care interpreting."*** Under the definitions outlined in the Model Policies and Procedures, health care interpreting may only be delivered by providers, staff and contracted services that have undergone a screening process to determine their competencies in the second language, knowledge of medical terminology and understanding of hospital privacy and confidentiality requirements. Bilingual staff with a degree or certification in medicine, nursing, social work, or medical technician functions have, through their credentialing process already been verified to hold some essential elements of training in medical terminology and hospital privacy and confidentiality requirements.

Over time, it is expected that health care interpreting will become a licensed and credentialed activity. Until then, health care providers should exercise a reasonable effort to ensure that those providing interpreting in their facilities have some explicit and defensible criteria of qualification. The California Healthcare Interpreting Association (CHIA) has developed standards for the provision of health care interpreting that can assist hospitals in evaluating the qualifications of those designated to provide that service.[25]

This recommended policy also requires physicians who would like to provide services to patients in a language other than their primary one to have their language skills verified in the same manner as other hospital personnel. Although many providers are attempting to improve their language skills to serve their patient populations better, those who are not yet able to demonstrate their full competency in a language other than their own are encouraged to practice their language skills when seeing patients, but should retain the hospital interpreter service to supervise this communication to ensure the accuracy of the process.

[25] *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention.* California Healthcare Interpreting Association (2002). (available at http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf)

A number of hospitals, including those with extensive interpreter services, allow patients to refuse hospital provided interpreter services in favor of friends and family members upon signing a waiver documenting this refusal. While friends and family members should certainly be allowed in the exam room to offer support and comfort and can participate in interpreting for patients, ***this should not substitute for a hospital-provided interpreter.*** Even if family members initially offer to interpret for the patient, the hospital provided interpreter is still necessary to confirm that the interpreting is accurate and complete. A number of hospitals have allowed patients to provide their own interpreter if they "insist" and sign a "waiver showing they have refused a hospital-provided interpreter." However, the OCR guidance requires that health care providers take "reasonable steps" to ascertain if family, legal guardians, caretakers, and other informal interpreters are "competent to interpret."[26] A health care provider has little capacity to verify the qualifications of a family member offering to provide health care interpreting that includes interpreting medical terminology.

Another reason that a patient may refuse a hospital provided interpreter is related to confidentiality. Many immigrant communities within the U.S. are small and tight-knit and a patient may be acquainted with the hospital interpreter from that community. As a result, requests for a different interpreter should be supported in the same way that patients can request services from a different hospital offered provider if they are personally acquainted with the offered provider. Telephone-based interpreter services can usually offer a different interpreter in the same language, often from another part of the country.

In light of the responsibility to provide high quality health care services to LEP patients, it is recommended that hospitals provide interpreter services in all circumstances even if this is a supplementary role to the patient's friend or family member.

[26]Office of Civil Rights, U.S. Department of Health and Human Services, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003). (available at http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.html)

3) Acquisition of interpreter services and determination of an acceptable wait time (Policy #1000.4 – 1000.10, 1005)

While a hospital may maintain policies offering the provision of interpreter services to LEP patients in principle, their operational procedures may not actualize this commitment. One of the most common reflections of disjointed operational policies and procedures in the field of language access is demonstrated when a hospital's policy states that staff will contact a contracted telephonic service provider when an interpreter is required, yet the steps required to secure interpreting are so cumbersome that providers are actually discouraged from using these services. For example, some hospitals require "approval" by administration or nursing managers to secure interpreter services. As a result, hospital staff, often already beleaguered by lines of waiting patients, must make several phone calls in order to obtain interpreter services. In addition, frontline emergency room staff may not be provided with the contact numbers or codes to call and/or access the contracted language service.

Other hospitals offer the use of bilingual hospital staff for interpreter services. However, in this situation, frontline providers often are given an extensive "must call" list of names and telephone extensions and, as a result, sometimes encounter names of personnel who are no longer employed, who are on their lunch break, or whose supervisor will not allow them to take a call because of their assigned responsibilities. If a provider is given a cumbersome and ineffective mechanism for securing interpreter services, he or she may be forced to abandon the process and resort to approaches that, while expedient, may jeopardize provider-patient communication.

Hospitals offering interpreter services or utilizing bilingual staff, rather than contracted telephone services, also experience significant wait times for patients requiring interpreter services. While the goal of offering in-person interpreter services is laudable, long hours of waiting for an interpreter can be avoided if telephonic contracted services are utilized as a reserve option when in-person interpreters or bilingual staff are not available within a reasonable time. The definition of "reasonable" recommended in the Model Policies and Procedures (Policy # 1005) is 30 minutes. This was based on review of wait time policies at several hospitals around the country as well as input from the Advisory Committee. Since contracted telephone interpreter services can be obtained on short notice, this standard should technically be achievable.

4) The importance of tracking LEP data in hospital information systems (Policy # 1001 – 1003)

One of the major concerns of hospitals attempting to address the issues of language access for LEP populations is the poor quality or absence of data that tracks the language needs and preferences of patients. This problem begins with the first interview of a patient by hospital staff for the purpose of entering the patient into the hospital information system. The gathering of data related to language should, of course, be a part of the first interview of patients along with other key elements of data such as name, birth date and address. In addition, it is important to ensure that questions regarding language needs are appropriate and consistent.

The recommended technique for gathering information from patients regarding their language needs utilizes the methodology of the U.S. Census. The Census collects national data on languages spoken by populations in the United States and has created a methodology for determining an individual as Limited English Proficient. The determination of LEP status by the U.S. Census is gathered by posing the following questions in the proper order: first, determining if a patient speaks a language other than English in their home; and second, asking the patient to articulate how well they speak English. Any answer to the question regarding how well they speak English other than "very well," assigns the patient the LEP grouping.

The Model Policies and Procedures adopt the U.S. Census methodology of determining LEP patients for several reasons. The U.S. Census has allocated extensive governmental resources to developing and field-testing this methodology. The use of the Census methodology allows a health care system to match up hospital data collection to the results of the Census most accurately. All regulatory agencies and any potential litigation would utilize Census data to track, for example, the LEP population within a hospital service area.

Additionally, the responsibility to track patients in need of language assistance and create provisions to ensure appropriate services belongs to the health care provider and not the patient. Under the methodology adopted in these Model Policies and Procedures, provision for an interpreter should be made once a patient has identified that they do not speak English "very well." The need for interpreter services should not be left to the patient to request. Patients may believe that their ser-

vices will be delayed if they request an interpreter or that they will be placing an imposition on the hospital which will result in retaliation and poor service delivery. Hospital providers should automatically secure interpreter service for patients who have identified that they do not speak English "very well."

Another important element to determine and track the language needs of health care patients is the proper configuration of patient data software. Proper information technology should encourage and require staff to ask and provide the answers to these questions. The hospital should also carefully train staff to implement this procedure correctly and consistently. The provision of language services to large numbers of LEP patients requires accurate data for planning and staffing purposes.

The procedure recommended for tracking data regarding language includes the following three data entry fields:

1) The categorization of patients as either LEP or not to determine need for language support services;

2) The articulation of the patient's primary language; and,

3) The articulation of the language in which the patient would like to receive written materials, as some patients may prefer to receive written materials in English rather than in their primary language.

It must be acknowledged that it is often difficult to secure additional data fields in a hospital data base, and requesting three fields for this area of information may not be feasible in some cases. If only one field is available for language, it should be for tracking "primary language." Any indication of the patient's primary language other than English would generate automatic assumptions regarding the need for language services and the generation of written material to the patient in their primary language.

Questions regarding Straight Talk: Model Hospital Policies and Procedures on Language Access should be directed to Melinda Paras of Paras and Associates at http://www.parasandassociates.net/ or Wendy Jameson of the California Health Care Safety Net Institute at wjameson@caph.org.

Policies and Procedures on Language Access for Limited English Proficient (LEP) Patients and Families

Department		Effective Date	
Campus	All	Date Revised	
Unit	All	Next Scheduled Review	
Manual	Administrative	Author	
Replaces the following Policies:		Responsible Person	

Background:

XXX Medical Center serves a significant population of limited English proficient (LEP) patients and their families. Ensuring that these patients can effectively provide hospital staff with a clear statement of their medical condition and history and understand the provider's assessment of their medical condition and treatment options is essential to the provision of quality patient care.

Purpose:

The purpose of the Language Access Policy is twofold. First is to ensure that all LEP patients and surrogate decision-makers are able to understand their medical conditions and treatment options. Second is for XXX Medical Center staff to provide quality patient care to their LEP patients.

1000. Policy on the Provision of Medical Services to Patients/Surrogate Decision-Makers Needing Language Assistance:

1000.1 Patients/surrogate decision-makers of XXX Medical Center, who are Limited English Proficient (LEP), shall have services provided to them in their primary language or have interpreter services provided to them during the delivery of all significant healthcare services. Interpreter services shall be available within a reasonable time, at no cost to patients.

1000.2 Effective communication is important in every area of hospital communication, but XXX Medical Center prioritizes the most careful attention to effective communication in the provision of medical, nursing and ancillary services, where patient safety, medical error, and ability to understand treatment options are affected. The following types of encounters and procedures which are performed by providers who do not speak the primary language spoken by the patient/surrogate decision-maker, and which require the use of healthcare interpreter services, include, but are not limited to:

- Providing clinic and emergency medical services;
- Obtaining medical histories;
- Explaining any diagnosis and plan for medical treatment;
- Discussing any mental health issues or concerns;
- Explaining any change in regimen or condition;
- Explaining any medical procedures, tests or surgical interventions;
- Explaining patient rights and responsibilities;
- Explaining the use of seclusion or restraints;
- Obtaining informed consent;
- Providing medication instructions and explanation of potential side effects;
- Explaining discharge plans;
- Discussing issues at patient and family care conferences and/or health education sessions;
- Discussing Advanced Directives;
- Discussing end of life decisions; and,
- Obtaining financial and insurance information.

1000.3 The policy of XXX Medical Center shall be to provide all patients and surrogate decision-makers requiring language assistance with medical care in their primary language spoken, or healthcare services that are accompanied by a healthcare interpreter provided by XXX Medical Center. Interpreters provided by XXX Medical Center shall be tested regularly and evaluated to ensure that the interpreting provided for healthcare services is comprehensive and accurate. LEP patients/surrogate decision-makers shall be advised of their right to have interpreter services provided within a reasonable time, at no charge to themselves. Should patients/patient representatives insist upon the use of a friend or family member to provide them with interpreting service, XXX Medical Center personnel shall additionally retain a healthcare interpreter to participate in the exchange to ensure that it represents an accurate portrayal of the information to hospital staff and patients. Necessary emergency care should not be withheld pending the arrival of interpreter services. All necessary contact numbers and access codes for the direct contact of contracted interpreter services shall be available to Emergency Room staff. Qualified providers of healthcare interpreting at XXX Medical Center include:

a. Bilingual XXX Medical Center medical providers whose bilingual qualifications will be tested and documented by XXX Medical Center Human Resources department
b. XXX Medical Center healthcare interpreters who have received training and meet XXX Medical Center qualifications for the provision of healthcare interpreting
c. XXX Medical Center bilingual designated employees who are licensed and certified to provide medical, nursing, medical technician or social work services and who have

been determined to be bilingual through XXX Medical Center Human Resource processes

d. Contracted XXX Medical Center interpreter services that have met the qualifications of healthcare interpreting determined by XXX Medical Center

1000.4 Acceptable methods for the provision of interpreter services include, but are not limited to the following:

a. In-person interpreting
b. Telephone-based interpreting
c. Videoconferencing interpreting

1000.5 Mechanisms for the provision of interpreter services and language access support at XXX Medical Center must be available to all clinical areas of hospital inpatient and outpatient services during all of their hours of operation.

