

Virtual Mentor

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Policy Forum

Can the Care Be High Quality if the Communication Is Not?

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What do the following things have in common: a 40-year-old law, the recent focus on quality health care, and 23 million people? Each offers a compelling reason for health care professionals to focus on accurate patient-centered communication with their patients who are of limited English proficiency (LEP).

In 1964, more than 40 years ago now, Title VI of the Civil Rights Act was enacted [1]. One of its goals was to prevent discrimination from being funded with federal money:

No person in the United States shall, on 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 (emphasis added) [2].

The federal Department of Health and Human Services (HHS) and the U.S. Supreme Court have construed “national origin” to include language, and thus recipients of federal funds can not discriminate against those who do not speak English [3]. Since virtually all health care organizations receive some federal funding [4], they must make certain that language barriers do not impact the quality of care provided to their LEP patients. Accurate communication is essential to a physician’s ability to obtain a patient’s history, make a correct diagnosis, and reduce medical errors; it is also critical to a patient’s understanding, so she can give informed consent and comply with treatment regimens.

According to the U.S. Census Bureau, more than 12 million individuals speak English “not well” or “not at all” and more than 23 million (8.6 percent of the population) speak English at a level lower than “very well” [5]. The number and diversity of languages is growing rapidly in rural states and counties as well as in urban environments [6]. Between 1990 and 2000, 15 states experienced more than 100 percent growth in their LEP populations [7]. Moreover, 80 percent of hospitals and 81 percent of internists encounter patients with limited English proficiency at least monthly [8].

Recognizing the changing demographics and the need to reinvigorate Title VI, President Clinton issued Executive Order 13166 (EO), entitled Improving Access to Services for Persons with Limited English Proficiency, [9] The EO—affirmed by

President George W. Bush—required each federal agency to issue a guidance statement to its federal funds recipients on making government-funded programs more accessible to these individuals. The HHS Office for Civil Rights’ “LEP Guidance” outlines four factors for evaluating whether a health care organization is doing enough to comply with Title VI: the number or proportion of LEP individuals eligible to be served or likely to be encountered by the program or grantee; the frequency with which LEP individuals come in contact with the program; the nature and importance of the program, activity, or service provided by the program to people’s lives; and the resources available to the grantee or recipient and costs.

Because there is no one-size-fits-all solution, the Office for Civil Rights evaluates compliance on a case-by-case basis, examining the totality of the circumstances. But the LEP Guidance does include a model plan [10], and the Office of Minority Health has released the “CLAS Standards” (Standards for Culturally and Linguistically Appropriate Services in health care) that, while reiterating the requirements of Title VI, also provide additional information on ensuring language access [11].

Beyond legal requirements, there are other equally vital reasons to support language access for patients with limited English proficiency. Health care providers from across the country have reported that language difficulties and inadequate funding of language services are major barriers to access to health care and a serious threat to the quality of the care patients with limited English proficiency receive [12].

In one study, more than a quarter of the patients who needed—but did not get—an interpreter reported they did not understand their medication instructions. This compared with only 2 percent of those who either did not need an interpreter or needed and received one [13]. Language barriers also impact source of care—non-English-speaking patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. Once at the emergency room, they receive far fewer services than do English-speaking patients [14].

Recognizing that quality of care should not be affected by the language one speaks, a national coalition of stakeholders formed in 2003 to develop a consensus-driven agenda to improve policies and funding for access to quality health care for individuals with limited English proficiency. This coalition, coordinated by the National Health Law Program and supported by The California Endowment, represents an ongoing, constructive approach for achieving consensus on addressing language access issues. The coalition includes numerous health care organizations, advocates, interpreter organizations, and accrediting organizations. It reflects the diversity of health care disciplines and perspectives found in the public, not-for-profit, and for-profit sectors of the U.S. health care system.

Statement of Principles

The national coalition’s Statement of Principles offers a conceptual guide for achieving quality care for patients with limited English proficiency by addressing

language access at the national, state, and local levels. The principles seek to ensure that language barriers do not affect health outcomes. Reaching consensus on these principles required a frank and thoughtful exchange about the health system's response to the needs of LEP populations. Coalition members sought to answer a fundamental question: Is it necessary that health care professionals offer linguistically competent care, and if so, why? The groups decided that such care is indeed necessary because providing quality and safe health care in our pluralistic society cannot be done without erasing language barriers. Thus the Statement of Principles guides the work of the coalition as it seeks to achieve practical solutions to the difficulties of providing care in an increasingly multilingual society [15]. The coalition's principles are:

Effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and assuring a patient's ability to adhere to treatment plans.

