INDEMAND
Interpreting

When Patients Don't Speak English

A Guide to the Why & How of a Quality Language Access Program

InDemand Interpreting

The United States is a nation of immigrants, rich in diversity with more than 200 spoken languages.

This guide covers the various medical, legal and patient safety reasons for providing a quality language access program.

It includes relevant facts, figures and legal explanations, as well as some guidance that will help you create an outstanding language access plan.

Introduction

SIXTY MILLION PEOPLE, **1 OUT OF 5**, SPEAK A LANGUAGE OTHER THAN ENGLISH IN THEIR HOME. TWENTY-FIVE MILLION PEOPLE, ABOUT 9% OF THE POPULATION, SPEAK ENGLISH LESS THAN VERY WELL. THESE INDIVIDUALS ARE CONSIDERED LIMITED ENGLISH PROFICIENT OR LEP.

In addition to residents and visitors who require spoken language interpretation, 28 million people in the United States are born deaf or with hearing loss significant enough to require sign language (ASL) or other language assistance.

With numbers like these, it is no surprise 80% of hospitals report frequent encounters with ASL or LEP patients.

To provide quality care for the Deaf, hard of hearing and LEP patients, and in order to comply with the various legal and accreditation requirements, hospitals must develop comprehensive language access plans across the continuum of care.

This guide covers the various medical, legal and patient safety reasons for providing a quality language access program. It includes relevant facts, figures and legal explanations, as well as some guidance that will help you create an outstanding language access plan.

WHY: LEGAL REQUIREMENTS FOR LANGUAGE ACCESS

A variety of Federal, State and local laws require or encourage medical practitioners to provide language access to patients who need assistance.

CIVIL RIGHTS ACT, TITLE VI

In support of Title VI of the Civil Rights Act of 1964, Executive Order 13166 make the failure of recipients of Federal financial funding to provide language access a form of national origin discrimination. Any organization receiving any Federal financial assistance, including Medicare, Medicaid, and/or SCHIP, is subject to this law. It does not matter whether your hospital receives $1 or millions of dollars in Federal assistance – if you receive any assistance you must comply in all parts of your organization. The only exception is for Medicare Part B patient assistance.

Title VI requires that providers, as recipients of federal funds, take reasonable steps to ensure LEP persons have meaningful access to programs, and at no cost. Meaningful access means that communications between the LEP patient and the provider are effective in promoting mutual understanding.

The Department of Health and Human Services (DHHS) uses a 4-factor test to determine whether providers have a legal obligation and the extent of that obligation.

ONE

The number or proportion of LEP persons eligible to be served or likely to be encountered by the program

TWO

The frequency with which LEP individuals come in contact with the program

THREE

The nature and importance of the program, activity, or service provided by the program to people's lives

FOUR

The resources available to the grantee/recipient and costs

No person in the United States shall, on the ground 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.

Title VI– Civil Rights Act of 1964

On the last point – cost – recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets. In addition, reasonable steps may cease to be reasonable where the expense substantially exceed the benefits.

However, as DHHS points out, technology advances can reduce resource and cost issues. A facility, which may not be required to provide an in-person interpreter, may now be able to provide interpretive services through Video Remote Interpreting (VRI).

THE REQUIREMENTS OF TITLE VI APPLY TO BOTH ORAL LANGUAGE AND WRITTEN MATERIALS.

Patients do not have to be citizens to have language access rights under Title VI. The law applies to all persons, regardless of national origin or citizenship status.

THE AMERICAN DISABILITIES ACT OF 1990

The Americans with Disabilities Act of 1990 (ADA) requires that hospitals provide language access to those with disabilities and take steps to provide qualified interpreters, note takers and written materials for the deaf and hard of hearing.

While there is no absolute requirement that an interpreter be provided in every medical situation, the medical provider must prove they were able to achieve effective communication. If a deaf person requests an interpreter, a medical provider risks violating this law when an interpreter is not provided.

Technology advances that make it easier and more economical to provide ASL interpreting make it more difficult to argue this is an undue burden. The ADA applies to all hospital programs and services, such as emergency room care, inpatient and outpatient services, surgery, clinics, educational classes, and cafeteria and gift shop services. Whenever patients, their family members, companions, or members of the public are interacting with hospital staff, the hospital is obligated to provide effective communication.

