



California Healthcare Interpreters Association

Supporting and promoting the healthcare interpreting profession by setting standards of excellence that ensures equal access to quality medical care for all people.

Monday, April 1, 2002

c/o Deena Jang
Office for Civil Rights, Room 506F,
U.S. Department of Health and Human Services,
200 Independence Avenue, SW.,
Washington, DC 20201,
Attention: LEP Comments

**RE: 4968 Federal Register / Vol. 67, No. 22 / Friday, February 1, 2002 / Notices
DHHS Office for Civil Rights; Title VI of the Civil Rights Act of 1964; Policy
Guidance on the Prohibition Against National Origin Discrimination as It Affects
Persons With Limited English Proficiency**

Dear Deena,

The California Healthcare Interpreters Association (CHIA) would like to respond to this re-posting of the OCR policy guidance on Title VI's prohibition against national origin discrimination as it affects limited English proficient (LEP) persons. CHIA submitted a letter to Carole Brown, of your office, dated October 24, 2000, when the Policy Guidance was first posted on the Federal Register, and we request that you review the comments that we submitted at that time. CHIA is a 501 (c)(3) organization with a mission of representing the healthcare interpreting profession, and represents 246 healthcare interpreters and 20 organizations, including hospitals, training organizations, and interpreter agencies, in California. CHIA's mission is to facilitate the development of the medical interpreting profession, through standards of practice and professional education for interpreters and providers. CHIA's website, <http://www.CHIA.ws>, has more information about our organization.

CHIA strongly supports OCR's LEP Guidance and applauds OCR's efforts to provide much needed clarifying provisions for health care and social service providers pursuant to Title VI of the Civil Rights Act of 1964. We view OCR's endeavor as critically important to ensure that limited English proficient (LEP) persons have fair and equal access to the health care and social services to which they are entitled. The HHS LEP Guidance, Executive Order No. 13166, and the recently re-published Department of Justice LEP Guidance, establish the key principle that all federal services – whether by a federal agency or a federal fund recipient -- must be accessible to every LEP person. As one of

the first agencies to issue (and re-issue) its LEP Guidance, OCR serves as an excellent model for other agencies as they develop their own guidance. We also urge HHS to continue to take a leadership role in developing an exemplary policy and practice for serving LEP populations in its administration of the Medicare program

CHIA believes that any potential modifications to the Guidance be based on a thorough review of the literature in the area of language barriers and interpreting in healthcare, and should reflect the best practices and ethical principles developed by OCR in consultation with the healthcare interpreting experts of the National Council on Interpreting in Health Care (NCIHC), Massachusetts Medical Interpreter Association (MMIA), CHIA, and other state organizations related to medical interpreting. The common practice some practitioners may wish to continue, of using minor children or family members as interpreters, is demonstrably unsafe and ethically inappropriate (as the American Psychological Association has also identified in its ethical standards). We strongly urge OCR to maintain the warning in the Guidance about using children and family members in this way.

We would like to respond to the questions contained in the re-posting:

(1) Have persons with limited English proficiency seeking health care or social services benefited as a result of the guidance? If so, what have been the benefits?

Answer: Yes, absolutely! There is no doubt that language access and the medical interpreting profession has had a major boost as a result of the Guidance. The Guidance has made explicit and publicized the legal linkages between the linguistic accessibility of healthcare and Title VI requirements for healthcare practitioners. The existence of the OCR policy guidance has led to greater publicity and awareness of healthcare interpreter issues among providers – even if the medical profession expresses this negatively as an unfunded mandate. The OCR Guidance has had a relatively direct impact on our organization. CHIA would not have nearly as many members, both individual and organizational, if there were no legal mandate for “qualified” interpreters.