1000.6 XXX Medical Center shall support the development of industry-wide standards for the training and qualification of medical interpreter services. XXX Medical Center will review annually the standards of healthcare interpreting to incorporate improvements in the evolving standards of healthcare interpreter certification and of testing to address the need for quality, accuracy and consistency in the provision of healthcare interpreter services.

1000.7 Considerations for determining the appropriate model for the delivery of interpreter services will include the critical nature of the clinical interaction, availability of trained in-person interpreters and of the technology to allow for telephonic or videoconferenced interpreters. Additional considerations such as the shortest wait times for patients and clinicians and the most cost-effective use of personnel and contracted agencies also will be considered.

1000.8 XXX Medical Center shall provide meaningful access for LEP patients/surrogate decision-makers to all patient services, including access to information, signage, appointments, financial services, and ancillary services. XXX Medical Center shall provide these services through the most effective utilization of bilingual hospital personnel and access to interpreter services.

1000.9 It shall be the policy of XXX Medical Center to translate and make available all Vital Documents in Threshold Languages. The translation of other hospital written materials in Frequently Encountered or other languages shall be at the discretion of the issuing staff.[1] Vital Documents that are not produced in a written translation shall be verbally translat-

[1]Threshold Languages, Frequently Encountered Languages and Vital Documents are defined in Appendix A.

ed to the patient or surrogate decision-maker. The provision of oral translation of all Vital Documents to patients shall be documented and documentation shall become a part of the medical record.[2]

1000.10 The most effective mechanism for the provision of language access at XXX Medical Center where large portions of the patient population speak a language other than English is the recruitment of bilingual personnel from the community. XXX Medical Center shall designate Required-Bilingual Positions[3] in any service area that serves a large proportion of patients from a single language group other than English. This will improve services to patients and reduce the need for costly interpreter services.

1000.11 Audit and Regular Review of Language Access Needs. It shall be the policy of XXX Medical Center to conduct an annual review of Language Access Needs of the patient population of XXX Medical Center. This shall include a statistical survey of the language needs of the users of XXX Medical Center and its service areas. The review shall annually update the list of Threshold Language and Frequently Utilized Languages of XXX Medical Center. Quality Assurance processes of XXX Medical Center shall include audits of the timeliness of the provision of interpreter services and the charting of patient primary language and provision of interpreter services in medical chart review. Other elements to be included in this annual review shall be the requirements of training and certification of healthcare interpreters to incorporate improvements in industry standards; the designation of required bilingual positions; the quality of data collection of LEP designation and primary language determination; and the accuracy of the tracking of primary language in data collection. The position responsible for conducting the Annual Review of Language Access Needs shall be _____. The results of the Annual Review of Language Access Needs shall be presented to the XXX Medical Center governing body.

1001.0 Procedure for the Determination of LEP Status:

1001.1 The first access point in which a patient acquires services at XXX Medical Center (emergency room registration, admissions, etc.) shall incorporate the determination of language needs into intake procedures.

1001.2 The patient or surrogate decision-maker shall be asked the following questions in this order during the course of their first intake process:

a. Do you speak a language other than English at home? If the answer to this question is yes, the language will be noted and the next question will be asked.

[2]Please note that the Medi-Cal Managed Care contracts do not make a distinction between "vital" and other types of documents and do not mention "frequently encountered languages."

[3]Required-Bilingual Positions is defined in Appendix A.

b. How well do you speak English?
   1. Very well
   2, Well
   3. Not well
   4. Not at all

c. In what language do you prefer to receive your medical services?

d. In what language do you prefer to receive written materials?

If the patient or surrogate decision-maker answers with a language other than English on question "a" and anything other than "very well" (number 1) in question "b," they shall be designated as LEP (limited English proficient) which shall be recorded in patient records.

All areas of first patient contact shall be equipped with Language Determination Cards to assist patients in identifying the patient primary language if communication barriers prevent hospital staff from effectively determining the language of the patient/surrogate decision-maker. The Language Determination Card will visually show all languages hospital staff can reasonably project they will encounter. Patients will be offered the card to allow them to point to their language on the card to allow hospital staff to request interpreter services in the appropriate language. Contracted telephonic interpreter services [substitute with internal hospital interpreter service department if available] should be called if the patient is unable to use the Language Determination Card, and hospital staff cannot determine the appropriate language to request.

1002.0 Procedure for the Tracking of LEP Patients in Hospital Data Sets:

1002.1 The language needs of patients and surrogate decision-makers will be recorded and tracked. This critical information will be captured and recorded in XXX Medical Center information systems. It shall be stored in the area containing other critical patient information (such as address, phone number, birth date, etc.). Data pertaining to the language needs of the patient/surrogate decision-maker shall be presented on all subsets of patient data, which contain these fields of critical patient information, such as the face sheet placed in the patient medical chart.

1002.2 The data shall be recorded with the following three fields:

1. Limited English Proficient ❑ Yes ❑ No

2. **Primary Language** (no default to English)

   showing list of languages by degree of utilization in XXX Medical Center (i.e. English, Spanish, Cantonese, Vietnamese, including American Sign Language)

3. **Language for Written Materials** (no default to English)

   showing list of languages by degree of utilization in XXX Medical Center (i.e. English, Spanish, Chinese, Vietnamese, etc.)

1002.3 All three fields must be completed to finish any patient registration process.

1003.0 Procedure for the Inclusion of Patient Primary Language and Documentation of the Provision of Interpreter Services in Patient Medical Records:

1003.1 Each medical record shall show the primary language spoken by the patient/surrogate decision-maker.

1003.2 The patient need for interpreter services shall be included in the following areas of documentation:

a. The nursing assessment for inpatient admissions
b. The patient record of outpatient encounters

1003.3 The documentation of the provision of interpreter service will be recorded in the patient medical record during the provision of medical and nursing procedures requiring interpreting as set forth in 1000.2.

1004.0 Procedure to Inform Patients of their Right to Have Interpreter Services

1004.1 During the interview as the patient first acquires services at XXX Medical Center, LEP patients shall be informed of their right to have a healthcare interpreter in their language, free of charge, within a reasonable time. If the patient's answer to the question "Do you speak a language other than English at home?" is "yes," the statement on the provision of interpreting services will be read aloud to the patient (except when it is clear the patient will not be able to understand the English text to follow):

"You have a right to an interpreter in your own language who can help you speak with your doctor or other health care provider at no cost to you."

1004.2 If the patient's answer to the question "Do you speak a language other than English at home?" is "yes," the statement informing patients of their rights to interpreter services will also be provided to patients in written form in their primary language. This policy shall be translated into all Threshold Languages and all Frequently Utilized Languages of XXX Medical Center and copies distributed to all units where patient contact occurs.

1004.3 XXX Medical Center shall develop, and post in conspicuous locations, notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter and the telephone numbers where complaints may be filed concerning interpreter service problems, including, but not limited to, a T.D.D. number for the hearing impaired. The notices shall be posted, at a minimum, in the emergency room, the admitting area, the entrance, and in outpatient areas. Notices shall inform patients that interpreter services are available upon request, shall list the languages for which interpreter services are available, shall instruct patients to direct complaints regarding interpreter services to the state department, and shall provide the local address and telephone number of the state department, including, but not limited to, a T.D.D. number for the hearing impaired.[4] In addition, the statement/notice informing patients of their rights to interpreter services and translated materials must be translated into all Threshold and Frequently Encountered Languages of XXX Medical Center along with other mandated signage.

1005.0 Procedure for the Acquisition of Interpreter Services:

■ VERSION A (for hospital systems that utilize internal resources such as healthcare interpreters, bilingual staff, volunteers, etc.)

1005.1 All hospital personnel seeking the utilization of interpreter services for patients or patient representatives requiring language assistance shall utilize the following procedures:

➤ **During regular business hours** (Monday – Friday x:00 – x:00), call _____ (list single phone number) for the acquisition of XXX Medical Center interpreter services, interpreters, bilingual designated staff, contracted interpreting service providers, volunteers etc.

➤ **If no interpreter can be provided** by XXX Medical Center within 30 minutes, call _____ for the hospital contracted language services provider.

[4]Kopp Act [Cal. Health & Safety Code §1259(b)(3)] (available at http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc).

➤ **After business hours,** contact _____ for the hospital contracted language service provider.

In emergency situations, patients will receive care from a medical provider in their primary language or interpreter services shall be provided concurrent with the timetable of needed medical provision.

■ **VERSION B (for hospitals that utilize remote (telephone and/or video-conferenced) interpreter services**

1005.1 All hospital personnel seeking the utilization of interpreter services for patients or patient representatives requiring language assistance shall utilize the following procedures:

➤ **For Interpreter Services** contact _____ for the hospital language service provider.

1005.2 New employees of XXX Medical Center will be trained in the procedure for the acquisition of interpreter services during their employee orientation to XXX Medical Center. Training on this procedure for current XXX Medical Center staff will be incorporated into other ongoing trainings for employees such as diversity trainings, customer service trainings, updates on new regulatory requirements, etc.

1005.3 A laminated card outlining these procedures shall be distributed and posted at all nursing stations and other points of patient contact throughout XXX Medical Center.

1006.0 Procedure for the Provision of Written Translations:

1006.1 All departments originating documents in English which require written translation shall submit them in English in their final and approved form to _____ ext. _____.

1006.2 Written translations of the Vital Documents of XXX Medical Center shall be presented in a bilingual version. The English and the non-English versions shall be visible on the same pages to ensure that hospital staff can understand the content of the document they are distributing to patients.

1006.3 The methodology for the development of written translations of the Vital Documents of XXX Medical Center shall be as follows:

a. The originating document will be translated into the second language.

b. The draft written translation will be reviewed and corrected by a second translator.

c. In the case of legal documents covering matters such as informed consent or culturally sensitive issues, the translated material will be finally reviewed for its accuracy through one of the following mechanisms:

1. The back translation of the material into English by a third translator (not the reviewing translator) and comparison to original material. The back translation of material from the second language to English shall be evaluated to ensure accuracy of the essential message of the original communication and should not be anticipated to be a word-for-word duplication of the originating English documents.

OR

2. Review of the completed translation by a team of hospital staff and/or community representatives for accuracy, appropriate literacy level and cultural sensitivity.

1006.4 No written translations from web sites or other institutions will be adapted for XXX Medical Center use unless the above standards for the translation process have been utilized.