Competent health care language services are essential elements of an effective public health and health care delivery system in a pluralistic society.

The responsibility to fund language services for LEP individuals in health care settings is a societal one that in all fairness cannot be visited upon any one segment of the public health or health care community.

Federal, state and local governments and health care insurers should establish and fund mechanisms through which appropriate language services are available where and when they are needed.

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

All members of the health care community should continue to educate their staff and constituents about LEP issues and help them identify resources to improve access to quality care for LEP patients.

Access to English as a Second Language instruction is an additional mechanism for eliminating the language barriers that impede access to health care and should be made available on a timely basis to meet the needs of LEP individuals, including LEP health care workers.

Quality improvement processes should assess the adequacy of language services provided when evaluating the care of LEP patients, particularly with respect to outcome disparities and medical errors.

Mechanisms should be developed to establish the competency of those who provide language services, including interpreters, translators and bilingual staff/clinicians.

Continued efforts to improve primary language data collection are essential to enhance both services for, and research identifying the needs of, the LEP population.

Language services in health care settings must be available as a matter of course, and all stakeholders—including government agencies that fund, administer or oversee health care programs—must be accountable for providing or facilitating the provision of those services [16].

Among the health care provider associations endorsing the principles are: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Hospital Association, and American Medical Association, to name a few. Both The Joint Commission and National Committee on Quality Assurance have endorsed them, along with over 50 other organizations [16].

Forty-three states have passed laws addressing language access, including a few that require cultural competency education in schools that train health professionals or for ongoing licensure [17]. While the federal requirements have existed for over 40 years, renewed focus on quality of care has reinforced the need for patient-centered communication that overcomes language barriers. The national coalition's principles recognize that effective communication is crucial to providing quality health care services and public health programs to patients with LEP. Thus, ensuring that language barriers do not impede health care access and quality is not merely an issue of law but also an issue of quality care.

Notes and References

1. Title VI of the Civil Rights Act of 1964, 42 USC sec 2000d et seq (1964).
2. Nondiscrimination under programs receiving federal assistance through the Department Of Health And Human Services. Effectuation of Title VI of the Civil Rights Act Of 1964. 42 USC sec 2000d (2000). which lists examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants.
3. *Lau v Nichols*, 414 US 563 (1974).
4. Funding is generally through Medicare, Medicaid, SCHIP, or other HHS sources. Providers who only receive funding through Medicare Part B are exempt from Title VI.

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7. 1990 and 2000 Decennial Census. "Limited English Proficiency" refers to people age five and above who report speaking English less than "very well." The states were: Arkansas, Colorado, Georgia, Idaho, Kansas, Kentucky, Minnesota, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Utah, and Washington. US Census Bureau. PCT 38, Age by Language Spoken at Home By Ability to Speak English for the Population 5 Years and Over (Census 2000 Summary File 4—Sample Data); Census FactFinder.
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11. See National standards on culturally and linguistically appropriate services (CLAS). *Fed Regist.* 2000;65(247):80865. <http://www.omhrc.gov/clas>. Other Office of Minority Health resources include a web site, Think cultural health. <http://www.thinkculturalhealth.org/LanguageAccessServices.asp>. Accessed June 20, 2007. And see, American Institute for Research. A patient-centered guide to implementing language access services in healthcare settings. <http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf>. Accessed June 20, 2007.
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15. Endorsing organizations view it as an inseparable whole that cannot legitimately be divided into individual parts. Each of the principles articulated derives its vitality from its context among the others, and any effort to single out one or another would therefore undercut the structural integrity of the entire framework. The endorsers recognize that the principles will be disseminated to other interested stakeholders, congressional and administration staff, and the media solely to raise awareness of this issue and

to support policies consonant with these principles. It is important to note that endorsement of these principles by an organization should not be interpreted as indicating its support for, or opposition to, any particular legislation or administrative proposal that may emerge.

16. Other endorsing organizations include American Medical Students Association, American Nurses Association, American Psychiatric Association, American Psychological Association, American Public Health Association, Association of Clinicians for the Underserved, Catholic Health Association, National Association of Community Health Centers, National Association of Public Hospitals and Health Systems, National Association of Social Workers, National Hispanic Medical Association, National Medical Association, Physicians for Human Rights, and Society of General Internal Medicine. For a list of current endorsing organizations see <http://www.healthlaw.org/library.cfm?fa=detail&id=56882&appView=folder> . Accessed June 20, 2007.
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