It is also evident that the intent of the Guidance is to provide safe, accurate and ethical communication for LEP patients and their English-speaking providers where this is required, in accord with the Civil Rights Act of 1964 as refined by the 1972 Supreme Court case *Lao vs. Nichols*. Part of my dissertation study¹ demonstrated that the policy environment for healthcare interpreter services had a significant impact in facilitating the change from ad-hoc interpreting to a system of trained professional interpreters for specific health organizations in Seattle, Chicago, Boston, Worcester and Oakland. As the health system becomes ever more resource poor, the OCR Policy Guidance has also had a

¹ Agger-Gupta, Niels (2001). *From "making do" to established service, the development of health care interpreter services in Canada and the United States of America: A grounded theory study of health organization change and the growth of a new profession* (PhD dissertation). The Fielding Graduate Institute / UMI

role reinforcing the necessity of maintaining interpreters in the health systems that do have interpreters but are looking for areas from which to recover funds.

(2) Have persons with limited English proficiency faced challenges or problems in accessing health care or social services following issuance of the guidance? If so, what have been the challenges or problems? Please be specific about your experiences.

The experiences of CHIA members, across California, which we heard in a series of focus groups on the draft CHIA standards last November, were unequivocal in the litany of stories about LEP patients who continue to face dramatic challenges in accessing health care.

The research literature, most recently identified in the **Institute of Medicine** report on Inequality in Healthcare, is clear that communication barriers in health care are real problems and is a demonstration of the racial/ethnic and linguistic disparities in healthcare. One finding in the IOM report, 5-1, is relevant to this discussion: *”5-1: As a result of the increasing linguistic diversity in the United States, professional interpreter services are increasingly needed to assist LEP patients in healthcare settings.”* One recommendation is critical: *“5-9: Support the use of interpreter services where community need exists. Professional interpreter services should be the standard where language discordance poses a barrier to care. Greater resources should be made available by payors to provide coverage for interpreter services for LEP patients...”*²

Here are other recent key studies looking at language barriers in healthcare and interpreters: A recently released **Commonwealth Fund** study³ demonstrates that one in three Hispanics and one in four Asian Americans have problems communicating with their doctor, and that Asian Americans are least likely to feel that their doctor understands their background, to have confidence in their doctor, and to be as involved in decision-making as they would like. They are also the least likely to receive preventive services.

A study by **Weinick and Krause** found that children whose parents spoke English were 2.6 times as likely to have a usual source of care as those who spoke Spanish⁴. This study found that language overrides Hispanic ethnicity as predictor: English-speaking Hispanics were no different from whites in having a usual source of care.

² Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care. Institutes of Medicine report: March 2002. pp.15-152.

³ Collins, K. S., Hughes, D.L., et. al. (2002). Diverse communities, common concerns: assessing health care quality for minority Americans: Findings from the Commonwealth Fund 2001 Health Care Quality Survey. (March 2002) (www.cmf.org)

⁴ Weinick RM, Krauss NA. Racial/ethnic differences in children’s access to care. Am J Pub Health 2000. 90:1771-4.

A study by **Crane** found that Spanish-speaking patients discharged from the Emergency Room (ER) were less likely than English-speakers to understand their diagnoses, prescribed medications, special instructions, and plans for follow-up care, and were also significantly less likely to find written instructions helpful and to feel that everything was explained adequately⁵.

In a study by **Baker, Hayes and Fortier**, comparing pre-visit interviews with one-week follow-up interview assessing Spanish-speaking patient satisfaction with patient-provider relationships at the UCLA ER, patients who did not receive an interpreter when they felt one was needed were less satisfied with the care they received, on measures of provider friendliness, respectfulness, concern, and time spent with provider⁶.

In a follow-up study, **Baker and Sarver** found that patients who did not get an interpreter when they felt one should have been called, or where an ad-hoc interpreter was used, were significantly more likely to be discharged without a follow-up appointment⁷.

In a survey of patients at a Boston ER with a post-visit follow up telephone interview, **Carrasquillo** and associates found ‘Non-English-speakers’ significantly less satisfied with care in the ER, less willing to return to the same ER, and reported more overall problems with care, communication, & testing⁸.

In a just released survey study of 4,161 uninsured respondents at safety net hospitals in 15 cities, **Andrulis** and associates found that adults who needed but did not get an interpreter had the most negative perceptions about their health experiences, were least likely to report satisfaction with staff, were most likely to say they did not understand medication instructions, were most likely to report not being asked if they needed financial assistance, and were much more likely to say they would not seek care at that facility in future because of their debt, when compared with patients who needed and were able to get an interpreter, and with a group of English-speaking patients⁹.