1007.0 Procedure for the Identification and Implementation of Required Bilingual Positions

1007.1 Specific recruitment plans for XXX Medical Center personnel shall be designed for all Threshold Languages by XXX Medical Center Human Resources Department and, upon the discretion of the hospital, for the Frequently Utilized Languages of XXX Medical Center.

1007.2 Where patient populations reach over 25% from any language other than English, the unit supervisor will submit to the Human Resources department proposals to designate Required-Bilingual Positions in their unit.[5] Where there is a single entry point for patients, that position shall be designated required-bilingual. Where there are multiple positions

[5]Required-Bilingual Position is defined in Appendix A.

(such as hospital operators, financial counselors, social workers, etc.), an appropriate proportion of positions shall be required to be bilingual designated.

1007.3 All designated Required-Bilingual Positions shall defer activation of the designation if the incumbent employee is not bilingual in the needed language. The designation shall become active when the non-bilingual employee relinquishes the position. All "difficult to recruit" positions shall be exempt from this requirement. "Difficult to recruit" positions shall be identified by the Human Resources Department.

1007.4 Review of the Required-Bilingual Positions will be conducted in the annual review of Language Access Issues of XXX Medical Center as set forth in section.

1008.0 Procedure for Language Accessible Hospital Signage

1008.1 Hospital signage at XXX Medical Center shall be designed to ensure access to LEP populations most frequently using XXX Medical Center facilities. Should the patient population of XXX Medical Center reach a proportion of 25% from a language group other than English, all hospital signage shall be designed in both English and that language. All signage required by state and federal statutes, regulations and licensing requirements will be translated into all languages other than English when a proportion of 5% of the patient population of XXX Medical Center has that language as their primary language.[6] Additional languages for the translation and wayfinding signage shall be added at the discretion of hospital management.

1008.2 These requirements for translation of hospital signage shall be implemented during the creation of any new signage of XXX Medical Center.

1009.0 Procedure for Adjustment of Hospital Equipment Requirements to Assure Language Access

1009.1 Clinical areas shall be equipped with devices necessary for the routine delivery of remote interpreter services through telephone or videoconferencing. Service areas requiring devices for the delivery of remote interpreter services include (but are not limited to) the following:

a. All stations of patient registration, financial counseling, and admission

[6]Such requirements include the Emergency Medical Treatment and Active Labor Act, Title VI of the 1964 Civil Rights Act and the Kopp Act [Cal. Health & Safety Code §1259].

b. Designated exam rooms and in-patient beds appropriate to the proportion of LEP patients seen

c. All nursing stations

d. All telephone based services developed for public access, including hospital operators and appointment scheduling

1009.2 Devices to allow effective access to remote interpreter services may include the following:

a. Dual handset and/or headset telephones

b. Speakerphones

c. Telephones equipped with three-way call capability for telephone-based services

d. Videoconferencing stations

1009.3 These standards shall be applied to all new outfitting activities involving hospital telecommunication services, including renovations and new facilities construction. New equipment purchases and redesign of existing facilities to meet these standards shall be incorporated into the ongoing hospital capital acquisition processes. Equipment purchases in medical settings that most greatly affect quality of care, patient safety, and improved patient outcomes (for example the emergency room and pharmacy) will be designated for immediate remediation.

References:

1. Title VI of the 1964 U.S. Civil Rights Act, 42 U.S.C. § 2000d.
2. Office of Civil Rights, U.S. Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. 47311 (Aug. 8, 2003).
3. California Government Code §§ 11135 and 7290 et seq.
4. California Health and Safety Code § 1259
5. Office of Minority Health, U.S. Department of Health and Human Services, *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care*, 65 Fed. Reg. 80865 (Dec. 22, 2000).

Approvals:

Departmental	Date
Medical Executive Committee	Date
Administrative Team	Date
Governing	Date

Appendices

APPENDIX A: DEFINITIONS

BILINGUAL MEDICAL PROVIDER – A physician, mid-level practitioner, or registered nurse who has completed the necessary requirements verifying bilingual status by the XXX Medical Center Human Resources department.

CERTIFIED MEDICAL INTERPRETER – XXX Medical Center uses the term Healthcare Interpreter as opposed to Medical Interpreter in its policies and procedures on language access. California law deems state certified Administrative Hearing Interpreters qualified as Medical Interpreters. Medical Interpreters do the same type of interpreting during medical examinations conducted for the purpose of determining compensation or monetary award. California State Certified Administrative Hearing Interpreters interpret during state agency hearings for persons lacking sufficient English language proficiency to understand the proceedings and/or to participate in the presentation of their appeal. The interpreter interprets all oral communication including conversations between the attorney and client, witness testimony, and statements made by the Administrative Hearing Law Judge or the designated hearing officer, attorneys and expert witnesses who frequently use legal and technical terminology. Interpreters may also translate written documents (orally or in writing), often of a legal nature. See Healthcare Interpreter.[1]

FREQUENTLY ENCOUNTERED LANGUAGES OF XXX MEDICAL CENTER – The governing body of XXX Medical Center shall, at its discretion, add or remove additional languages from the designation of Frequently Encountered Languages based on the changing demographics of the hospital system's patients and service area. The Frequently Encountered Languages of XXX Medical Center at this time are:

HEALTHCARE INTERPRETER – One who has

1) been trained in healthcare interpreting,
2) adheres to the professional code of ethics and protocols of healthcare interpreters,
3) is knowledgeable about medical terminology, and
4) can accurately and completely render communication from one language to another.

Ideally, healthcare interpreters have been tested for their fluency in the languages in which they interpret. A healthcare interpreter may include a bilingual or multilingual provider or medical staff. As well as being ethically inappropriate to act as healthcare interpreters, minor children lack the training, skills and competencies.[2]

[1]The California State Personnel Board Interpreter Certification Exam Site: http://www.cps.ca.gov/spb/spbta/jobduties.asp.

[2]*California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention.* California Healthcare Interpreting Association (2002): 69. (available at http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf).

IN-PERSON INTERPRETING – Interpreter services delivered at the site of medical service delivery so that an interpreter is in the room with the physician (or other hospital personnel) and patient.

INTERPRETING – The oral rendering of one language into a second language and vise versa to facilitate the exchange of communication between two or more persons speaking different languages.

LEP – See Limited English Proficient

LIMITED ENGLISH PROFICIENT – A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies.[3]

ORAL TRANSLATION – The verbal reading of a document written in one language into another language.

QUALIFIED BILINGUAL DESIGNATED EMPLOYEE – A XXX Medical Center employee who is licensed and certified to provide medical, nursing or medical social services and has completed the necessary requirements verifying bilingual status by XXX Medical Center Human Resources department.

REASONABLE TIME – Defined to include an outside limit of 30 minutes for the provision of interpreter services for LEP patients/patient representatives who require language assistance. This time shall be marked from the time a clinician is available to see a patient until the acquisition of interpreter services. For all conditions indicating clinical urgency for the provision of medical services, XXX Medical Center shall acquire interpreter services on a STAT basis with the same timeline as the provision of medical services.

REQUIRED-BILINGUAL POSITION – A position that within its job description includes the requirement of bilingual certification in a language other than English.

TELEPHONE (OR TELEPHONIC) INTERPRETING – A form of remote interpreting that offers the delivery of interpreter services through telephone technology. The interpreter is at a different physical location than the patient/physician encounter. Telephone interpreting allows for an audio connection between the patient, physician (or other hospital personnel) and interpreter. Telephone interpreting is best conducted with auxiliary telephone equipment such as a dual headset or speakerphone to allow for the most effective communication among the three parties.

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[3] *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention.* California Healthcare Interpreting Association (2002): 71. (available at http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf).

THRESHOLD LANGUAGES – Languages that meet the following standards, "A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000; or, a population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes."[4] The Threshold Languages of XXX Medical Center at this time are:

TRANSLATION – The conversion of a written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.[5]

VIDEOCONFERENCING INTERPRETING – A form of remote interpreting that offers the delivery of interpreter services through videoconferencing technology. In this format, the interpreter is at a different physical location than the patient/physician encounter. Videoconferencing units show a visual image of the patient and provider to the interpreter and a visual image of the interpreter to the patient and provider, along with an audio connection of their exchange.

VITAL DOCUMENTS – Vital Documents shall include, but are not limited to, documents that contain information for accessing XXX hospital services and/or benefits. The following types of documents are examples of Vital Documents:

1) Informed Consent;
2) Advanced Directives;
3) consent and complaint forms;
4) intake forms with potential for important health consequences;
5) "notices pertaining to the denial, reduction, modification or termination of services and benefits, and the right to file a grievance or appeal;"[6] and,
6) other hearings, notices advising LEP persons of free language assistance, or applications to participate in a program or activity or to receive benefits or services.[7]

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[4]MRMIB/HFP, Health Plan Model Contract, Agreement #05MHF000, Exhibit A, Exhibit A, Attachment 9, § 13(C) at 8-9 (June 2003).

[5]California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention. California Healthcare Interpreters Association (2002): 76. (available at http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf).

[6]Cal. Health & Safety Code §1367.04(b)(1)(B)(i)-(vi) (available at http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc).

[7]According to the Title VI Office of Civil Rights Guidance, the definition of Vital Documents "may depend upon the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner." (available at http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.html).

APPENDIX B: SUGGESTED RESOURCES

General Resources

- The Access Project: http://www.accessproject.org/about.htm
- California Healthcare Interpreting Association: http://www.chia.ws/
- Cross Cultural Health Care Program: http://www.xculture.org/index.cfm
- Hablamos Juntos (We Speak Together): Improving Patient-Provider Communication for Latinos: http://www.hablamosjuntos.org/
- Cultural Competence Publications and Resources by The California Endowment: http://www.calendow.org/reference/publications/cultural_competence.stm
- Hospitals, Language, and Culture: A Snapshot of the Nation Initiative (Joint Commission on Accreditation of Healthcare Organizations Initiative): http://www.jcaho.org/about+us/hlc/index.htm
- National Center for Cultural Competence: http://www.georgetown.edu/research/gucdc/nccc/
- National Health Law Program (NHeLP): http://www.healthlaw.org/
- The Network for Multicultural Health, UCSF Center for the Health Professions: http://futurehealth.ucsf.edu/TheNetwork/

Laws, Policies and Standards Resources

- California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention (California Healthcare Interpreting Association): http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf
- California State Codes (i.e. Health and Safety Code, Welfare and Institutions Code, etc.): http://www.leginfo.ca.gov/calaw.html
- Cultural and Linguistic Competency Standards, County of Los Angeles Department of Health Services: http://ladhs.org/odp/standards.htm
- Ensuring Linguistic Access in Health Care Settings in California: Legal Rights and Responsibilities (National Health Law Program, Available in the summer of 2005): http://www.calendow.org/
- Ensuring Linguistic Access in Health Care Settings: Legal Rights & Responsibilities: (National Health Law Program): http://www.healthlaw.org/pubs/2003.linguisticaccess.html

