PRINCIPLES FOR
HEALTH REFORM AND LANGUAGE ACCESS

Over 55 million people in the U.S. speak a language other than English at home.[1] The number of people with limited English proficiency (LEP) – those who speak English less than "very well" – is over 25 million individuals, or 9% of the U.S. population.[2] In national studies, 80% of hospitals and 81% of general internal medicine physicians report treating LEP patients, at least monthly (with an even greater intensity at safety net hospitals) while 84% of federally qualified health centers report treating LEP patients daily (with 45% treating more than 10 LEP patients per day).[3]

Research demonstrates how the lack of language services creates a barrier to and diminishes the quality of care for LEP individuals.[4] In one study, 27% of LEP patients who needed but did not get an interpreter reported that they did not understand medication instructions. In contrast, only 2% of patients who did not need an interpreter, or needed and received one, reported not understanding medication instructions).[5] Language barriers also impact access to care – LEP patients are less likely to use primary and preventive care and public health services and more likely to use emergency rooms thereby increasing both short and long-term costs for the health care system.[6]

In 2004, a diverse group of stakeholders (including health care provider associations, advocates, language companies, interpreters and interpreter organizations, and accrediting organizations) adopted a broad set of principles related to language access in health care. To date, over 90 groups have endorsed these principles.[7] This document offers more detailed recommendations to inform the current discussions on health reform.

ACCESS TO LANGUAGE SERVICES

- All limited English proficient patients should have access to language services (including oral interpretation and written translations) in all health care and public health settings.

- All health care and public health providers and their staff should have access to competent interpreters and translated materials to ensure effective communication with individuals and families they serve during health services and administrative interactions.

FUNDING LANGUAGE SERVICES

- Medicaid should extend the enhanced language services match enacted in CHIPRA 2009 (Public Law 111-3) to all Medicaid beneficiaries and state Medicaid agencies should pay for language services.

- Medicare should provide payment adequate to cover the costs of language services for hospitals, community health centers and other Medicare healthcare providers. For clinicians receiving payment through the Physician Fee Schedule, Medicare should examine different alternatives and how payments would affect clinician payments, a clinician's practice, and beneficiary cost-sharing.

- Any new coverage program should provide and pay for language services for all clinical and administrative interactions.

- Each federal agency that carries out health care and public health-related activities should prepare and implement a language access plan to ensure that LEP individuals have access to the agency's federally conducted health care and public health-related programs and activities.

- Medicare and any new coverage program must, within one year of enactment of health reform legislation, translate beneficiary-related documents into the 15 most frequently encountered languages. After the first year, these programs should develop a plan for translating documents into additional languages.

- Funding should be provided for the training of competent interpreters and translators and the training of health care and public health providers and their staff on how to effectively use language services.

- Funding should be provided to explore, develop and implement technological innovations that can improve language access, such as telemedicine and video interpreting.

- Because it is important for providing all individuals the environment most conducive to positive health outcomes, linguistic diversity in the health care and public health workforce should be encouraged, especially for individuals in direct contact positions.

ASSESSING AND EVALUATING LANGUAGE SERVICES

- HHS should work with the Institutes of Medicine to evaluate, report, and make recommendations on language services and best practices for collecting language data and interpreter utilization across all health care and public health programs and insurers.

- HHS should establish a federal Center for Cultural and Linguistic Competence in Health Services that will provide:

    - Resources to link providers to competent interpreters/translators and to language competency screening tools for bilingual staff/interpreters
    - Toll-free customer service for LEP individuals on how to obtain language assistance and enroll in publicly funded programs;
    - A Health Information Clearinghouse with standard document templates, cultural and linguistic competence training and self-assessment tools, and information on model language assistance strategies;
    - Interpretation and translation guidelines and standards;
    - Education to inform patients, providers, and health professions schools about federal and state laws and guidelines governing access to language services, the value of using trained interpreters and the risks associated with using family members and untrained bilingual staff, funding sources for developing and implementing language services, and available resources and promising practices to effectively provide language services.

ACCOUNTABILITY FOR LANGUAGE SERVICES

- Language services in health care and public health settings must be available as a matter of course**,** and all stakeholders – including government agencies that fund, administer or oversee health programs – must be accountable for providing or facilitating the provision of those services.

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ENDORSING ORGANIZATIONS

AARP
Aetna
Allergy & Asthma Network Mothers of Asthmatics
American Academy of Pediatrics
American Academy of Physician Assistants
American Hospital Association
American Psychological Association
American Public Health Association
Asian & Pacific Islander American Health Forum
Asian American Justice Center
Association of Asian Pacific Community Health Organizations
Association of Clinicians for the Underserved
Association of Language Companies
Catholic Health Association of the US
Cross-Cultural Communications, LLC
Families USA
Institute for Diversity in Health Management
Japanese American Citizens League
La Clinica del Pueblo
Medicare Rights Center
Migrant Legal Action Program
National Asian Pacific American Women's Forum
National Association of Public Hospitals and Health Systems
National Association of Social Workers
National Committee to Preserve Social Security and Medicare
National Council on Aging
National Committee for Quality Assurance
National Forum for Latino Healthcare Executives
National Health Law Program
National Hispanic Medical Association
National Immigration Law Center
National Partnership for Women and Families
Out of Many, One Coalition
Racial and Ethnic Health Disparities Coalition

[1] U.S. Bureau of the Census, *American Community Survey 2007, Table B16001, Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over, available at* http://factfinder.census.gov.

[2] *Id.*

[3] R. Hasnain-Wynia, et. al., *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey* (2006), *available at* http://www.healthlaw.org/library/item.118638-Full_Report_Hospital_Language_Services_for_Patients_with_Limited_English_P; American College of Physicians, *Language Services for Patients with Limited English proficiency: Results of a National Survey of Internal Medicine Physicians* (2007), *available at* http://www.healthlaw.org/library/item.140432-Language_Services_for_Patients_with_Limited_English_Proficiency_Results_of; National Association of Community Health Centers, *Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey* (2008), *available at* http://www.healthlaw.org/library/item.198374-Serving_Patients_with_Limited_English_Proficiency_Results_of_a_Community_He.

[4] *See, e.g.,* Flores G, Barton Laws M, Mayo SJ, et al.., *Errors in medical interpretation and their potential clinical consequences in pediatric encounters*, Pediatrics 2003, 111(1):6-14; Ghandi TK, Burstin HR, Cook EF, et al. *Drug complications in outpatients,* Journal of General Internal Medicine 2000, 15:149-154l; Pitkin Derose K, Baker DW, *Limited English proficiency and Latinos' use of physician services,* Medical Care Research and Review 2000, 57(1):76-91. *See also*, Jacobs, et. al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), *available at* http://www.calendow.org/pub/publications/LANGUAGEBARRIERSAB9-03.pdf.

[5] *See* Dennis P. Andrulis, Nanette Goodman, and Carol Pryor, *What a Difference an Interpreter Can Make* at 7, The Access Project (Apr. 2002).

[6] *E.g.* Judith Bernstein *et al., Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up,* J. OF IMMIGRANT HEALTH, Vol. 4 No. 4 (October 2002); IS Watt et al, *The health care experience and health behavior of the Chinese: a survey based in Hull*, 15 J. PUBLIC HEALTH MED. 129 (1993); Sarah A. Fox and J.A. Stein, *The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups*, 29 MED. CARE 1065 (1991).

[7] The broad principles are available at http://www.healthlaw.org/library/folder.56882.