When communicating with the Deaf, exchanging written notes or pointing to items for purchase can constitute effective communication for brief and relatively simple face-to-face conversations. Examples include a visitor's inquiry about a patient's room number or a purchase in the gift shop. Written forms or information sheets may provide effective communication in situations where there is little need for interactive communication, such as providing billing and insurance information or filling out admission forms and medical history inquiries.

For more complicated and interactive communications—like discussing symptoms, presenting a diagnosis and treatment options or group therapy sessions—it may be necessary to provide a qualified sign language interpreter or other interpreter.

The National Standards on Culturally and Linguistically Appropriate Services (CLAS) apply to all recipients of any Federal financial aid, and they are primarily directed at healthcare organizations. There are 14 standards, organized by themes. Standards 4-7, listed below, apply specifically to language access services.

CLAS STANDARDS

STANDARD 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.

STANDARD 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.

STANDARD 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).

STANDARD 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.

In short, the CLAS Standards specify that language assistance must be provided:

- **In a timely manner**
- **At no cost to the patient**
- **For both verbal and written communication**
- **By competent interpreters**

CLAS Standards provided by the Office of Minority Health

STATE LAWS

In addition to the Federal language access laws, all 50 states have their own language access requirements centered around: continuing education for health professionals, reimbursement for language services for Medicaid patients, and the certification of interpreters.

CALIFORNIA, AS YOU MIGHT EXPECT, HAS SOME OF THE MOST EXTENSIVE LAWS GOVERNING LANGUAGE ACCESS. IN PARTICULAR, TWO LAWS IN CALIFORNIA GOVERN LANGUAGE ACCESS RIGHTS.

The California Civil Rights Act

The California Civil Rights Act prohibits discrimination by agencies that receive state funds and requires them to provide equal access to benefits without regard to the beneficiary's race, color, national origin, or ethnic group identification among other factors.

The Bilingual Services Act (Act)91

The Bilingual Services Act (Act)91 requires local agencies to provide language access services to limited English-proficient speakers.

The National Health Law Program has a guide to California laws (http://bit.ly/language-health-law), or to learn more about language access laws by state go to: State language access laws (http://bit.ly/appeals-court-language).

WHY: REDUCING RISKS TO PATIENTS

Communication breakdowns cause nearly 3,000 unexpected patient deaths every year and the majority of these involve Limited English proficient patients. The chance of miscommunication increases dramatically with LEP patients and with miscommunication increases the risk of medical error. In fact, LEP patients suffer severe harm or death twice as often as English speaking patients.

THE NATIONAL HEALTH LAW PROGRAM

The National Health Law Program published a report detailing the harm caused by 35 malpractice cases involving LEP patients. In the study preventable LEP deaths occurred from:

- **Drug reactions**
- **Delayed treatment due to language barriers**
- **Misdiagnoses because of an inability to communicate symptoms**

In addition to the deaths, amputations and severe infections occurred because of miscommunications in symptoms and an inability to communicate discharge instructions properly. It was decided in court that there is a significant chance that these medical errors and deaths could have been prevented had certified interpreters been used.

The failure of the doctor and the facility to provide a professional medical interpreter was a substantial factor in causing [the patient's] death.

Statement of an expert witness in the Tran malpractice case

The report analyzed medical malpractice claims filed with a single carrier across four states, identifying 35 claims, or 2.5% of the total. These alone resulted in over $5 million in damages and legal fees.

HERE ARE SOME OF THE HIGHLIGHTS FROM THE STUDY:

- The cases resulted in many patients suffering death and irreparable harm. Two children and three adults died. In one case, the deceased child was used as an interpreter before suffering respiratory arrest. In another, the deceased child's 16- year-old sibling was used as the interpreter. One patient was rendered comatose, one underwent a leg amputation, and a child suffered major organ damage.

- In 32 of the 35 cases, the health care providers did not use competent interpreters. In 10 of 12 cases, family members or friends were used as interpreters, including minor children in two cases.