- National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, U.S. Department of Health and Human Services, Office of Minority Health: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf
- Title VI of the Civil Rights Act of 1964: http://www.usdoj.gov/crt/cor/coord/titlevi.htm

Government Resources

- **United States**
  - Centers for Medicare & Medicaid Services: http://www.cms.hhs.gov/
  - LEP.gov: http://www.lep.gov/
  - U.S. Department of Health & Human Services Office for Civil Rights: http://www.hhs.gov/ocr
  - U.S. Department of Health and Human Services Office of Minority Health: http://www.omhrc.gov/omhhome.htm

- **California**
  - California Department of Health Services: http://www.dhs.ca.gov/
  - California Department of Health Office of Multicultural Health: http://www.dhs.ca.gov/director/omh/default.htm

- **Other Resources**
  - Oral, Linguistic, and Culturally Competent Services Guides for Managed Care Plans, Agency for Healthcare Research and Quality: http://www.ahrq.gov/about/cods/cult-comp.htm

APPENDIX C: RELEVANT LAWS, POLICIES AND ACCREDITATION REQUIREMENTS[8]

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Health programs and services are required to provide culturally and linguistically competent care under numerous statutory, regulatory, contract and accreditation authorities. Many of these requirements have been in effect for years; other requirements have arisen more recently, driven by the continuing diversification of the U.S. and California populations. The laws, policies and requirements most relevant to DHS are summarized below.[9]

FEDERAL LAWS AND POLICIES

Federal Legal Requirements

The most important federal law governing language accessibility in health care is Title VI of the Civil Rights Act of 1964, but there are other key statutory and regulatory bases at the federal level, including the Hill-Burton Act as well as requirements under Medicaid, the State Children's Health Insurance Program (SCHIP), Medicare and federal categorical grant programs. Recently, the federal government has also issued a number of federal LEP guidelines on complying with civil rights laws, indicating the federal government's strong interest in encouraging federally funded programs and services to better serve LEP populations.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Title VI of the Civil Rights Act of 1964 states: "No person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[10] Nearly every health care provider is subject to Title VI, because federal funding of health care is almost universal. Federal

[8]Appendix from the Los Angeles County Department of Health Services Cultural and Linguistic Competency Standards (available at http://ladhs.org/odp/docs/dhsculturalstds.pdf).

[9]For a comprehensive review of laws and policies governing culturally and linguistically competent health care, see National Health Law Program (NHeLP), Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities (August 2003) (available from The California Endowment, www.calendow.org, and NHeLP); Perkins, Jane, Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities (August 2003) (available from the Kaiser Family Foundation, www.kff.org or (800) 656-4533). Significant sections of this appendix are taken from these NHeLP publications.

[10]42 U.S.C. § 2000d.

financial assistance for health care includes Medicare, Medicaid, SCHIP, and block grants to health and welfare agencies, among other sources.[11]

As a recipient of federal financial assistance, DHS and all of its facilities and operations are subject to Title VI and to the U.S. Department of Health and Human Services (HHS) Title VI regulations and guidelines.[12] Title VI and the HHS regulations and guidelines prohibit discrimination on the basis of race, color, or national origin in any federally funded program or activity.[13] Federal courts and agencies have consistently interpreted Title VI protections to extend to limited English proficient (LEP) persons.[14]

PRESIDENTIAL EXECUTIVE ORDER 13166

In August 2000, President Clinton issued Executive Order (EO) 13166, entitled *Improving Access to Services for Persons with Limited English Proficiency.*[15] EO 13166, which applies to all "federally conducted and federally assisted programs and activities," has two main requirements: (1) each federal agency providing federal funding must issue LEP guidance specially tailored to its recipients; and (2) all federal agencies (whether or not they provide federal financial assistance) must develop and implement their own plans to improve linguistic access to their federally conducted programs.[16] EO 13166 designates the U.S. Department of Justice (DOJ) as the lead agency with the responsibility for providing technical assistance to other federal agencies. It incorporates by reference contemporaneously issued DOJ general guidance and instructs all federal agencies to issue LEP guidance consistent with DOJ policies.

HHS OFFICE FOR CIVIL RIGHTS AND TITLE VI LEP GUIDANCE

The U.S. Department of Health and Human Services, through its Office for Civil Rights (OCR), enforces Title VI for federally funded health care programs and services. OCR monitors and enforces compliance with Title VI primarily through responding to complaints received.[17] Over the years, OCR has handled hundreds of complaints and initiated numerous compliance reviews regarding discrimination against national origin minorities due to linguistic barriers. OCR also provides technical assistance to federal fund recipients seeking to make their programs and services accessible to LEP persons. The responsibility for investigations, compliance reviews and technical assistance fall on the ten regional OCR offices, located

[11] 45 C.F.R. § 80 app. A.

[12] 42 U.S.C. § 2000d-4a.

[13] 45 C.F.R. § 80 et seq.

[14] See *Lau v. Nichols*, 414 U.S. 563 (1974) (finding that a school system violated Title VI by failing to take assist non-English speaking students).

[15] 65 Fed. Reg. 50121 (Aug. 16, 2000).

[16] HHS released its plan on December 14, 2001. See U.S. Department of Health and Human Services, *Strategic Plan to Improve Access to HHS Programs and Activities by Limited English Proficient (LEP) Persons* (Dec. 14, 2001), available at http://www.hhs.gov/gateway/language/languageplan.html.

[17] 45 C.F.R. § 80.8.

throughout the country. California is in Region IX, which has a regional office in San Francisco but also a field office in Los Angeles, which focuses on civil rights enforcement in health care in the Southern California area.

A review of OCR Title VI LEP decisions by the National Health Law Program identified certain elements common to programs or services that comply with Title VI:[18]

- Developing a written plan for providing LEP services;
- Designating a staff person to coordinate Title VI compliance;
- Providing information and training to staff on these policies;
- Posting translated notices regarding the availability of no cost interpreters;
- Maintaining effective interpreter services by emphasizing in-person interpretation and, to the extent possible, minimize telephone interpretation;
- Providing translation of important forms and documents
- Collecting, analyzing, and maintaining data to determine if interpreter services are adequately provided; and
- Monitoring subcontractors and including a nondiscrimination clause in all contracts for services.

Subsequent to the release of EO 13166, OCR issued LEP guidance on August 30, 2000, the first federal agency to do so.[19] Following the DOJ's request for federal guidances to be coordinated and reissued, OCR has subsequently reissued its guidance. The current version, entitled *"Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons"* (Guidance), was issued on August 8, 2003.[20]

The Guidance states HHS' intent that federal fund recipients take reasonable steps to ensure that LEP persons have meaningful access to programs and activities. Adopting a "flexible and fact-dependent" approach articulated by DOJ, the Guidance asks all fund recipients to assess the following four factors:

- Number or proportion of LEP persons eligible or likely to be served, directly affected, or encountered by the program, using program-specific data along with census, school, state and local, and community-based data from the relevant service area;
- Frequency with which LEP individuals have or should have contact with the program, activity, or service;
- Nature and importance of the program or service to people's lives; and
- Resources available to the fund recipient and costs.[21]

[18]Perkins, Jane, Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities (August 2003) at pp. 13-14.

[19]65 Fed. Reg. 52762 (Aug. 30, 2000).

[20]68 Fed. Reg. 47311 (Aug. 8, 2003).

[21]*Id.* at 47314-15.

HHS notes that the four-factor analysis necessarily implicates the "mix" of language services, that is, whether oral interpretation and/or written translation services will be offered.[22] The correct mix should be based on what is both necessary and reasonable in light of the four factors. HHS notes that, depending on the circumstances, the assistance may need to be expedited while in other situations, "pursuant to an agreement, 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."[23] For example, if a physician knows that a nearby physician's office can provide linguistically appropriate services to an LEP patient and the offices have a custom/practice of referring patients between each other, it may be appropriate to refer the patient to the other physician.

The Guidance provides specific information about oral interpretation. It describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines,[24] and using community volunteers. It notes that interpreters need to be competent, though not necessarily formally certified. The Guidance allows the use of family members and friends as interpreters but clearly states that an LEP person may not be required to use a family member or friend to interpret. HHS says recipients should make the LEP person aware that they have the "option" of having the recipient provide an interpreter without charge. "Extra caution" should be taken when the LEP person chooses to use a minor to interpret. Recipients are asked to verify and monitor the competence and appropriateness of using the family member or friend to interpret, particularly in situations involving administrative hearings; child or adult protective investigations; life, health, safety or access to important benefits; or when credibility and accuracy are important to protect the individual. Moreover, if the fund recipient determines that the family member or friend is not competent or appropriate, the recipient should provide competent interpreter services in place of or, if appropriate, as a supplement to the LEP person's interpreter.[25]

With respect to written translation, HHS says it will determine compliance on a case-by-case basis, taking into account the totality of the circumstances (the four factors test).[26] However, like the DOJ guidance, the HHS guidance designates "safe harbors" that, if met, will provide strong evidence of compliance with respect to written translations:

- The recipient provides written translations of "vital" documents (e.g., intake forms with the potential for important consequences, consent and complaint forms, eligibility and service notices) 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; or

[22] *Id.* at 47315.

[23] *Id.*

[24] Previous guidance cautioned federal recipients that telephone interpreters should not be the sole language assistance option, unless other options were unavailable. *See* 67 Fed. Reg. 4968 (Feb. 1, 2002) at 4975.

[25] 68 Fed. Reg. at 47317-18.

[26] *Id.* at 47319. The previous guidance called for the review to include the nature of the service, the size of the recipient, the size of the LEP language groups in the service area, the nature and length of the document, the objectives of the program, total resources available to the recipient, the frequency with which translated documents are needed, and the cost of translation. *See* 67 Fed. Reg. at 4973.

- If there are fewer than 50 persons in a language group that reaches the five percent trigger, above, the recipient provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of vital written materials, free of cost.[27]

According to HHS, after the four factors have been applied, fund recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Fund recipients may choose to develop a written plan as a means of documenting compliance with Title VI.[28] If so, the following five elements are suggested for designing such a plan:

- Identifying LEP individuals who need language assistance, using for example, language identification cards;
- Describing language assistance measures such as: the types of language services available, how staff can obtain these services and respond to LEP persons, and how competency of services can be ensured;
- Training staff to know about LEP policies and procedures and how to work effectively with in-person and telephone interpreters;
- Providing notice to LEP persons about available language assistance services through, for example, posting signs in intake areas and other entry points, providing information in outreach brochures, working with community groups, using a telephone voice mail menu, providing notices in local non-English media sources, and making presentations in community settings;
- Monitoring and updating the plan, considering changes in demographics, types of services, and other factors.[29]

HHS also notes that an effective plan will set clear goals and establish management accountability. Recipients may want to provide opportunities for community input and planning throughout the process.[30]

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[27] 68 Fed. Reg. at 47319. The Guidance makes it clear that the safe harbors only apply to translation of written materials. Previous guidance established different safe harbors, calling for (a) translation of written materials, including vital documents, for each eligible LEP language group that constituted 10 percent or 3,000, whichever is less, of the eligible population to be served; (b) for LEP language groups that did not meet the above threshold, but constituted five percent or 1,000, whichever is less, of the population to be served, the recipient ensured that, at a minimum, vital documents are translated, with oral translation of other documents, if needed; and (c) notwithstanding the above, a recipient with fewer than 100 persons in a language group did not translate written materials but provided written notice in the primary language of the patient of the right to receive competent oral interpretation of written materials. *See* 67 Fed. Reg. at 4973.

