Meeting the Needs of Patients With Limited English Proficiency

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Recent guidelines have been promulgated to protect the rights of patients with limited English proficiency when they receive care from health Providers. It behooves Providers to supply access to proper interpreter services to assure appropriate and efficient care. Furthermore, legal strictures that apply include issues of malpractice on the basis of lack of informed consent and the government’s ability to exclude non-compliant Providers from federally funded programs including Medicare and Medicaid.

Key words: Limited English proficiency; Medicare; Medicaid; interpreter services; informed consent.

INTRODUCTION

How often have you or your colleagues encountered the situation in which a patient with limited or no command of the English language presents at your office with a small child in tow as interpreter? If the nature of patient’s condition is sensitive or embarrassing, the patient may be hesitant to convey all of the information necessary to allow for an accurate diagnosis or proper treatment. Likewise, the child will be unfamiliar with complex medical terminology, limiting his ability to convey accurate information to his parent. In either case, the patient may not receive the appropriate care, and neither the patient nor the physician will feel comfortable and confident about the encounter. This scenario is becoming more and more common with the diversification of the United States population.

Last year, the Office of Civil Rights (OCR) of the Department of Health and Human Services (HHS) published a 13-page set of guidelines to help address this growing problem.

These controversial guidelines require providers of health and social services (collectively, “Providers”) to meet the needs of patients with limited English proficiency (LEP) at no cost to the patient. Providers must follow these guidelines to comply with Title VI of the Civil Rights Act of 1964 (the Act), which prohibits all entities receiving federal funds from discriminating on the basis of race, color, or national origin. The HHS guidelines must be incorporated into an overall corporate compliance program. This article provides the basic steps Providers must implement to be compliant with the Act and the HHS guidelines and explores the implications of non-compliance.

COVERED ENTITIES

The HHS guidelines apply to all entities that receive federal financial assistance from HHS, either directly or indirectly, through a grant, contract, or subcontract. At this point, you may want to stop reading, believing that you are not a recipient of “federal financial assistance.” If you continue, however, you may be surprised to learn that you are. Covered entities include any state or local agency, private institution or organization, or any public or private individual that: (a) operates, provides, or engages in health or social service programs and activities and (b) receives federal financial assistance from HHS directly or through another recipient/covered entity. In particular, Providers that participate in Medicare or Medicaid programs fall under these guidelines.
Specific examples of covered entities include, but are not limited to: physicians; hospitals; nursing homes; home health agencies; managed care organizations; state, county, and local health agencies; state Medicaid agencies; state, county, and local welfare agencies; programs for families, youth and children; Head Start programs; public and private contractors; and other private and non-profit facilities and programs that benefit from HHS assistance.

BACKGROUND

The purpose of these guidelines is to clarify the responsibilities of Providers to LEP persons pursuant to the Act. These guidelines impose no new requirements on Providers but offer guidance as to how to avoid violations of the Act. The Act requires that where language differences prevent meaningful access to services on the basis of national origin, the covered entity must provide oral and written language assistance at no cost to the person with LEP. This requirement has been in effect for over 30 years, but government investigations indicate that language differences continue to present barriers to the receipt of services. These investigations resulted in Executive Order 13166, in which President Clinton mandated all federal agencies to issue guidance to ensure that federally funded services are accessible to persons with LEP.

REQUIREMENTS

To ensure compliance with the Act, it requires that covered entities provide the language assistance necessary to ensure such access at no cost to the person with LEP. The HHS guidelines recognize the differences among Providers and that meaningful access will depend on a variety of factors, including the size of the entity, the size of the LEP population served, the nature of the services provided, and the resources available to the entity. Although no set compliance requirement exists, a Provider must demonstrate that it has taken steps to ensure that persons with LEP are given adequate information and are able to understand and receive the services for which they are eligible. The most important element is to ensure that a person with LEP can effectively communicate the relevant circumstances of his or her situation so that the appropriate service is provided.

The minimum steps that can be taken by a Provider to assure compliance with these guidelines include:

(a) assessment of the language needs of the population served;
(b) development and implementation of comprehensive written policies on language access;
(c) training staff to ensure they understand the policies and are capable of carrying them out; and
(d) regular monitoring of the language assistance program to ensure its effectiveness.

To demonstrate that these minimum steps have been taken, the Provider should document its efforts in these areas.

Failure to implement one or more of these measures will not necessarily be a violation of the Act. Compliance will be evaluated on a case-by-case basis taking into account the financial resources required to implement such measures. OCR will investigate any complaint it receives alleging non-compliance with Title VI. Therefore, Providers should respond quickly and effectively to anyone with LEP.

