

The Georgia Hospital Accountability Project

Language access at hospitals

Issue brief – June 2011

More than one million Georgians – about 12 percent – do not speak English at home.ⁱ These Georgians may be Limited English Proficient (LEP), meaning they cannot speak, read, write or understand the English language in a manner that allows them to effectively interact with health care providers. Without a doubt, effective communication between patients and health care providers is vital in ensuring access to appropriate, affordable care that leads to better health. Unfortunately, many of these patients experience a breakdown in communication that can lead to greater health issues.

In a survey of approximately 290 Spanish-speaking uninsured and underinsured metropolitan Atlanta consumers in 2009, approximately 72 percent said they felt language was a barrier when attempting to access both care and financial assistance at their hospital, and 25 percent said they were not given financial information in their native language.

For example, a 2007 Commonwealth Fund study found that LEP hospital patients are much more likely than their English-proficient counterparts to experience adverse events that result in harm, and the severity of that harm is often greater.ⁱⁱ Problems in communicating were a primary reason for these adverse events. Furthermore, in a national study of more than 2,700 limited English-speaking patients, researchers found that language barriers between patients and health care providers result in longer hospital stays, more medical errors and lower patient satisfaction.ⁱⁱⁱ

Patient access to adequate translation and interpretation services can boost a hospital's bottom line as well. Effective communication means fewer duplicated tests and examinations the patient, hospital and, when present, insurer bear. Discharge instructions, including prescription drug directions, are more likely to be followed, thereby decreasing the chance of a preventable readmission and the cost associated with that readmission.

While there is no substitute for a doctor and her patient speaking the same language, numerous studies show patients fare much better when professional medical interpretation services are provided, as opposed written translation or ad hoc interpretation services, such as the use of a volunteer, friend or family member. While well-

meaning, volunteers, friends and family members may not understand the complexities of medical jargon, instructions and diagnoses necessary for proper care and follow-up treatment.

Additionally, it isn't always easy to identify LEP consumers; many individuals may know enough English to manage basic life skills but may not speak, read, or comprehend English well enough to understand the more complicated concepts they may encounter when receiving healthcare. When a person does speak the same language and is of the same culture as the clinician who delivers the care, and does not ask questions regarding their care, the clinician may presume the patient understands the diagnosis and recommended treatment.

Interpretation is oral communication such that the message is spoken in the native language so that the patient responds to it as if he or she had heard it in the original. Translation, on the other hand, is written communication. Of the two, interpretation is considered more effective.

Both state and federal law compel providers to provide limited English proficiency patients with adequate language assistance. Specifically, there are three particular regulations that address what a hospital must do for its LEP patients, with one particular provision providing the most protection for those who do not speak English well.

Title VI of the Civil Rights Act

Held within the landmark 1964 Civil Rights Act, Title VI is an executive order signed in 2000 that requires hospitals and providers receiving certain federal funds, such as Medicaid and Medicare reimbursements funds, to take reasonable steps to ensure that LEP individuals are able to have meaningful access to vital programs and services.^{iv} Title VI is the most comprehensive of laws discussed in this paper in regards to language access in health care settings.

Because of their size, available programs and location, hospitals and providers will encounter varying numbers of those who are language limited. Because of this, they have different obligations to ensure access to their programs. For example, obligations for organizations that serve these individuals on a daily basis are different than for those who serve limited English individuals on a more sporadic basis.

Hospitals and other health providers must determine their obligation to provide translation services based on five factors: how many individuals may be served by the program; how often these individuals come into contact with the program; the nature and importance of the program, activity or service; and, the resources available to the facility and the costs of interpretation/translation services. When a facility is obligated to provide an interpreter, it must notify its patients of the option to be provided with an interpreter without charge. If the person prefers, a family member or friend can act as the interpreter. No one can be forced to provide their own interpreter.