In a 1988 chart review study in a NY academic outpatient clinic looking at the effects of language concordance between adult Spanish-speaking patients with asthma and English-

⁵ Crane JA. Patient comprehension of doctor-patient communication on discharge from the emergency department. *J Emerg Med* 1997;15:1-7.

⁶ Baker DW, Hayes R, Fortier JP. Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Med Care* 1998; 36: 1461-1470.

⁷ Sarver J, Baker DW. Effect of language barriers on follow-up appointments after an emergency department visit. *JGIM* 2000; 15: 256-264.

⁸ Carrasquillo O, Orav EJ, Brennan TA, Burstin HR. Impact of language barriers on patient satisfaction in an emergency department. *JGIM* 1999; 14: 82-87.

⁹ Andrulis, D. (SUNY), Goodman, N. (Cornell), Pryor, C. (Brandeis) (2002). What a Difference an interpreter can make: Health care experiences of uninsured with limited English proficiency. (Report March 2002)

speaking providers over an 8-year period, **Manson** found that established Spanish-speaking patients were more likely to miss an appointment, and tended to be less adherent to medication regimen if they had a physician who did not speak Spanish¹⁰.

In a recent historical cohort study comparing LEP Spanish/Portuguese-speaking patients with non-LEP patients before and after institution of comprehensive interpreter services, **Jacobs** and her team at Harvard Pilgrim Health Care found a greater increase in use of colo-rectal exams, and flu shots in LEP group, and significantly greater increase in utilization of preventive services - office visits, prescriptions written and filled, following the implementation of professional interpreter services¹¹.

A retrospective review study of the Boston Medical Center ER comparing English-speaking, interpreted, and non-interpreted patients for volume & intensity of ER services utilization & charge patterns in 30 day follow-up, **Bernstein** and associates showed that patients who received a trained, professional interpreter had the lowest costs after 30 days compared even with English-speakers, while patients who did not receive an interpreter spent the least time in the ER, but had the fewest tests & procedures, and received the fewest prescriptions, but returned to ER more frequently and followed-up in clinic less frequently than interpreted patients¹².

In a survey of physicians in a Chicago pediatric ER, **Hampers** and associates found that 24% of “language barrier present” visits did not use any type of interpreter, even ad-hoc¹³. A chart review was performed and charges tallied, finding that patients with language barrier had higher charges (\$38) and longer stays (20 min).

It is evident from the research that the lack of trained interpreters contributes to a lack of access and poor health outcomes for LEP patients, while the use of trained interpreters contributes to reduced costs and improved health outcomes for LEP patients. The OCR Policy Guidance is a significant policy document underpinning the legal need for qualified interpreters.

(4) Are there areas of the guidance that you believe need to be clarified or modified? If so, please explain what areas, why the area(s) need clarification or modification, and provide any suggestions for clarification or modification.

One area that could be made more explicit is a **definition of “qualified” interpreter**. It is important to cite or refer to the **Massachusetts Medical Interpreter Standards of**

¹⁰ Manson A.. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. Med Care 1988; 26: 1119-1128.

¹¹ Jacobs EA, et.al.. Impact of interpreter services on delivery of health care to Limited-English-proficient patients. JGIM 2001;16:468-74.

¹² Bernstein J, et. al.. Trained medical interpreters in the ED: effects on services, subsequent charges, and follow-up. Abstract, presented at 2000 annual meeting of Society for Academic Emergency Medicine.

¹³ Hampers LC, et. al.. Language barriers and resources utilization in a pediatric emergency department. Peds 1999; 103(6): 1253-1256.

Practice¹⁴, and the **CHIA California Standards for Healthcare Interpreters**¹⁵, as examples of what is meant by the term, “qualified.” The lack of such definition has resulted in a patchwork of sometimes-conflicting standards, a lack of any clear training requirements for interpreters, no recognized professional certification (unlike court interpreters) and a resulting poor compensation for healthcare interpreter services attributable to the lack of state reimbursement for interpreter services, making it difficult to keep skilled interpreters in the profession. The lack of any specific definition allows providers to say that since there is no set standard for interpreters, there is therefore no clear direction to employ professional, trained interpreters.