- Twelve of the claims involved the failure to translate important documents such as informed consent forms and discharge instructions.

- Nearly all the cases demonstrated poor documentation of a patient's limited English proficiency or the need for an interpreter (as well as documentation of other basic information).

- Some cases illustrated how both health care providers and lawyers presumed that the apparent concordance of race, ethnicity or language between patient and physician ensured effective communication. For example, one medical team incorrectly assumed that when the patient and physician were–or appeared to be – of the same ethnic background, they must have shared the same language.

- One of the more obvious deficiencies identified was that patients were asked to sign consent forms that were only available in English, despite the health care providers recognizing the responsible party spoke no or inadequate English. Also, medical personnel failed to note the patient's primary language or documented whether an interpreter was present. All of these practices should be standard practice when treating limited English proficiency patients.

- In a number of these malpractice cases family members or friends were used as interpreters with disastrous consequences. In one instance, a young girl suffered a severe concussion. While trying to interpret between her family and the hospital staff she went into respiratory arrest from a brain aneurism. The court decided in this case that had an interpreter been provided the girl and her family could have communicated with doctors more effectively and quickly and the aneurism may have been caught before it turned fatal.

- With family members, children, or other untrained interpreters, medical language is often misunderstood and they are unable to translate properly. Biases, impatience, misunderstandings and omissions can also get in the way and have potentially fatal consequences. The way to prevent sad stories such as this one is to provide certified interpreters to your patients.

WHY: ACCREDITATION AND THE JOINT COMMISSION

In early 2010, The Joint Commission and the Department of Health and Human Services released the Patient-Centered Communication Standards, which went into effect on July 1, 2012. These standards require healthcare organizations to provide to all patients, regardless of language, patient-centered communication. Organizations that fail to comply risk jeopardizing their accreditation.

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The Joint Commission and the Department of Health and Human Services

ACCREDITATIONS

In addition to The Joint Commission and CLAS Standards, National Committee for Quality Assurance (NCQA) and Magnet Status for Nurses all require language access to receive accreditation. If a medical facility fails to meet their standards they will be denied accreditation, which can affect Medicaid and Medicare reimbursement and the facility's ability to attract patients.

In order to receive accreditation, organizations have to bring their language access program above and beyond federal standards. To receive Joint Commission accreditation you must provide proof that interpreters are trained and fluent in both spoken English and their secondary language, and interpreters must prove cultural competency as well. For CLAS Standards accreditation you must demonstrate that you have staff training in cultural competency, and a formal and documented Language Access Plan.

WHY: AVOIDING MEDICAL MALPRACTICE SUITS

THE JOINT COMMISSION SAYS: IF DEATH OR SERIOUS INJURY OCCURS DUE TO A LANGUAGE BARRIER HEALTHCARE PROVIDERS CAN BE HELD RESPONSIBLE.

Failure to acquire informed consent, breach of duty to warn or breach of patient's privacy rights because communication was not provided in the proper language could all lead to medical malpractice lawsuits. And to make matters worse - most medical malpractice insurance plans do not cover language access claims. Not having language access for patients and their families places hospitals at significant financial risk.

Those costs [of medical malpractice] include legal fees; the loss of time from one's medical practice to defend oneself; the loss of reputation and patients; the reporting to the National Practitioner Data Bank, the fear of possible monetary loss; and the stress and distraction of litigation. The heightened risk of patient harm is also a critical and avoidable cost when providers fail to use competent interpreters.

National Health Law Program

WHY: IMPROVING THE QUALITY OF PATIENT CARE

Another reason to provide quality language access is to improve the quality of patient care. According to recent studies, LEP patients associate the quality of interpreter services with the overall quality of care. Medical facilities with certified interpreters scored higher in patient satisfaction surveys than those without certified interpreters.

Research also shows that Hispanic patients choose hospitals based on the quality of their language assistance programs. LEP patients that receive interpretive services have more doctor's appointments and prescriptions and use preventative services more often than those not receiving interpretive services. By ensuring your facility has a language access program you not only improve your quality scores, but can increase the number of patients entrusting themselves to your care.

