LIMITED ENGLISH PROFICIENCY (LEP) PATIENTS AND THEIR UNDERSTANDING OF THE AMERICAN HEALTH CARE SYSTEM

A Research Article by Patient Orator

Abstract

Unless they are traveling and become ill in a non-English–speaking country, likely, most English-speaking clinicians in the United States have never had the experience of explaining their illness symptoms to a health professional who didn't speak their language. But, for millions of people with limited English proficiency (LEP) living in the United States, this is an everyday occurrence. [1] This article focused on LEP patients and a historical overview of the American healthcare system concerning languages non-English speaking patients. [1]

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Background:

The U.S. health system features a bewildering complexity of institutions, barriers to entry, programs to bypass them, contradictory requirements, and red tape. The system has become so complex that it not only defies understanding but leads to analysts themselves becoming ensnared in its web, adopting its "logic" and language as the only way to make sense of at least some of the system's features.[1] An area of increasing concern among physicians is providing care for patients with limited abilities to speak English. This concern is warranted by—among other factors—logistical uncertainties in treating patients who may not understand physician instructions, the risk of potential litigation in treating such patients, and the fiscal impact on medical practice of treating such patients.[2]

Unless they are traveling and become ill in a non-English–speaking country, likely, most English-speaking clinicians in the United States have never had the experience of explaining their illness symptoms to a health professional who didn't speak their language. But, for millions of people with limited English proficiency (LEP) living in the United States, this is an everyday occurrence.[3] The struggles between institutions and organized groups advocating each of these positions have cumulated over time, leading to the present self-contradictory institutional landscape.[1]

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[1] Alejandro Portes, Donald Light, and Patricia Fernández-Kelly, "The U.S. Health System and Immigration: An Institutional Interpretation," Sociological forum (Randolph, N.J.) (U.S. National Library of Medicine, September 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3628610/.

[2] Joshua S. Coren, Frank A. Filipetto, and Lucia Beck Weiss, "Eliminating Barriers for Patients With Limited English Proficiency," The Journal of the American Osteopathic Association (American Osteopathic Association, December 1, 2009), https://jaoa.org/article.aspx?articleid=2093746.

[3] Barb Jacobs et al., "Medical Interpreters in Outpatient Practice," Annals of family medicine (American Academy of Family Physicians, January 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5758324/.

Immigrants and Linguistic Diversity in the United States:

Language diversity refers to the number of languages spoken in the United States and the number of people who speak them. Since 1980 information on languages spoken has been gathered from three questions posed to census and survey respondents: Does this person speak a language other than English at home? What is this language? How well does this person speak English? Among other purposes, answers to these questions are used to determine bilingual election requirements under the Voting Rights Act.[4] The revival of mass immigration after 1970 spurred a revival of linguistic diversity in the United States and propelled the nation back toward its historical norm. [4] The table below summarizes these data by showing the share of U.S. residents who said they spoke a non-English language at home as well as the share who spoke only English by decade between 1980 and 2010. Since Spanish is by far the most widely spoken non-English tongue in the United States, it also reports the share who speak Spanish at home.[4]

[4] Rubén G Rumbaut and Douglas S Massey, "Immigration and Language Diversity in the United States," Daedalus (U.S. National Library of Medicine, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4092008/.

Language Use Patterns in the United States, 1980 to 2010

	1980		1990		2000		2010		
Languages spoken at home	N (millions)	%	N (millions)	%	N (millions)	%	N (millions)	%	Foreign-born %
Total population 5 years or older	210.2	100%	230.4	100%	262.4	100%	289.2	100%	13.6%
Spoke English only	187.2	89.1	198.6	86.2	215.5	82.1	229.7	79.7	2.6
Spoke non-English language	23.1	11.0	31.8	13.8	47.0	17.9	59.5	20.3	56.7
Spoke Spanish	11.1	5.3	17.3	7.5	28.1	10.7	37.0	12.6	49.4

Sources: 1980, 1990 and 2000 U.S. censuses; 2010 American Community Survey.