(5) Has the guidance been effective in identifying reasonable ways of providing services to individuals with limited English proficiency?

(6) What technical assistance from the Office for Civil Rights (OCR) and other components of HHS would be most helpful to recipients/covered entities?

The approach taken by OCR, that of facilitating understanding and a four-fold approach for providers (developing policy, assessing need, implementing service and monitoring), is an approach designed to reduce adversarial relations with providers already stressed out because of low Medi-Cal/Medicaid and Medicare reimbursements. Strong internal recommendations need to be forthcoming from OCR that this approach in the healthcare arena needs to be balanced with the need for federal reimbursement for the majority of states which do not yet have such assistance.

(7) In providing services to persons with limited English proficiency, what costs have health care ...providers incurred in providing translation, interpreter, or other language services? what costs are anticipated?

The question of costs is a serious problem for medical interpreting. From the perspective of a health economist there are various types of economic evaluations. According to **Drummond et. al.**¹⁶, there are 4 different types of economic evaluation: **cost-minimization** analysis; **cost-effectiveness** analysis; **cost-benefit** analysis; and **cost-utility** analysis. Each of these approaches considers different ingredients in the equations they are asking.

A **cost-minimization** comparison can only be made if one is simply trying to find the least expensive approach between two equally successful approaches. This is not the case with trained compared with untrained interpreters. This may be the opinion of some physicians and the AMA with regard to comparing what most physicians usually do about language questions (ad-hoc interpreters), but I believe that the **Jacobs et. al.** study and the **Bernstein et. al.** study, have provided the basis for an affirmative provisional

¹⁴ See the MMIA website, <http://www.mmia.org>

¹⁵ See the CHIA website for a copy of the draft standards, <http://www.CHIA.ws>

¹⁶ Drummond et. al. (Methods for the Economic Evaluation of Health Care Programmes, 2nd Ed.),

answer to the question of whether trained interpreters make a difference to health outcomes (see earlier footnotes).

If a study can include overall outcomes, including life-years gained by the patient, or quality of life arguments, one could study **cost-effectiveness**. Fortunately or unfortunately, there is no one single, common effect (other than potentially worse patient health outcomes) from using any given type of interpreter. **Drummond** et. al say that the results of such comparisons between alternate programs or courses of action in a cost-effectiveness study typically have one single, common effect and are stated either in terms of cost per unit of effect, or in terms of effects per unit of cost (life-years gained per dollar spent). It is not easy to predict a common effect resulting from the use of various types of interpreters. This would require the health system participating in such a study to have tracked the language spoken by their patient population prior to taking action by employing interpreters to remedy the lack of language concurrence between patient and physician. This is a major failing of most health organizations without interpreters, both in California and across the US, since this information is typically not recorded. The NCQA HEDIS 3.0 data set does request HMOs to track such information, and if this is heeded, will make such comparisons easier in the future. An attempt to determine the costs of EO13166 in the healthcare field, as the Office of Management and Budget attempted to do this past spring, was a virtually impossible request at the present time. Without the patient language data, the potential size of the language service need is not easily estimated. Further, should such costs be measured by the cost of professional trained and qualified medical interpreters based on what they currently earn, or on what they might earn if their salaries were on par with the salaries of court interpreters?

Drummond et.al. suggest that studies attempting to measure both the costs and the consequences of alternatives in monetary outcomes in dollars are doing a **cost-benefit analysis**. Results are stated "either in the form of a ratio of dollar costs to dollar benefits or as a single sum - possibly negative - representing the net benefit or loss of one program over another." The implicit assumption of such an analysis is that each approach is compared to a "do-nothing" approach with no costs and no benefits, or at least no costs and the perception of some benefits, in the example of family/friend ad hoc interpreters. Of course, the costs related to the patient's poor health outcome and its effect on their family, their employer, their community, and to society as a whole, need to be included in this equation, not just the direct costs to the physician, but these costs are typically left out.