Patient Protection and Affordable Care Act

While no provision within the 2010 Patient Protection and Affordable Care Act speaks directly to the offering of interpretation and translation services to patients, hospitals and some other providers are required to include the needs of LEP consumers when designing programs. For example, all private nonprofit hospitals are required to conduct a community health needs assessment every three years, which should establish the health needs of vulnerable populations in a hospital's community. Hospitals are to then establish a game plan to address those documented needs, which can include increased access to interpretation services.

Several organizations have asked for further comment and clarifications on provisions relating to LEP patients and the Affordable Care Act, including US Health and Human Services Secretary Kathy Sebelius. Her office issued a request for comments regarding development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.

Indigent Care Trust Fund

Most Georgia hospitals receive funds from the Indigent Care Trust Fund (ICTF), a 20-year-old program that expands Medicaid eligibility and services, supports rural health care facilities that serve the medically indigent, and funds primary health care programs for medically indigent Georgians. Georgia's Disproportionate Share Hospital (DSH) program is funded through the ICTF, which provides funding to hospitals and other health care providers to help offset financial losses on uninsured, underinsured and low-income individuals, as defined by the state plan in accordance with federal regulations. Approximately 145 private and public hospitals participated in Georgia's DSH program. Participating hospitals include both rural and urban facilities.

In exchange for receiving that money, participating hospitals must, among other things, post signage in languages appropriate for their patient base, particularly the top four languages of patients served at their hospitals as well as provide materials related to financial assistance in relevant languages.

In a review of facilities, though, only a small handful actually provided information in varying languages. For example, in a survey of approximately 95 websites for Georgia hospitals participating in the ICTF, only about one-sixth had any information on available financial assistance programs in a language other than English. No Georgia hospital website provides information on available assistance programs – or any hospital program – in a language other than English or Spanish.

Other provisions

The Office of Minority Health within Health and Human Services has issued National Standards on Culturally and Linguistically Appropriate Services in Health Care, or CLAS.^v These 14 provisions directly address cultural and language services, and are similar to Title VI obligations with some expansions, including standard seven, which states that 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.

The importance of cultural competency

It isn't just enough for a hospital to have on-hand translated materials. Differences in perceptions of the patient's health problem, different expectations of medicine and different communication styles can all contribute to gap in communication and adequate care. Hospitals can work to ensure that cultural competency is included in their plan for addressing populations from varying backgrounds and cultures.

Cultural competence is the set of attitudes, skills, behaviors, and policies that enable organizations to work effectively in these cross-cultural situations.

Cultural competency can also help a hospital better understand health-related beliefs, attitudes, practices and communication patterns of patients so it can then improve services, strengthen programs, increase community participation, and close gaps in health status due to disparities.

Creating a good program for patients

Hospitals can take certain steps to effectively create and implement a medical interpretation and translation program. To start, it should identify individuals who need language assistance, which can be done through a well-designed community needs assessment, which is required by law to be conducted every three years. These assessments can help the hospital not only better understand how many consumers in its area may need language assistance, but also what additional programs or resources should be available to these consumers.

A good community needs assessment should involve representative community members in order to best understand the needs of its LEP individuals. These representatives could be from official organizations that represent certain populations, such as the Atlanta-based Center for Pan Asian Community Services, or could include individuals who can well-represent their communities, including pastors from churches with a high ethnic population.

Once need is established, the hospital or provider should then determine how staff can best help LEP patients. If demand is great, the organization should consider staffing an interpreter and/or translator. If demand is small, the use of an interpreter telephone line or contract translation services may make more sense.

At a minimum, vital documents such as financial assistance forms and admission sheets should be translated into prevalent languages and be on hand for distribution. Certain cost-saving measures can be taken such as sharing language assistance materials among facilities, training bilingual staff to act as interpreters, standardizing documents to reduce translation needs, using qualified translators to ensure that documents are accurate, and centralizing translation services to achieve economies of scale.

After a hospital determines which plan is best for its patients, it should then establish a protocol that is effectively communicated to all staff, and reinforced through regular workshops and employee oversight. The hospital should also ensure that their patients and the community are aware that interpretation and translation services are available.