As one would expect during an age of mass immigration, the percentage speaking only English at home has steadily fallen in recent decades, declining from 89.1% in 1980 to 79.7% in 2010, while the share speaking a language other than English correspondingly rose from 11% to 20.3%.[4] Most of the increase in Spanish language use was driven by mass immigration from Latin America. Indeed, most (56.7%) of the country's nearly 60 million speakers of non-English languages *are* immigrants. Among those who spoke only English at home in 2010, just 2.6% were born outside the United States (mostly immigrants from English-speaking countries); among those who spoke Spanish, half (49.4%) were foreign-born.[4]

The table below examines the geography of foreign language use by showing the share of persons aged five and older speaking a non-English language at home in selected states and metropolitan areas. To create the list, we examined all 50 states and metropolitan areas with at least 500,000 inhabitants and ranked the top 25 according to the percentage of non-English speakers.[4]

Percent speaking a non-English language at home in selected states and metro areas, 2008-2010, in rank order

(population 5 years or older)			
Top 25 States	**%**	**Top 25 Metros**	**%**
California	43.4	McAllen, TX	85.4
New Mexico	36.1	El Paso, TX	74.7
Texas	34.5	Miami, FL	73.0
New York	29.6	Jersey City, NJ	59.0
New Jersey	29.1	Los Angeles, CA	56.8
Nevada	28.8	San Jose, CA	50.8
Arizona	27.0	New York, NY	46.3
Florida	27.0	Orange County, CA	44.8
Hawaii	26.0	Fresno, CA	43.1
Illinois	21.9	San Francisco, CA	42.2
Massachusetts	21.5	Bakersfield, CA	41.0
Rhode Island	21.0	Riverside, CA	40.5
Connecticut	20.8	Bergen-Passaic, NJ	40.5
Washington	17.8	San Antonio, TX	40.2
Colorado	16.9	Houston, TX	38.8
Maryland	16.4	Oakland, CA	38.8
Alaska	16.0	Ventura, CA	37.4
Oregon	14.5	Fort Lauderdale, FL	37.1
Virginia	14.4	San Diego, CA	36.9
Utah	14.1	Middlesex-Somerset, NJ	34.4
District of Columbia	13.9	Las Vegas, NV	32.8
Georgia	12.9	Dallas, TX	32.1
Delaware	12.1	Albuquerque, NM	31.3
Kansas	10.6	Vallejo-Faiifield-Napa, CA	30.9
North Carolina	10.6	Chicago-Gary, IL	30.2

Source: American Community Survey (ACS), 2008-2010 merged files.

Language diversity, like immigration, is also chiefly a metropolitan phenomenon. Over 91% of the population of non-metropolitan areas in the U.S. speaks English only. The 25 metropolitan areas with the highest percentages of residents who speak a non-English language at home are confined entirely to the six gateway states.[4] Speaking a foreign tongue at home does not necessarily imply a lack of fluency in English, of course; but if the past is any guide to the future, the prospects for stable bilingualism in the United States are slim given the nation's well-established reputation as a graveyard for immigrant languages.[4] Among the nearly 60 million people who speak a foreign language at home, the table below takes up the issue of their English language proficiency by showing the percentage who reported speaking English only or very well, and the percentage speaking it not well or not at all.[4] The table shows percentages for non-Hispanic whites, non-Hispanic blacks, and major ethnic groups of Latin American and Asian

origins, along with the percentage foreign-born in each group. Once again, the 2008-2010 waves of the American Community Survey to derive more reliable estimates.[4]