LANGUAGE ASSISTANCE OPTIONS

Successful implementation of an effective language assistance program includes:

- providing oral language assistance
- displaying a notice to persons with LEP in languages they understand of the right to free language assistance, and
- translation of certain written materials.

Based on the needs of the LEP population served, a Provider may choose which oral language assistance option is most suited to satisfying those needs. Options include:

- hiring a bilingual staff;
- hiring staff interpreters;
- using contract interpreters;
- using community volunteers for providing interpreter services; and
- establishing a telephone interpreter service line.

Whenever interpreter services are used, the Provider must ensure that the interpreter is trained and competent and that the patient’s right to privacy will be protected.

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In addition to oral language assistance, Providers must also make available written translation of documents routinely provided to patients in regularly encountered languages. Of particular importance, Providers must provide written translation of “vital” documents. These include such documents as:

- applications;
- consent forms;
- letters outlining conditions of participation;
- notices pertaining to a reduction, denial or termination of services or benefits;
• notices pertaining to the right to appeal such actions; and
• notices advising persons with LEP of the availability of free language assistance.  

The HHS guidelines provide examples of situations in which a Provider would be in compliance with its Title VI obligations with respect to written translations. For example:
1. The Provider translates all written materials, including vital documents, for each eligible LEP language group that constitutes 10% or 3,000, whichever is less, of the population to be served or likely to be directly affected by the Provider's program.
2. For LEP language groups that do not fall into the above, but constitute 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected, the Provider ensures that vital documents are translated into the appropriate non-English languages of such LEP persons. Translations of other documents, if needed, can be provided orally.

These examples are not intended to establish numerical thresholds for when a Provider must translate documents. To determine a particular Provider's obligation with respect to translation of written documents, OCR will review the totality of that Provider's circumstances. If it determines that written translation of certain documents would be so financially burdensome as to defeat the purpose of the program, or if there is an alternative to providing meaningful access, written translation will not be necessary for compliance with the Act.

It is important to note that many states have enacted legislation requiring language assistance to LEP persons in many service settings. In addition, the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance require language assistance in a variety of settings.

APPLICATION

How a covered entity applies the HHS guidelines to its operations will depend on the size and resources available to it as well as the population it serves. Where a physician office or practice group serves a localized or homogeneous population, assessment of the language needs of its patients, preparation of the necessary written translations and providing oral translators, will be simple tasks because patients will speak and understand only one or two languages. The effort and expense associated with implementing a language assistance program under this set of circumstances should be manageable.

The difficulty arises when the demographics of the service area begin to change or when patients from outside the area are referred to the practice for treatment. In these situations, the practice may encounter persons with LEP for which it is totally unprepared. Although it will be impossible to prevent these situations from occurring, the practice can take steps, such as the following, to reduce its exposure under the Act. The best way to ensure that LEP persons will be able to communicate their needs is to plan ahead. One way to plan ahead is to add "Primary Language" to the set of questions asked of new patients at the time the initial appointment is made. If time permits, the necessary written translations can be prepared and an oral translator scheduled to be available when the patient comes in. The local hospital is an excellent resource for locating medical interpreters. Medical interpreters are trained to explain medical terminology in a patient's native language and help to ensure that the diagnosis and treatment plan are explained properly. If the hospital does not have its own in-house interpreter service, it will most likely have access to one. Other sources include community groups or schools.

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The practice should, however, be prepared for situations in which the need for an interpreter is imminent. In these situations, the practice should be prepared to provide, at minimum, oral translation by telephone. Foreign language interpretation services, such as the Language Line, are available any time of day or night. 8 To use the service in the most effective manner, it is best to establish a client relationship with the service before it is needed so that lengthy billing arrangement discussions do not impede the delivery of medical care to the patient. Having an established account with a telephone interpretation service will also provide evidence that the practice has taken steps to comply with the Act. Even more significant, implementing these steps will help to ensure that a person with LEP will be able to effectively communicate his or her symptoms and condition so that the appropriate treatment can be provided.