Finally, the hospital should monitor and update its translation, interpretation and outreach plan regularly to make sure all patients are receiving the crucial information they need in order to get the best, appropriate and affordable care possible.

It is important to note that the ACA, Title VI and ICTF only address language barriers; health literacy, illiteracy, blindness and deafness are not covered through those regulations. Effective communication in any language requires an understanding of the literacy levels of the eligible populations. When a LEP individual also has a limited understanding of health matters or cannot read, access to care is further complicated. Hospitals should take appropriate measures to ensure patients are able to understand and/or read medical instructions.

Recommendations

- **Compliance with existing laws:** Hospitals and other providers should ensure they act in accordance with existing regulations to best serve their patients and themselves. This includes the translation of all key written materials and signage indicating the availability of financial assistance and other key hospital programs and policies.
- **Education on staff of language access policies and programs:** Hospital and provider staff that work with patient accounts should be made familiar with policies, laws and obligations the hospital has to the patient

in regards to translation and interpretation services. Hospitals should also ensure that staff who may greet a patient – such as those at an information desk – should be well-equipped to address the language needs of a patient by either being bi- or multilingual themselves or by having immediate access to adequate language services.

- Cultural competency training: Hospitals and providers should require relevant staff to undergo cultural competency training as to best equip their staff with the necessary skills and resources to adequately address the needs of LEP patients.
- Thoughtful community health needs assessments: Private nonprofit hospitals should make efforts to include LEP populations in their tri-annual community health needs assessments, and develop appropriate programs to address that population’s particular and unique needs.
- Oversight: The appropriate federal and state entities should regularly assess hospital and/or provider compliance with existing regulations, and impose the appropriate penalties for noncompliance. Increased oversight of state and federal programs is crucial to ensure compliance with existing laws.

Resources

There are several resources available for hospitals attempting to determine their interpretation and translation needs.

- American FactFinder on the US Census Bureau website. On this site, an organization can obtain access to tables providing information on the language spoken at home by ability to speak English in their geographic area. Unlike most census data which is updated every ten years, this information is updated annually, and provides the most detailed language data available.
- The *Language Assistance Self-Assessment and Planning Tool*, which is located on the Department of Justice’s website,^{vi} directs organizations to sources of demographic information, such as the Census Bureau, Department of Education or community-based organizations in the geographic area. The tool also provides questions an organization can ask of itself to determine whether it has the information necessary to answer the four community needs assessment components to determining Title VI obligations.
- *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations* outlines in detail the steps involved in assessing language needs of the community, assessing the organization’s capacity, planning and implementing services and evaluating the quality of LEP services. This tool is located on the website of the Office of Minority Health.^{vii}

For more information on any of these topics, please visit **GaHAP.org**. Sample translated financial assistance applications and notifications are also available on the site.

ⁱ US Census, 2009.

ⁱⁱ Divi, Chandrika, et al. “Language proficiency and adverse events in US hospitals: A pilot study.” *International Journal for Quality in Health Care*, April 2007.

ⁱⁱⁱ Ngo-Metzger, Quyen. “Language barriers adversely impact healthcare quality.” *Journal of General Internal Medicine*, November 2007.

^{iv} Meaningful access means the ability to use services and benefits comparable to those enjoyed by members of the mainstream cultures. It is achieved by eliminating communication barriers and ensuring that the patient and doctor can communicate effectively. This term was inserted into Title VI language after court rulings disallowed federal funding for segregated hospitals. However, the courts also ruled that simply allowing entrance into desegregated schools and hospitals meant nothing if individuals were unable to use them due to language barriers. Thus, the term “meaningful access” was added to Title VI requiring facilities receiving federal funds to not only allow entrance, but to ensure that services were received in an understood language and manner.

^v <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

^{vi} <http://www.justice.gov/crt/lep/selfassesstool.htm>

^{vii} <http://minorityhealth.hhs.gov/templates/content.aspx?ID=4375>