

HHS' Office of Civil Rights Focuses on Title VI Policy Provides Guidance for Ensuring Linguistic Access

By Houkje Ross

Closing the Gap, Cultural Competency Part II • February/March 2001

In August 2000, the U.S. Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) released a written policy guidance to help ensure that persons with limited English skills can effectively access critical health and social services.

The guidance outlines the legal responsibilities of providers who receive federal financial assistance from HHS. Providers such as hospitals, HMOs, and human service agencies now have an outline for complying with the "Policy Guidance on the Prohibition Against National Origin Discrimination As it Affects Persons with Limited English Proficiency." The guidance applies to part of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of national origin.

Publication of the OCR guidance makes HHS the first federal agency to publish guidance since the issuance of Executive Order 13166 on serving persons with limited English skills. Signed in August 2000, the executive order requires each federal agency to have written policies on providing effective service to those with limited English proficiency who are served by federally funded programs.

The OCR policy guidance recommends that health care agencies and providers develop a plan for providing written materials in languages other than English. This should be done in areas where a significant number or percentage of the affected population needs services or information in a language other than English to communicate effectively. To ensure satisfactory services to limited-English-proficient (LEP) clients, providers also should:

- ❖ Have policies and procedures in place for identifying and assessing the language needs of the individual provider and its client population;
- ❖ Provide a range of oral language assistance options, appropriate to each facility's circumstances;
- ❖ Provide notice to LEP persons of the right to free language assistance;
- ❖ Provide staff training and program monitoring, and
- ❖ Establish a plan for providing written materials in languages other than English.

Meaningful Access Must be Provided



According to OCR, agencies and providers must ensure meaningful access to LEPs. Office of Civil Rights (OCR) Director Thomas Perez commented in a press

release that, "Effective communication is the key to meaningful access, whether it is a hospital, a clinic or a benefits program. Failure to communicate effectively can have serious consequences for millions of Americans."

According to the Cross Cultural Health Care Program (CCHCP), a nonprofit organization in Seattle, many institutions are now depending upon family members, friends, or support staff such as receptionists and technicians, to provide language assistance. But family members are notoriously bad interpreters because they routinely edit, add, or change messages from patient to doctor, according to CCHCP.

Providing health care across language barriers without the use of an interpreter can be like walking blindfolded across a minefield. The practice can be dangerous, and in some cases, life-threatening.

"A doctor in our hospital was treating a diabetic patient who only spoke Spanish," said Estela McDonough, coordinator of training and education at the Interpreter Services Program at the University of Massachusetts Memorial Medical Center.

According to McDonough, the doctor said he did not need an interpreter because he said he knew Spanish. But the physician failed to pick up that the patient had been fasting due to religious beliefs. The patient was in a much more serious sugar crisis than the physician was aware of. Luckily, the interpreter had stayed in the room as a precaution. "Later on, the doctor told me that for many years he thought he had been communicating accurately with his patients. He had no idea he was putting his patients at risk," said McDonough.

Interpreting - More than Words

Interpreting is more than just translating the words, according to McDonough. "The interpreter acts as the conduit between the patient and the health care provider. A trained and qualified interpreter has to have certain skills, including memory, concentration, knowledge of medical terminology, anatomy, physiology, and an understanding of how to deliver a message in the target language," she added.

Using professional on-site interpreters is a more reliable approach for providers because these persons have been screened for their language skills, trained in interpretation ethics and techniques—which includes learning to be accurate, complete, and to consider cultural frameworks—and contracted only to interpret, according to CCHCP.

Professional interpreters should also have a good grasp of the nuances of culture and language, according to McDonough. "I had an interpreter who came to our program from Europe. She had a full year of training in Spain, but she still

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misunderstood what the patients from Puerto Rico were saying when describing “fatiga,” which in her native Spain means “tired.” For the patients from Puerto Rico, “fatiga” is a word used to describe wheezing from asthma,” said McDonough.

Massachusetts is one of a handful of states that has standards for the use of medical interpreters. The Massachusetts Medical Interpreter Association's (MMIA) standards address issues of interpreter skill, behavior, linguistic and cultural knowledge, and ethics. In April 2000, the Massachusetts Emergency Room Interpreter Bill was signed into law. The law requires that all hospitals, public or private, which provide acute care, either in emergency rooms or in acute psychiatric facilities, when treating non-English speakers, must use competent interpreter services. The law goes into effect in July 2001.

Getting Everyone on the Same Page

Some medical associations and other critics of the OCR guidance strongly oppose requirements that doctors who accept Medicaid funds provide and pay for interpreter services for patients with limited English speaking abilities. The high cost of the requirements will place an “unreasonable burden” on physician practices, critics say. OCR officials maintain that the guidelines do not represent a new initiative but are intended to more fully explain existing policies in place to enforce Title VI of the Civil Rights Act of 1964.

Although some physicians and other organizations may feel the OCR guidance is burdensome, there are ways to get everyone on the same page. A 1995 study conducted by the New York Task Force on

Immigrant Health, *Access through Medical Interpreter and Language Services*, found that motivation to develop an interpreter program is often shaped by several factors. These include: pressure from physicians; a desire to gain a larger share of the market through increased patient volume; the threat of malpractice law suits; a response to the influx of refugees and immigrants; and the fact that providing in-person interpreter services is more cost-effective than telephone interpreter services.

Federal funds are available for States' expenditures related to the provision of oral and written translation administrative activities and services provided for the Health Care Financing Administration's State Children's Health Insurance (SCHIP) and Medicaid programs.

Some of the most common complaints OCR works to resolve include: failing to inform LEP persons of the right to receive free interpreter services or requiring them to provide their own interpreter; or providing services to LEP persons that are not as effective as those provided to persons with proficiency in English.

In cases where OCR has found health care organizations to provide inadequate access for LEP patients, the agency has required these agencies to establish a system for tracking LEP clients and client needs. It has also required organizations to publicize the availability of no cost programs and services in non-English community media outlets and to provide cultural sensitivity training for staff.

For information on the OCR guidance, go to <http://www.hhs.gov/ocr/lep/> or call OCR at (800) 368-1019. To contact the Interpreter Services Program at University of Massachusetts Memorial Medical Center, call (508) 856-5793. MMIA can be reached at (617) 636-5479. ❖

Good Communication is Good Medicine

In a recent study conducted by the Office of Ethics and Health Policy Initiatives at the Albert Einstein Healthcare Network in Philadelphia, focus group participants who were limited-English-proficient felt that their ability to communicate with providers was restricted. One focus group participant in the 1999 study, *Approaches to End-of-Life Care in Culturally Diverse Communities*, commented, “If you don't speak English, you're a handicap. You're going to take a long time to deal with. I'm going to leave you for last, and I'm going to help that person who speaks English.” Richard Lerner, MD, a general practitioner at the University of Massachusetts Medical Center in Worcester, admits that it does take more time to use an interpreter. “But without them, the interaction between provider and patient would be limited,” he said.

In 1999, the Agency for Healthcare Research and Quality sponsored a workshop on cultural competency in health systems, entitled *Providing Care to Diverse Populations: State Strategies for Promoting Cultural Competency in Health Systems*. Workshop presenters indicated that research and anecdotal evidence suggest that the improved communication between doctors and patients leads to greater patient satisfaction.

Looking for more information on communicating in health care? Check out the third edition of *Health Communication: Strategies for Health Professionals*, by Peter G. Northouse, Ph.D, and Laurel L. Northouse. The 1998 book, which provides health care professionals with theory-based strategies they can use to improve communication with patients, families, and other health care professionals, includes a chapter on intercultural communication. ❖