[28] 68 Fed. Reg. at 47319. The Guidance recognizes additional benefits that a written plan can provide to recipients in the areas of training, administration, planning, and budgeting. It further notes that absence of a written plan does not obviate the need to comply with Title VI, and the recipient may want to consider alternative ways to articulate how it is providing meaningful access in compliance with Title VI. *Id.*

[29] *Id.* at 47319-21. Previous guidance called on recipients to develop and implement a language assistance program that addressed: (1) assessment of language needs; (2) development of a comprehensive policy on language access; (3) training of staff; and (4) vigilant monitoring. *See* 67 Fed. Reg. at 4971.

[30] 68 Fed. Reg. at 47321.

The August 2003 Guidance notes that systems will evolve over time, and HHS will look favorably on intermediate steps taken that are consistent with the Guidance. HHS repeatedly states its interest in working with fund recipients to disseminate examples of model plans, best practices, and cost saving approaches.[31]

THE HILL-BURTON ACT

Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers.[32] In return for receiving Hill-Burton funds, recipients agreed to comply with a "community service obligation," which requires the recipient to make services available to all persons residing in the service area without discriminating on the basis of race, color, creed, or national origin.[33] OCR, which enforces the Hill-Burton Act, has consistently interpreted this to require the provision of language assistance to those in need of such services.[34] This obligation lasts in perpetuity.[35] Hill-Burton facilities are also required to post non-discrimination notices in English, Spanish and other languages that represent ten percent or more of the households in the service area.[36]

- Past OCR decisions have required hospitals to:
- Develop lists of bilingual interpreters;
- Establish procedures for communicating with LEP patients at all hours of a facility's operation;
- Notify patients that interpretive services are available; and
- Treat migrant workers and undocumented immigrants who live in a facility's service area.[37]

MEDICAID, SCHIP AND MEDICARE

Medicaid, SCHIP and Medicare are government funded health insurance programs that are accepted by DHS entities. Medicaid is a federal-state program that provides health insurance coverage to indigent aged, blind and disabled persons; children; and pregnant women.[38] A number of Medicaid provisions require state Medicaid agencies and participating Medicaid providers to assure that services are cultural-

[31] *Id.* at 47321-22.

[32] Hill-Burton is the popular name for the Hospital Survey and Construction Act of 1946, Title VI of the Public Health Services Act, 42 U.S.C. § 291 et seq. (1995).

[33] 42 C.F.R. § 124.603(a) (1996).

[34] *See* U.S. Department of Health and Human Services, Office for Civil Rights, *Guide to Planning the Hill-Burton Community Service Compliance Review* at 16, 27 (June 30, 1981).

[35] 42 U.S.C. § 291c(e), 300s-1(b)(1)(k) (1995); 42 C.F.R. §§ 124.601, 124.603 (1996).

[36] 42 C.F.R. § 124.504(a)-(b) (1996).

[37] *See* NHeLP, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* at pp. 2.29-2.30.

[38] 42 U.S.C. § 1396 (1992); 42 C.F.R. § 430 (1994).

ly and linguistically appropriate. For example, the Centers for Medicaid and Medicare Services (CMS, formerly the Health Care Financing Administration) states in its primary Medicaid guidance that states must communicate orally and in writing in a language understood by the beneficiary and provide interpreters at Medicaid hearings.[39]

The State Children's Health Insurance Program (SCHIP) is a federal-state program that provides health insurance to uninsured children. HHS regulations governing the implementation of SCHIP programs address language access (e.g., the regulations address the collection of primary language data of applicants and enrollees[40]).

Medicare is the federal health insurance program for persons 65 years or older and certain disabled persons under 65. CMS addresses linguistic accessibility in its Medicare policies. For example, Medicare-participating hospitals may seek reimbursement for the costs incurred for providing bilingual services to inpatients to the extent that the costs are "reasonable in amount and in relationship to the need."[41] Bilingual services include the costs of interpreters for communication between the provider and patients, printed provider informational material to be distributed to patients, and special personnel recruitment efforts designed to recruit bilingual employees.

FEDERAL CATEGORICAL GRANT PROGRAMS

Federal categorical grant programs intended to increase health services for poor, disabled and older Americans also include linguistic access requirements. HHS makes grants to plan, develop and operate community health centers that serve medically underserved populations and areas suffering health staff shortages.[42] HHS also provides grants for clinics serving migratory and seasonal agricultural workers, and their families.[43] Federal law requires these health centers to:

- Develop plans and arrange to provide services "to the extent practicable in the language and cultural context most appropriate to such individuals;"[44]
- Identify an individual on staff "who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences;"[45]

[39]U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services, State Medicaid Manual §§ 2900.4, 2902.9 (Mar. 1990).

[40]*See* 66 Fed. Reg. 33810, 33816 (June 25, 2001).

[41]U.S. Department of Health and Human Services, Health Care Financing Administration, Medicare Provider Manual § 2147 (Aug. 1979).

[42]42 U.S.C. § 254c et seq. (1996).

[43]Id.

[44]42 C.F.R. §§ 51c.303 (l) (community health centers), 56.303(l), 56.603(j) (migrant health centers) (2003).

[45]42 C.F.R. §§ 51c.303 (l), 56.303(l) (2003).

- Provide language-appropriate outreach;[46]
- Have governing boards with majorities consisting of clients served by the facility that, as a group, represent the individuals being served in terms of demographic factors such as race, ethnicity, and sex.[47]

National Standards on Culturally and Linguistically Appropriate Services in Health Care

In December 2002, the U.S. Department of Health and Human Services Office of Minority Health (OMH) issued National Standards on Culturally and Linguistically Appropriate Services in Health Care ("CLAS Standards").[48] Issued by OMH after a lengthy development and public comment period, the CLAS Standards were promulgated to "correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers."[49] Since their release, the CLAS Standards have served as an important model for other efforts to improve cultural and linguistic competence in health care, including the development of these DHS Standards.

The 14 CLAS Standards are organized into three areas: culturally competent care (standards 1-3); language access services (standards 4-7); and organizational supports for cultural competence (standards 8-14). The "language access services" standards are considered mandates, as they are based on the legal requirements of Title VI. The other standards are not required per se but OMH strongly recommends their adoption and implementation. Appendix C provides a detailed summary of the CLAS Standards.

California Laws and Policies

State laws and policies provide other sources of protection for LEP persons. California, in particular, has strong statutes, regulations and policy requirements.[50]

[46] 42.U.S.C. §§ 254c(a)(5), 254b(a)(1)(G) (1995).

[47] 42 C.F.R. §§ 51c.304 (b) (1), 56.304 (b)(1) (1996).

[48] 65 Fed. Reg. 80865-79 (Dec. 22, 2000), reprinted at http://www.omhrc.gov/clas.

[49] *Id.* at 80873.

[50] For a detailed review of California laws and policies governing culturally and linguistically competent health care, *see* Wong, Doreena, and Jane Perkins, *Ensuring Linguistic Access in Health Care Settings in California: Legal Rights and Responsibilities (2003)* (available from The California Endowment, www.calendow.org, and NHeLP).

GOVERNMENT CODE § 11135

Similar to Title VI, California law prohibits discrimination in programs and services funded by the state. However, California Government Code § 11135 is more expansive than federal law because it includes more protected categories and applies to the state itself. In relevant part, the statute states: "No person in the state of California shall, on the basis of race, national origin, ethnic group identification, religion, age, sex, color, or disability be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under any program or activity that is conducted, operated, or administered by the state of by any state agency, is funded directly by the state, or receives any financial assistance from the state."[51] The implementing state regulations define "ethnic group identification" to mean the "possession of the racial, cultural or linguistic characteristics common to a racial, cultural or ethnic group or the country or ethnic group from which the person or his or her forebears originated."[52] The regulations also address language-based discrimination specifically – for example, one section states that it is a discriminatory "to fail to take appropriate steps to ensure that alternative communication services are available to ultimate beneficiaries."[53] "Alternative communication services" means the method used or available for purposes of communicating with a person unable to read, speak or write in English, including providing a multilingual employee or an interpreter, or written translated materials in a language other than English.[54]

KOPP ACT (HEALTH & SAFETY CODE §1259)

Passed in 1983, the Kopp Act requires acute care hospitals to take numerous steps to serve LEP patients, including:

- Adopt and annually review language assistance service policies;
- Ensure availability of interpreter services either on site or by telephone, "to the extent possible as determined by the hospital," 24 hours-a-day to patients who are part of a language group that comprises at least five percent of the population of the geographic area served by the hospital;
- Post multi-lingual notices of the availability of interpreters and how to obtain an interpreter, and directions on how to complain to state authorities about interpreter services;
- Identify and record patients' primary/preferred languages in hospital records;
- Prepare and maintain a list of qualified interpreters;
- Notify employees of the requirement to provide interpreters to all patients who request them;

[51] Cal. Gov't Code § 11135(a).

[52] 22 Cal. Code Regs. Tit. 22 § 98210(b) (2001).

[53] *Id.* § 98101.

[54] *Id.* § 98210(a).

- Review standardized forms to determine which should be translated;
- Consider providing non-bilingual staff with picture and phrase sheets for communication with LEP patients;
- Consider establishing community liaison groups to LEP communities.[55]

The Kopp Act defines interpreters as individuals who are fluent in English and a second language, who can accurately speak, read and readily interpret a second language, and who have the ability to translate the names of body parts and describe symptoms and injuries competently in both languages.[56] As the state agency that licenses hospitals, the California Department of Health Services is responsible for compliance.[57]

DYMALLY-ALATORRE BILINGUAL SERVICES ACT (GOVERNMENT CODE § 7290 et seq.)

Passed in 1973, the Dymally-Alatorre Bilingual Services Act requires all state agencies and their local offices that furnish information or render services to the public to provide oral interpretation and translated materials. Among other things, agencies must:

- Employ sufficient numbers of qualified bilingual persons in public contact positions to ensure access for non-English speaking persons;[58]
- Translate materials explaining their services;[59]
- Distribute translated materials or provide alternative translation assistance if the written materials request, require or provide information or the information requested, required or provided affects the individuals' rights or duties;[60]
- Conduct bi-annual surveys of local offices to determine the number of bilingual employees and the number and percentage of non-English speaking persons served by each office, broken down by language.[61]

The law requires bilingual staffing and translation for limited-English speaking groups comprising five percent or more of the people served[62] and implementation "to the extent that local, state or federal funds

[55]Cal. Health & Safety Code § 1259(c)(1)-(9).

[56]*Id.* § 1259(b)(1).

[57]*Id.* § 1259.5(d).