There is no room for error when it comes to communication in healthcare: misdiagnosis, serious drug interactions, premature death, and overall patient health lies in the balance.

Luckily there are many different language access solutions available to help curtail this problem. Between onsite interpreters, Video Remote Interpreting and telephone interpreting you can provide great language access services, ensure compliance with both federal and state laws, reduce the risk to your patients and your organization and dramatically increase the quality of care.

[With VRI Interpreting Services] There has been a great increase in both patient satisfaction and staff satisfaction. The patients are happy to speak in their own language, and thrilled that they no longer have to wait for an interpreter to become available. With the wide camera angle the interpreter can easily hear and see the interaction between the doctor, nurse, and patient and is able to translate everything that takes place increasing their effectiveness and minimizing the margin of error.

Central Washington Hospital

WHY: CREATING A QUALITY LANGUAGE ACCESS PLAN

DEVELOPING A QUALITY LANGUAGE ACCESS PLAN INVOLVES AT LEAST FOUR STEPS:

STEP 1: ASSESSMENT

Perform a thorough self-assessment to determine what types of contact your organization has with Deaf, hearing impaired and LEP populations. Identify the specific needs for language access and the resources currently available for providing that language access.

STEP 2: POLICY AND PROCEDURES

Develop comprehensive policies and procedures for meeting the language access needs of the population served. The policies set forth standards, operating principles, and guidelines that govern the delivery of language appropriate services. The procedures are the "how to" for staff members. They specify for staff the steps to follow to provide language services, gather data, and deliver services to LEP individuals.

STEP 3: IMPLEMENTATION

Once the policies and procedures are decided upon, they must be implemented. Typically this involves a written implementation plan that sets deadlines, priorities and responsibilities, plus allocation of resources to deliver the language access plan.

STEP 4: EVALUATION

Periodic re-assessment and evaluation are an important part of any quality language access plan. Evaluations determine whether the policies and procedures have been effectively implemented and whether they are being followed.

Periodic reassessment and evaluation are necessary to recognize and respond to changes in the patient population and changing patient needs.

EFFECTIVE LANGUAGE ACCESS SELF-ASSESSMENT

Diagram courtesy of the Department of Justice guide to Language Access Assessment (http://bit.ly/language-planning). This website contains a sample self-assessment questionnaire that can be used as a basis for an initial assessment of needs.

HOW: Language Access Plan

AN EFFECTIVE LANGUAGE ACCESS PLAN IS NECESSARY FOR MORE REASONS THAN SIMPLE COMPLIANCE. IT IS ESSENTIAL TO PROVIDE HIGH QUALITY CARE AND ASSURE THE SAFETY AND PROTECTION OF BOTH YOUR PATIENTS AND STAFF.

Luckily there are many resources available to create quality Language Access Plans and assess your current language access needs. InDemand Interpreting offers free Language Access Audits to evaluate your current program. We will help you adopt state-of-the-art language services that will utilize multiple modes of interpretation, provide effective language access and maximize financial savings.

To get your free assessment contact InDemand Interpreting:

Web: www.indemandinterpreting.com
Email: info@indemandinterpreting.com
Call: 1-877-899-3824

Additional Resources

Here are some resources that may be helpful for you in creating your Language Access Plan.

Title VI Language access is federally mandated by Title VI of the Civil Rights Act of 1964.
http://bit.ly/title-vi

CLAS Standards The National Standards on Culturally and Linguistically Appropriate Services
http://bit.ly/clas-standards

American Disabilities Act
Requirements for providing ASL services to those with disabilities.
http://bit.ly/ada-asl

State Language Access Laws
Different state laws for language access.
http://bit.ly/state-access-laws

Joint Commission
Resources for language access plans and applying for accreditation with the Joint Commission.
http://www.jointcommission.org

National Health Law Study
Study conducted by the National Health Law Program through the School of Public Health at the University of California, Berkeley. Study details 35 medical malpractice cases and their ties to language access.
http://bit.ly/national-health-law

Video Remote Interpreting
On-Demand Video Remote Interpreting services provide medically certified interpreters that comply with both federal and state language access laws.
http://www.indemandinterpreting.com