PENALTIES FOR NON-COMPLIANCE

The Act prohibits both intentional discrimination and policies and practices that appear neutral but have a discriminatory effect. Thus, a Providers' practices regarding service to LEP persons need not be intentional to be considered discriminatory. OCR has the authority to exclude Providers from Federal assistance programs (including Medicaid) and to refer Providers to the Department of Justice for possible criminal sanction if it finds that Providers have not taken voluntary steps to come into compliance with the Act. Although OCR will focus its compliance review efforts on larger Providers, it has a legal obligation to investigate all complaints alleging violations of Title VI. This means that all Providers must take the necessary steps to ensure that persons with LEP have meaningful access to appropriate medical care.
Although exclusion from Federal programs will impact Providers, a more devastating consequence would result from charges of medical malpractice. Such claims can arise where the incorrect or inadequate treatment is provided, proper informed consent is not obtained or with breach of a patient's privacy rights in connection with failure to provide appropriate interpretation services. Recently a group of physicians was charged with providing inadequate medical care resulting from failure to provide interpreters to a patient whose primary language was Ramuri. As a member of the Tarahumara Indian tribe, the patient spoke some Spanish, but no English. During her 12-year commitment in a state mental facility, interpreters were not always provided, and at no time was a Ramuri interpreter provided. It was found that much of the patient's behavior that was being treated with psychotropic drugs resulted from cultural differences and language barriers. The Tenth Circuit Court of Appeals found that the patient had a right to be informed of the nature of medications administered to her and their side effects and rejected any claim that these requirements could be fulfilled by conducting the explanation in a language she could not understand.

In another recent case, physicians were charged for failure to obtain the informed consent of a hearing impaired patient whose "native" language was sign language. During the patient's 89-day hospital stay, a sign-language interpreter was never provided to adequately explain the treatment options available and their associated risks. The patient ultimately died as a result of the removal of a tracheal shunt, which was removed without explanation and without her permission.

While the U.S. District Court for the District of Maryland found there is no per se rule that language interpreters are necessary, the test is whether an interpreter was necessary to provide the individual with an equal opportunity to benefit from the services provided by the defendants to patients who do not suffer from language barriers. The Court found that the hospital and physicians in this case did not comply with the standard of care expected of them in that they failed to provide equal access, in the form of sign language interpreters, as part of the services provided.

Other recurring legal issues related to interpreter services involve the use of friends, family members, or minor children as interpreters and the need to ensure that interpreters are competent and will protect the patient's right to privacy. A Provider may expose itself to legal liability under the Act if it requires or encourages the use of friends, family members or children as interpreters. Use of such persons as interpreters may compromise the quality and effectiveness of the care provided due to patients' reluctance to reveal personal information critical to their condition and could result in a breach of confidentiality. In addition, such persons may not be sufficiently skilled in both languages, unskilled in interpretation and unfamiliar with specialized medical terminology.

Ensuring the competence of interpreters does not necessarily mean requiring that the person have a formal certification as an interpreter, but requires more than self-identification as bilingual. The person must be able to demonstrate proficiency in both English and the other language and the skills and ethics of interpreting, including confidentiality. Providers must ensure that the persons it provides as interpreters are trained and demonstrate competency as interpreters. For this reason, the most prudent approach may be to utilize telephone interpreter services or hire live interpreters.

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Use of such professional interpreters who are trained in the ethics of interpreting will reduce exposure to breaches of confidentiality. To avoid violating a patient's privacy rights, Providers should not rely on their non-professional staff as interpreters. For example, use of a bilingual security guard, janitor or receptionist may likely be seen as a violation of the LEP person's confidentiality and as a violation of the Act.

If the LEP person declines the offer of free interpretation services and elects to use a family member or friend, the Provider may use this person but is advised to document the offer and declination in the patient's chart. In addition, the Provider should explain the patient's right to confidentiality and obtain assurance that the interpreter will comply.

THE FUTURE

Since their release in August of 2000, the HHS guidelines have been surrounded by controversy. The principle complaint is the requirement to provide translation services at no cost to the patient. Although telephone translation services are a more cost-effective option than hiring a live translator, the cost often equals or exceeds the Medicaid reimbursement received. In addition, Providers must incur the costs of installing speakerphones in each examination room and obtaining written translations of documents in multiple languages. Without financial assistance to cover the significant costs of providing treatment to LEP persons, Providers may choose to withdraw from Medicaid programs. Such action would have the paradoxical result of reducing access to medical care for LEP persons.

To avoid this result, Providers, and particularly physicians, have asked for funds to implement the HHS guidelines.
Such funds would only be available through state Medicaid programs and would require a change in state law to add translators as a new class of eligible Provider. In addition, a new set of billing codes would be required to cover the broad range of translation services provided. Providers have also asked for the guidelines to be withdrawn. Although legislation has been introduced in the House of Representatives which would quash the guidelines, withdrawing the guidelines will not address the underlying need to provide proper treatment to patients with limited ability to speak and understand English. To avoid exposure to claims of malpractice and lack of informed consent, Providers are urged to implement policies that will assure that these patients can effectively communicate their symptoms so that proper treatment can be provided.

REFERENCES
2. Id. at 52,765.
3. Id. at 52,763.
6. Id.
7. Id. at 52,767.
8. The Language Line can be reached at (800) 874-9426.
11. H.R. 969, introduced by Bob Stump (R-AZ).