[58]Cal. Gov't Code §§ 7292, 7293.

[59]*Id.* §§ 7295, 7295.2.

[60]*Id.* § 7295.4.

[61]*Id.* § 7299.4.

[62]*Id.* § 7296.2.

are available."[63] The State Personnel Board (SPB) is responsible for monitoring and educating agencies.[64] Efforts to strengthen the Dymally-Alatorre Act resulted in a budget bill (AB 3000), signed by the Governor in 2002, requiring state agencies to develop long-term implementation plans to come into compliance and providing the SPB with limited enforcement powers.[65]

OTHER STATE STATUTES AND REGULATIONS

Numerous other California statutes and regulations also protect LEP individuals who obtain health care in specific settings and contexts.[66] For example:

- Health care entities must post notice of patients' rights in English and other languages – for example, hospitals (Spanish);[67] general acute care hospitals and skilled nursing facilities (Spanish);[68] adult day health centers (any other predominant language of the community).[69]
- Counties must provide public notice of availability of county funded emergency, urgent care, and non-urgent clinical services in Spanish and English.[70]
- Local health departments must make family planning pamphlets and circulars available in languages spoken by ten percent or more of the county's population.[71]
- Physicians are required to inform a patient by written consent of possible alternatives to hysterectomy in a language she understands.[72] Physicians and surgeons must inform patients being treated for any form of breast cancer of alternative treatment methods by providing the patient with a written summary in a language understood by the patient.[73]
- Community-based, low-income perinatal health care providers must have staff that reflect, to the maximum extent feasible, the cultural, linguistic, ethnic and other social characteristics of the community served.[74]

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[63] *Id.* § 7299.

[64] *Id.* §§ 7299.2, 7299.4, 7299.6.

[65] A multi-year effort to strengthen and clarify provisions of the Dymally-Alatorre Act resulted in SB 987, which was passed in 2002 by the California legislature but was vetoed by the Governor.

[66] For a comprehensive list of California statutes and regulations addressing language and cultural competency in health care, *see* NHeLP, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* .at Appendix D; Wong, Doreena, and Jane Perkins, *Ensuring Linguistic Access in Health Care Settings in California: Legal Rights and Responsibilities* at Attachment 4.

[67] 22 Cal. Code Regs. § 70707(b).

[68] *Id.* §§ 70577, 72453.

[69] *Id.* § 78437(b).

[70] Cal. Welf. & Inst. Code § 16946(h)(1)(D).

[71] *Id.* § 124300.

[72] Cal. Health & Safety Code § 1691.

[73] *Id.* § 109275.

[74] *Id.* § 123515.

MEDI-CAL MANAGED CARE CONTRACT REQUIREMENTS

The Medi-Cal Managed Care Division (MMCD) of the California Department of Health Services contracts with health plans to serve Medi-Cal recipients and requires, as part of the contract, that plans build systems that meet the needs of the diverse Medi-Cal population. In April 1999, the MMCD released Policy Letters 99-01 to 99-04 and All Plan Letter 99005 clarifying contract requirements of Medi-Cal Managed Care Plans. Noting the "inextricabl[e] link" between culture, language and health,[75] these policy letters provide guidelines for culturally and linguistically competent health care. Key requirements from the contracts and policy letters include:

- Assessing health education as well as cultural and linguistic needs of members and identifying resources which will enable the plan to provide culturally and linguistically competent care;[76]
- Providing 24-hour access to interpreter services for members;[77]
- Providing interpreter services at "key points of contact" if the number of LEP mandatory eligibles living in the service area exceed quantified thresholds;[78]
- Not requiring or suggesting that LEP members provide their own interpreters;[79]
- Developing and implementing standards and performance requirements for the provision of linguistic services and monitoring performance of persons providing services;[80]
- Maintaining "community linkages" through the formation of community advisory committees, with demonstrated participation of consumers and traditional safety net providers;[81]
- Ensuring that informing materials are available in the threshold languages and that they are accurate and complete.[82]

One key Medi-Cal Managed Care contract requirement is the adoption of a numerical instead of a percentage threshold. MMCD Policy Letter 99-03 states: "Threshold languages in each county … are pri-

[75] California Department of Health Services, Medi-Cal Managed Care Division (MMCD), *Policy Letter* 99-02 (April 2, 1999) at p. 4 (regarding conducting needs assessments).

[76] *Id.* at p. 1.

[77] California Department of Health Services, MMCD, Policy Letter 99-03 (April 2, 1999) at p. 2 (regarding the provision of linguistic services).

[78] *Id.* at p. 3. "Key points of contact" include medical encounters with providers (e.g., telephone or face-to-face) and non-medical contact (e.g., membership services, orientation, appointments). Id.

[79] *Id.* at p. 2. However, a family member or friend may be used if requested by the LEP member and after they are informed of their right to free language assistance. Id.

[80] *Id.* at p. 4.

[81] California Department of Health Services, MMCD, Policy Letter 99-01 (April 2, 1999) (regarding establishing a community advisory committee).

[82] California Department of Health Services, MMCD, *Policy Letter* 99-04 (April 2, 1999) at pp. 1, 3 (regarding the provision of translated written materials). "Informing documents" are those that provide essential information to all members regarding access to and usage of plan services; examples include evidence of coverage booklet, member services guide, disclosure forms, provider listings, and form letters. *Id.* at p. 2.

mary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible beneficiaries residing in a county. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county."[83] The advantage of the numerical threshold is that it covers a significant proportion of the non-English speaking population that would not benefit from a percentage threshold.

HEALTHY FAMILIES CONTRACT REQUIREMENTS

The Healthy Families program is administered by the Managed Risk Medical Insurance Board (MRMIB), which seeks to improve the health of Californians by increasing access to affordable, comprehensive, quality health care coverage. In December 1999, MRMIB adopted model contract requirements, including the following:

- Improve linguistic services by providing 24-hour access to interpreters; developing and implementing interpreter services, policies and procedures; avoiding unreasonable delay in providing interpreters; recording the language needs of patients; prohibiting the use of minors to interpret except in the most extraordinary circumstances; informing patients of the availability of linguistic services; and requiring demonstrated bilingual proficiency by providers who list their bilingual capabilities;
- Provide translated written materials, in Spanish and any language comprising the lesser of 5 percent or 3,000 of the contractor's enrollment, and ensuring quality translated materials;
- Conduct cultural and linguistic group needs assessment, including the input of subscribers; and
- Operationalize cultural and linguistic competency by providing cultural competency trainings to staff, improving internal systems to meet cultural and linguistic needs of subscribers, and reporting annually regarding the contractor's linguistic and cultural services.[84]

The Healthy Families contract language includes many of the Medi-Cal Managed Care contract requirements (e.g., 24-hour access to interpreter services) – however, the Healthy Families contracts have several key additional requirements: prohibiting the use of minors except in emergencies; annual reporting on culturally and linguistically supportive services; and inclusion of race, ethnicity and primary language data in all standard measures of assessment.[85] In addition, the threshold triggering the provision of written materials is also different.[86]

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[83] MMCD *Policy Letter* 99-03 (April 2, 1999), at p. 3.

[84] Managed Risk Medical Insurance Board, Healthy Families Program, *Health Plan Model Contract,* 2000-2003 (2000) at 9-17.

[85] *Id.*

[86] *Id.*

HEALTH ACCREDITATION AGENCIES

Private accrediting agencies play an important role in shaping the delivery of health care. Many health facilities voluntarily undergo review and certification from these agencies. High marks from accrediting agencies can give providers an advantage in the market. State and federal agencies use private accrediting agencies to set standards for care and determine compliance with those standards,[87] and loss of accreditation can result in the loss of government funding. Courts also have considered the standards and findings of accrediting agencies when deciding whether a provider has committed malpractice.[88]

The largest and most-used accrediting agencies are the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions, and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations. Both have adopted standards that require cultural and linguistic competency.

a) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards

JCAHO standards establish the accreditation requirements for various health care organizations. The standards are organized into eight sections[89] and cultural and linguistic competency are addressed or encompassed in most of these sections. The standards vary for each type of health care organization, so the most relevant types of organizations – hospitals and ambulatory care facilities – are discussed below.[90]

(1) Hospitals

■ **Rights, Responsibilities and Ethics (RI):** JCAHO requires hospitals to address ethical issues in patient care. This includes establishing and maintaining structures to support patient rights that address both patient care and organizational ethical issues. Also, a patient has a right to care that is considerate and respectful of their personal values and beliefs. Standard RI.1.2 states that patients must be involved in all aspects of their care. JCAHO recognizes that spiritual and cultural values affect how patients respond to care and that hospitals must allow patients and their families to express their spiritual beliefs and cultural practices as long as these practices do not harm others or interfere with treatment. According to JCAHO, hospitals must also address care at the end of life, including respecting the

[87] Claudia Schlosberg and Shelly Jackson, "Assuring Quality: The Debate Over Private Accreditation and Public Certification of Health Care Facilities," 30 *Clearinghouse Rev.* 699 (Nov. 1996).

[88] *See* NHeLP, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* at p. 5.1.

[89] The eight sections are: Rights, Responsibilities and Ethics (abbreviated RI); Education (PF); Leadership (LD); Management of Human Resources (HR); Assessment (PE); Continuum of Care (CC); Health Promotion and Disease Prevention (PS); and Care (TX).

[90] JCAHO accredits 17,000 health care organizations, including hospitals, ambulatory care organizations, behavioral health care organizations, health care networks, home care agencies, and long-term care organizations.

patient's values and responding to the spiritual and cultural concerns of the patient and the family.[91] Further, patients have the right to appropriate assessment and management of pain. Hospitals should communicate that pain management is an important part of care, taking into account cultural, spiritual, and/or ethnic beliefs of the patient and family.[92]

This standard also requires hospitals to demonstrate respect for patient communication needs.[93] The hospital must have a way to provide effective communication for each patient; effective communication is defined as "any form of communication (for example, writing or speech) that leads to demonstrable understanding."[94] If a patient's care requires restriction of access to communication, the communication restrictions must be explained in a language the patient understands.

Finally, upon admission, hospitals must provide each patient with a written copy of the hospital's statement of patient's rights.[95] This must be appropriate to the patient's age, understanding, and language. If a patient does not understand the written communication, the patient must be informed of her rights in a manner that they can understand.[96]

■ **Education (PF):** A hospital's patient education activities must consider cultural characteristics of the patients being taught.[97] In determining the resources necessary for achieving patient educational objectives, the hospital must include other community resources to do the teaching, if needed, and referrals to other programs, special devices, interpreters or other aids to meet specialized needs.[98]

■ **Leadership (LD):** Hospital leaders, and, as appropriate, community leaders must collaborate to design services responsive to community needs.[99] The scope of care and level of care provided throughout the hospital must satisfy accepted standards of practice.[100] Further, the hospital's priority setting must be sensitive to emerging needs in the community such as those identified through data collection and assessment. This could include changes in demographics that increase the need for oral interpretation and written translation.[101]

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[91] Joint Commission on Accreditation of Healthcare Organizations, *Hospital Standards* at RI.1.1.