If dollar terms are not appropriate, then health economists talk about **cost utility**, referring to the preferences individuals or society may have regarding specific health outcomes. All of the economic evaluations are done in relation to the willingness to pay - either by the patient, their employer, physician, health system, insurer, or government. In the case of interpreters related to Medicaid/Medicare, patients are exempted from inclusion in the payer group. However, **if the other payers do not see the value-added of a trained interpreter, or the value-deducted/ risk enhancement of no or poor**

interpreters, the utility remains low no matter how urgent patient advocates may think this issue is.

The OCR Policy Guidance plays a critical role as an essential context for health organizations to rationalize committing to spending the dollars required to contract with professional interpreters or to establish an interpreter service. But such a commitment is a real challenge when it is not clear what the scope of interpreter costs is likely to be. Providers typically see the opening gulf of scarce healthcare dollars for interpreters as an unending source of costs and little else. Other essential pre-conditions, in addition to the OCR Policy Guidance, which I identified in my dissertation study, include CEO buy-in; physician and administrator awareness of the risks of doing without tested and trained interpreters; executive champions for professional interpreters; some magical threshold number of patients showing up at the door for whom English is a problem in order to provide the necessary experience of what no or poor interpretation means; community advocacy groups complaining on a regular basis to health organization management about the lack of trained interpreters; a history of court cases focusing on legal liability of the provider for adequate communication with their patient; and then, unfortunately, some critical incident which has taken place at the site directly as a result of a lack of interpreters: a "trouble case" as Joe Kaufert calls it, where bad or no interpreting led to tragic outcomes¹⁷.

(8) Some may assert that the guidance has materially assisted in achieving the goal of access to health or social services by limited English proficient individuals. Others may assert that the guidance has unintentionally had the opposite effect. Is there actual experience to support either view? Please describe.

Please see the section on the research literature. The provision of trained interpreters unequivocally assists in providing health care access to LEP populations. The continued use of ad-hoc interpreters, although the past practice of most providers, contributes to an inaccessible and dangerous healthcare system for LEP populations. The Policy Guidance on Title VI of the Civil Rights Act of 1964 is clearly part of the legal and legislative context of why trained interpreters are required by healthcare providers, therefore materially assisting in achieving the goal of healthcare access by LEP populations.

(9) Based on your experience, does the guidance and/or OCR's application of the guidance in practice, strike the right balance with respect to the factors enunciated in the Department of Justice's October 26, 2001 memorandum: (1) The number or proportion of limited English proficient persons, (2) the frequency of contact with the program, (3) the nature and importance of the program, and (4) the resources available? In particular, in considering the resources available, does the guidance and/or OCR's application of the guidance adequately factor in the costs of providing translation,

¹⁷ Kaufert, Joseph M., Koolage, W. W., Kaufert, P. L., O'Neil John D. (1984). The use of "trouble case" examples in teaching the impact of sociocultural and political factors in clinical communication. *Medical Anthropology*, 8: 36-45.

interpreter or other language services to limited English proficient individuals, as well as the resources available to the recipient/covered entity?

I would like to reiterate a portion of CHIA’s October 2000 letter to OCR:

“We also suggest that your office continue to work with the Health Care Financing Administration (now Centers for Medicaid/Medicare Financing), state departments of health, and federal legislators, to ensure that there are targeted and cost-shared sources of additional funding to providers to, at least in part, pay for the costs of providing trained, professional interpreters.” Our view has not changed on this. In the absence of additional funds, OCR’s policy of application of the Policy Guidance is the best that can be done under the circumstances, and appropriately helps providers to understand and take action to meet their responsibilities.

CHIA, together with the National Council for Interpreting in Health Care (NCIHC) and with other state associations of healthcare interpreters, is committed to developing a healthcare profession with standards, professional accreditation, and appropriate compensation. CHIA wishes OCR continued success.

Best wishes,

A handwritten signature in black ink that reads "Niels Agger Gupta". The signature is written in a cursive, flowing style.

Niels Agger Gupta, PhD.
CHIA Executive Director
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