[92] *Id.* at RI.1.2.9.

[93] *Id.* at RI.1.3.6.

[94] *Id.*

[95] *Id.* at RI.1.4.

[96] *Id.*

[97] *Id.* at PF.1.

[98] *Id.* at PF.1.1.

[99] *Id.* at LD.1.3.1.

[100] *Id.* at LD 1.3.2.

[101] *Id.* at LD.1.4.

■ **Management of Human Resources (HR):** JCAHO recognizes that a hospital's ability to fulfill its mission and provide for its patients is directly related to its ability to provide a qualified, competent staff.[102] In projecting staffing needs, the hospital should consider the case mix of patients served as well as the expectations of the hospital, its patients, and other customers. Further, the hospital should orient its staff and regularly collect and analyze data to assess staff competence and training needs.[103] Data may be collected from performance reports, staff surveys or other needs assessment. Hospital policies and procedures must specify those aspects of patient care which might conflict with staff members' cultural values or religious beliefs and whether these values or beliefs are sufficient to grant a request of a provider not to participate in care. The hospital must have policies and procedures in place to allow a provider to request not to participate in care and to ensure that granting such a request will not negatively affect a patient's care.[104]

(2) Ambulatory health care organizations

■ **Rights, Responsibilities and Ethics (RI):** The same standards for RI that apply to hospitals also apply to ambulatory health care organizations. Ambulatory health care standards specifically require: that patients' rights be respected and supported;[105] that patients be involved in all aspects of care;[106] that patients' cultural, psychological, spiritual and personal values be respected;[107] and that the organization demonstrate respect for a patient's communication needs. JCAHO provides example of implementing the communication standard that states that the needs of patients who have difficulty communicating might be addressed by offering translation services for non-English-speaking patients. The explanation also states that documents such as consent forms, patient rights and responsibilities statements, and educational materials should be available in the primary languages of the common populations served.

■ **Assessment (PE):** The assessment standards discuss conducting an initial assessment of a patient.[108] Explaining its intent, JCAHO says that the initial assessment should take into account the patient's needs, including culture. The explanation recognizes that a patent's cultural and family contexts and individual background are important factors in responding to illness and treatment. Further, when an ambulatory care facility serves a large, culturally distinct population, patient assessment and education information should be appropriately modified and information about the culture should be shared with staff.

[102] *Id.* at HR.1.

[103] *Id.* at HR.4-4.3.

[104] *Id.* at HR.6-6.2.

[105] Joint Commission on Accreditation of Healthcare Organizations, *Ambulatory Health Care Standards* at RI.1.1.

[106] *Id.* at RI.1.2.

[107] *Id.* at RI.1.2.1.

[108] *Id.* at PE.1.

Ambulatory care assessment standards provide that data collected at an initial assessment should include information about cultural or religions practices that may affect care as well as the patient's and family's educational needs, abilities, motivation and readiness to learn.[109] In addition, when nutritional status is assessed, patients at high nutritional risk should be assessed for cultural, ethnic, and personal food preferences.[110]

- **Education (PF):** These standards mirror those of hospitals.[111]

- **Leadership (LD):** Under leadership standards, ambulatory care organizations must define their scope of services in writing and have them approved by their leaders. The intent of this standard is to ensure that the needs of different types of patients are addressed. JCAHO suggests that planning documents describe the languages in which consent documents are written for the patient population served.[112]

- **Management of Human Resources (HR):** Ambulatory care organizations are expected to conduct ongoing data collection about staff competence patterns and trends to respond to staff learning needs.[113] The ambulatory care organization, like a hospital, should have policies and processes to define which specific aspects of patient care will not be performed due to conflict with a staff member's values, ethics, or religious beliefs. This includes processes to ensure that staff refusals will not compromise patient care. A staff member's ongoing performance evaluation may consider whether a staff member's refusal is legitimately justified by cultural values or ethics.[114]

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) STANDARDS

NCQA provides accreditation for managed care organizations (MCOs).[115] In addition, it produces a highly influential set of performance measures, which are used by many purchasers to judge the MCO's performance.

[109] *Id.*

[110] *Id.* at PE.1.2.

[111] *Id.* at PE.1.

[112] *Id.* at LD.1.3.5.

[113] Id. at HR.4.2.

[114] Id. at HR.6.1-2.

[115] NCQA has reviewed almost half of the nation's HMOs, covering 75% of all HMO enrollees.

Accreditation Standards

NCQA's accreditation process involves 60 standards and one specific standard focuses on "Translation Services."[116] Each MCO must provide translation services within its member services telephone function based on the linguistic needs of its members. NCQA explains that this requires organizations to consider data about the population needs of its members. If the organization serves individuals whose principle written and spoken language is not English, the organization must have a mechanism in place to provide language services (oral and/or written). Examples of actions that could satisfy this requirement include contracting with translation/interpreter services and hiring staff who speak languages prevalent in the population.[117]

Health Plan Employer Data and Information Set (HEDIS)

NCQA also developed and maintains the Health Plan Employer Data and Information Set (HEDIS), which is the most widely used set of performance measures in the managed care industry. NCQA requires all participating plans to report HEDIS results as part of the accreditation process; in addition, the federal Centers of Medicaid and Medicare Services (CMS) requires all Medicare + Choice plans to use HEDIS, and some state Medicaid and SCHIP agencies use HEDIS to evaluate their managed care plans.

HEDIS consists of two parts: technical specifications for measuring performance and a consumer survey. The technical specifications include reporting measures related to language access.

One HEDIS 2003 measure requires MCOs that serve Medicare or Medicaid members to report on the availability of language services. MCOs must complete a table on the number of MCO practitioners (primary care, OB/GYN and prenatal care, behavioral health care, and dental) and member services staff who speak languages other than English.[118] MCOs must also provide a description of out-of-MCO interpreter services secured during the year for Medicaid, commercial and Medicare members. MCOs are asked to identify up to 30 languages for which interpreter services were secured, prioritized by the most relevant languages.[119] The required information includes the source of the interpreter service provided (e.g., in person or by telephone), the type of interpreter service agreement (e.g., formal written contract), and any restrictions on availability of services (e.g., time of day).[120] If no interpreter services were secured during the year, the MCO must state this and document the reason.[121] HEDIS 2003 also requires

[116] E-mail from Cynthia Martin, National Committee for Quality Assurance, to Mara Youdelman, Natioanl Health Law Program (Dec. 27, 2002, 14.32) (on file with NHeLP).

[117] *Id.*

[118] National Committee for Quality Assurance, HEDIS 2003 *Technical Specifications*, at Vol. 2, 144-45, Tbl. A5a-1/3 (Health Plan Practitioners and Member Services Staff Serving Members Who Speak Languages Other Than English) (2002).

[119] *Id.* at 145-46.

[120] *Id.* at 146, Tbl. A5B-1/2/3 (Out-of-MCO Interpreter Services Secured During the Measurement Year).

[121] *Id.* at 146.

reporting on diversity of membership by Medicaid participating MCOs. Although not mandating a specific reporting format, NCQA does provide a reporting table[122] which asks for the number and percentage of unduplicated members by race, Hispanic origin and spoken language.[123]

b) Health Profession Organizations Cultural and Linguistic Standards

The bodies representing health professionals have also integrated cultural and linguistic competencies into their standards of practice and ethical codes. The following section is reprinted from. *Resources in Cultural Competence Education for Healthcare Professionals*, edited by Jean Gilbert, PhD, published by The California Endowment and available online at http://www.calendow.org.62

1. **Accreditation Council for Graduate Medical Education Outcome Project:** *General Competencies*. Outcomes@acgme.org . Patient Care is made up of the following: (1) A commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse population; and (2) Sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

2. **2001 American Academy of Family Physicians** (AAFP). *Cultural Proficiency* Guidelines. The guidelines were approved by the AAFP Board of Directors in March, 2001. For more information, contact AAFP at 11400 Tomahawk Creek Parkway, Leawood, KS 66211 or call 913-906-6000. Web site: www.aafp.org.

■ Cultural Proficiency Guidelines

The AAFP believes in working to address the health and educational needs of our many diverse populations. A list of issues to consider in preparing informational or continuing medical education material and programs has been developed to ensure cultural proficiency and to address specific health related issues as they relate to special populations of patients and providers. The list, while perhaps not complete, is meant as a dynamic template to assist those developing Academy material and programming for patients and physicians.
Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Care. Like, R, Steiner, P, & Rubel, A. Family Medicine, Vol. 28 (4).

3. **2001 American College of Emergency Physicians.** *Cultural Competence and Emergency Care*. Approved by the ACEP Board of Directors, October. For more information, contact ACEP at 1125 Executive Circle, Irving, TX 75038- 2522 or call 800-798-1822.

   "The American College of Emergency Physicians believes that: "Quality health care depends

[122] *See id.* at 278, Tbl. D7-1 (Diversity of Medicaid Membership).

[123] *Id.* at 278-79.

on the cultural competence as well as the scientific competence of physicians;" Cultural competence is an essential element of the training of healthcare professionals and to the provision of safe, quality care in the emergency department environment; and • Resources should be made available to emergency departments and emergency physicians to assure they are able to respond to the needs of all patients regardless of the respective cultural backgrounds."

4. **1998 The American College of Obstetricians and Gynecologists** (ACOG) Committee on Health Care for Underserved Women. Committee Opinion, No. 201, March. Copyright Clearance Center Danvers, MA 01923. Call 978-750-8400. For more information, contact ACOG at 409 12th Street, SW, PO Box 96920, Washington, D.C. 20090-6920.

   "During every health care encounter, the culture of the patient, the culture of the provider, and the culture of medicine converge and impact upon the patterns of health care utilization, compliance with recommended medical interventions and health outcomes. Often, however, health care providers may not appreciate the effect of culture on either their own lives, their professional conduct or the lives of their patients (3). When an individual's culture is at odds with that of the prevailing medical establishment, the patient's culture will generally prevail, often straining provider-patient relationships (4). Providers can minimize such situations by increasing their understanding and awareness of the culture(s) they serve. Increased sensitivity, in turn, can facilitate positive interactions with the health care delivery system and optimal health outcomes for the patients served, resulting in increased patient and provider satisfaction."

5. **American Nurses Association.** *Position Statements: Cultural Diversity in Nursing Practice.* http://www.nursingworld.org/readroom/position/ethics/etcldv.htm

   "Knowledge of cultural diversity is vital at all levels of nursing practice. Ethnocentric approaches to nursing practice are ineffective in meeting health and nursing needs of diverse cultural groups of clients. Knowledge about cultures and their impact on interactions with health care is essential for nurses, whether they are practicing in a clinical setting, education, research or administration. Cultural diversity addresses racial and ethnic differences, however, these concepts or features of the human experience are not synonymous. The changing demographics of the nation as reflected in the 1990 census will increase the cultural diversity of the U.S. population by the year 2000, and what have heretofore been called minority groups will, on the whole constitute a national majority (Census, 1990). Knowledge and skills related to cultural diversity can strengthen and broaden health care delivery systems. Other cultures can provide examples of a range of alternatives in services, delivery systems, conceptualization of illness and treatment modalities. Cultural groups often utilize traditional health care providers, identified by and respected within the group. Concepts of illness, wellness and treatment modalities evolve from a cultural perspective or worldview. Concepts of illness, health and wellness are part of the total cultural belief system."

6. **1990 American Psychological Association** (APA). *APA Guidelines for Culturally Diverse Populations: (Approved by the APA Council of Representatives)* For more information, write to 750 First Street, NE, Washington, DC 20002. Tel. 202-336-5500. www.apa.org/pi/guide.html .

This public interest directorate consists of guidelines, illustrative statements and references. The guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations. There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs and cultural expectations have been introduced into educational, political, business and health care systems by the physical presence of these groups. The issues of language and culture impact on the provision of appropriate psychological services.

7. **1998 Association of American Medical Colleges.** *Teaching and Learning of Cultural Competence in Medical School.* Contemporary Issues in Medical Education, Feb; Vol. 1(5). Division of Medical Education, AAMC, Washington, DC.

8. **2000 CLAS Culturally and Linguistically Appropriate Services in Managed Care Organizations.** (US Department of Health & Human Services, Office of Minority Health) http://www.omhrc.gov/clas/ . National standards for culturally and linguistically appropriate services in health care posted on Federal Register. Based on an analytical review of key laws, regulations, contracts and standards currently in use by federal and state agencies and other national organizations, these standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

9. **1999 Committee on Pediatric Workforce and the American Medical Association** Advisory Committee on Minority Physicians. *Culturally Effective Pediatric Care: Education and Training Issues.* American Academy of Pediatrics, Jan; Vol. 103 (1):167-170. This policy statement defines culturally effective health care and describes its importance for pediatrics. The statement also defines cultural effectiveness, cultural sensitivity and cultural competence, and describes the importance of these concepts for training in medical school, residency and continuing medical education. The statement is based on the premise that culturally effective care is important and that the knowledge and skills necessary for providing culturally effective health care can be taught and acquired through 1) educational courses and other formats developed with the expressed purpose of addressing cultural competence and/or cultural sensitivity, and 2) educational components on cultural competence and/or cultural sensitivity that are incorporated into medical school, residency and continuing education curricula.

10. **1997. New York State Cultural and Linguistic** *Competency Standards.* New York State Office of Mental Health. For information, contact Design Center, 44 Holland Avenue, Albany,

NY 12229. Tel. 518-473-2684. The methods and strategies employed are discussed and the team members introduced. The scope of the project is presented along with a review of the five domains, or standards for cultural competency in mental health services.

11. **Liaison Committee on Medical Education.** *Standard on Cultural Diversity.* Full text of LCME Accreditation Standards (from Functions & Structure of a Medical School, Part 2). www.lcme.org "Faculty & students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness & respond to various symptoms, diseases, & treatments. Medical students should learn to recognize & appropriately address gender & cultural biases in health care delivery, while considering first the health of the patient."

12. **National Association of Social Workers (NASW)**. http://www.naswdc.org/diversity/default.asp#top NASW is committed to social justice for all. Discrimination and prejudice directed against any group are damaging to the social, emotional and economic well-being of the affected group and of society as a whole. NASW has a strong affirmative action program that applies to national and chapter leadership and staff. It supports three national committees on equity issues: the National Committee on Women's Issues, National Committee on Racial and Ethnic Diversity and the National Committee on Gay, Lesbian and Bisexual Issues. The information contained in their web site reflects some of NASW's material and work on diversity and equity issues.

13. **Society for Public Health Education (SOPHE).** *Code of Ethics for the Health Education Profession.* http://www.sphe.org/ (click on "About SOPHE" and then click "Ethics."

    "The Health Education profession is dedicated to excellence in the practice of promoting individual, family, organizational, and community health. Guided by common ideals, Health Educators are responsible for upholding the integrity and ethics of the profession as they face the daily challenges of making decisions. By acknowledging the value of diversity in society and embracing a cross-cultural approach, Health Educators support the worth, dignity, potential, and uniqueness of all people. The Code of Ethics provides a framework of shared values within which Health Education is practiced. The Code of Ethics is grounded in fundamental ethical principles that underlie all health care services: respect for autonomy, promotion of social justice, active promotion of good, and avoidance of harm. The responsibility of each health educator is to aspire to the highest possible standards of conduct and to encourage the ethical behavior of all those with whom they work. Regardless of job title, professional affiliation, work setting, or population served, Health Educators abide by these guidelines when making professional decisions."

14. **WICHE Western Interstate Commission for Higher Education.** *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups.* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; U.S. Department of Health and Human Services. "The standards are

designed to provide readers with the tools and knowledge to help guide the provision of culturally competent mental health services within today's managed care environment. This document melds the best thinking of expert panels of consumers, mental health service providers, and academic clinicians from across the four core racial/ethnic populations: Hispanics, American Indians/Alaska Natives, African Americans, and Asian/Pacific Islanders. Developed for states, consumers, mental health service providers, educators and organizations providing managed behavioral health care, the volume provides state-of-the-science cultural competence principles and standards – building blocks to create, implement and maintain culturally competent mental health service networks for our diverse population." The site provides educators, policymakers and legislators with data and issues-oriented analysis by subject matter.[124]

[124] http://www.mentalhealth.org/publications/allpubs/SMA00-3457/default.asp

APPENDIX D: NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE (CLAS)[125]

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National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care [Department of Health and Human Services. Office of Minority Health.]

These standards were issued to ensure that all people entering the health care system receive "equitable and effective treatment in a culturally and linguistically appropriate manner." There are 14 standards which are divided into themes, each with varying stringency: mandates, guidelines and recommendations.

CLAS Standards

■ Culturally Competent Care

Standards 1-3 are CLAS Guidelines which are activities that are recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies

1) Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language
2) Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area
3) Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in Culturally and Linguistically Appropriate Service delivery

■ Language Access Services

Standards 4-7 are CLAS Mandates which are current Federal requirements under Title VI for all recipients of Federal funds

[125]Appendix from Providing Linguistic Access to Limited English Proficient Individuals: Findings and Recommendations for Improving, Monitoring, and Maintaining Language Assistance Services. Contra Costa Health Services (Dec. 2003).

4) Health care organizations must offer and provide Language Assistance Services, including bilingual staff and interpreter services, at no cost to each patient/consumer with Limited English Proficiency at all points of contact, in a timely manner during all hours of operation

5) Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive Language Assistance Services

6) Health care organizations must assure the competence of language assistance provided to Limited English Proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)

7) Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area

■ Organizational Supports for Cultural Competence

Standards 8-13 are CLAS guidelines.
Standard 14 is a CLAS recommendation that is suggested by OMH for voluntary adoption.

8) Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide Culturally and Linguistically Appropriate Services

9) Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations

10) 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

11) Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area

12) Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities

13) Health care organizations should ensure that conflict arid grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers

14) Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information

APPENDIX E: FEDERAL POLICY DIAGRAM[126]

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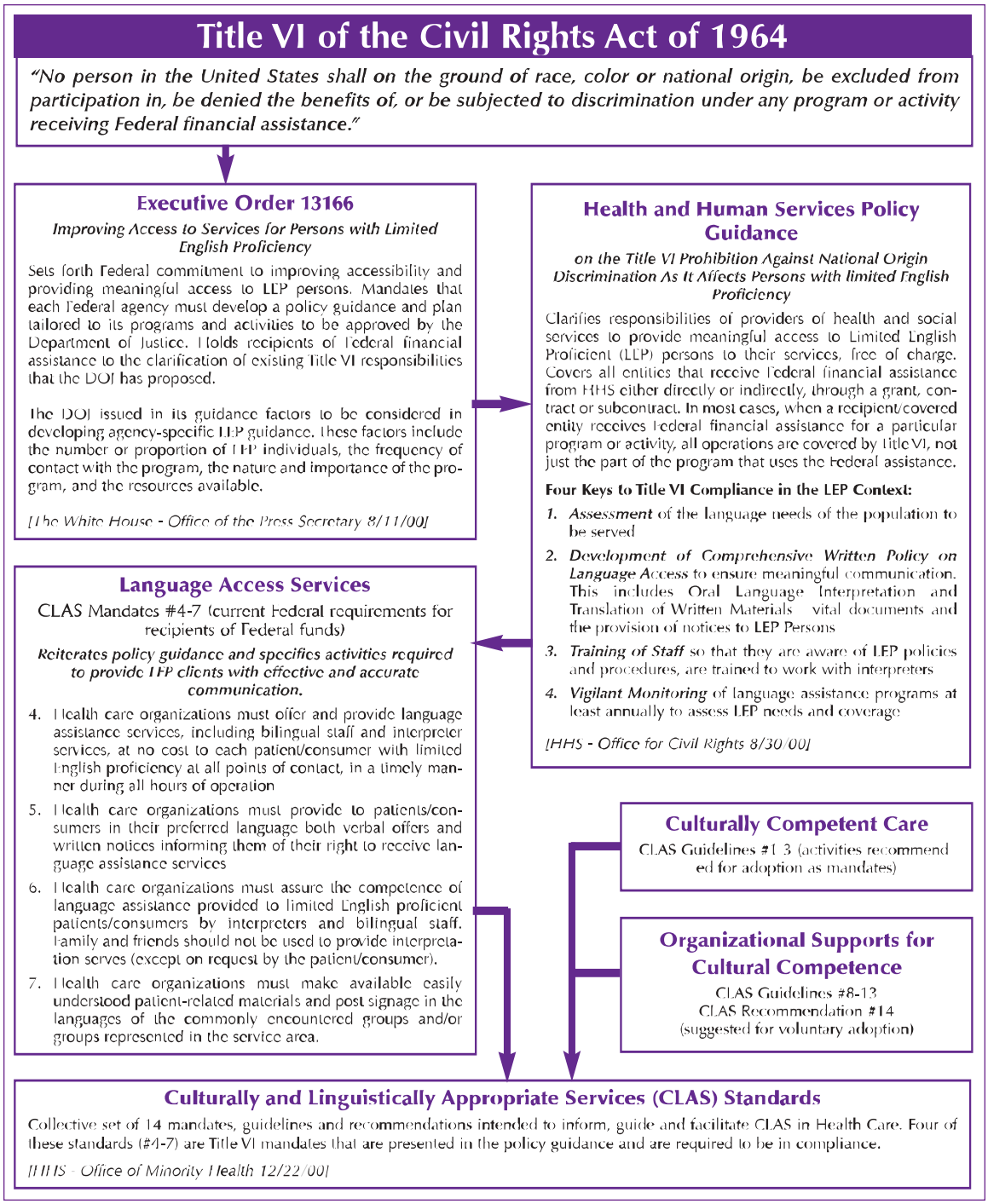

[126]Appendix from *Providing Linguistic Access to Limited English Proficient Individuals: Findings and Recommendations for Improving, Monitoring, and Maintaining Language Assistance Services.* Contra Costa Health Services (Dec. 2003).

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