Size, immigrant share, and English proficiency of U.S. ethnic groups, 2008-10

Ethnic/pan-ethnic groups	N	% of U.S. population	% foreign- born	Speaks English*...		
				only	very well	not well or at all
White, non-Hispanic	199,925,233	65.2	3.8%	94.2%	4.1%	0.7%
Black, non-Hispanic	39,405,797	12.8	7.7%	93.1%	4.6%	0.9%
Latin American origins:						
Mexican	32,054,091	10.4	36.2%	24.3%	38.8%	22.9%
Puerto Rican (in mainland)	4,562,169	1.5	1.1%	34.9%	46.5%	8.3%
Cuban	1,760,256	0.6	58.9%	17.6%	41.4%	27.2%
Dominican	1,421,609	0.5	57.1%	8.8%	45.6%	28.8%
Salvadoran, Guatemalan	2,811,922	0.9	65.5%	8.7%	34.3%	37.7%
Colombian	943,989	0.3	65.8%	13.4%	45.3%	20.2%
Peruvian, Ecuadorian	1,201,984	0.4	66.7%	11.3%	41.9%	25.6%
Other Central/South American	2,169,199	0.7	64.5%	15.9%	42.8%	23.4%
Asian origins:						
Chinese	3,369,879	1.1	69.0%	18.0%	36.4%	23.8%
Asian Indian	2,831,277	0.9	72.6%	20.3%	57.7%	7.3%
Filipino	2,590,676	0.8	66.0%	32.9%	45.0%	5.2%
Vietnamese	1,601,842	0.5	68.0%	12.1%	34.8%	28.9%
Korean	1,492,080	0.5	74.1%	21.8%	32.8%	22.5%
Japanese	816,299	0.3	40.2%	55.6%	20.7%	9.0%
Cambodian/Hmong/Laotian	734,354	0.2	54.3%	14.7%	43.0%	22.1%
Other Asian	1,227,546	0.4	59.1%	27.4%	41.6%	11.5%
All other ethnic groups	5,818,232	1.9	12.2%	65.3%	25.4%	3.7%
Total population	306,738,434	100.0	12.8%	79.7%	11.6%	4.7%

*Asked of those speaking a language other than English at home (ages 5 and older).

Source: American Community Survey (ACS), 2008-2010 merged files.

Three key determinants of English language fluency among the foreign-born (from non-English speaking countries) are age at arrival, years of education, and time in the United States. It is much easier for human beings to learn languages prior to adolescence, and education generally increases exposure to English as well as cognitive skills.[4]

An Introduction to Limited English Proficient (LEP) Patients:

Limited English proficiency (LEP) is a term used to describe individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.[2] The United States is changing demographically. According to the most recent US Census, from 2010 to 2014, about 62 million people (born in the United States or another country) spoke a language other than English at home. About 41% of these individuals (25 million people) have LEP, defined in the census as individuals older than 5 years who speak English "less than very well." The Census Bureau projects a similar percentage into 2020.[3] Of course, not all patients who primarily speak non-English languages are foreign-born. Some of these patients may be US-born but live in relatively isolated ethnic enclaves.[2]

Immigrants and children of immigrants currently number approximately 60 million or a fifth of the U.S. population. They include an estimated 12 million unauthorized immigrants, mostly poor and poorly educated laborers. This human will eventually encounter the U.S. health system, leading to a clash whose multiple dimensions are poorly understood. Immigrants, the poor and unauthorized, are also mostly uninsured. When in need, their claims on the health system are based on their humanity rather than on their resources or entitlements. These claims precisely encounter the core dilemma of the system, facing a resolute barrier among medical institutions committed to the concept of health as a commodity.[1]

The surging immigrant population presents U.S. health institutions with a series of challenges. They can be summed up into a four-fold set of handicaps: lack of English fluency, different cultural definitions of illness and health, tenuous legal status and residential instability, and poverty and lack of insurance.[1] People with LEP can face daily challenges; however, one significant threat to wellbeing is access to health care. Research has identified that language

barriers in a health care setting can result in miscommunications between patients and health workers, which significantly increases the chances of serious medical events.[5]

Professional

immigrants with high levels of human capital are much better able to overcome these constraints. They have both legal status and work-linked health insurance and are commonly fluent in English. Still, even among them, problems of linguistic and cultural translation are quite frequent. Professionals from non-English-speaking countries may have enough command of the language to meet their work obligations, but not to express their health needs. The latter may be defined quite differently, as when Korean and Chinese professionals complain of "lack of energy" to refer to physical ailments or sheer depression. Such discrepancies are commonly reported by U.S. physicians and administrators and have prompted some hospitals and clinics to hire "cultural mediators" to try to bridge the gap.[1]

The systemic need of the U.S. economy for low-wage labor migration has led to the arrival of such workers by the hundreds of thousands, leading to their growing impact on health institutions. The health system has been forced to come up with a new set of coping strategies given the increase of the immigrant population, its distinct health needs, and the potential public hazards posed by infectious diseases. By the same token, the clash between immigration and health institutions has brought into sharp relief the contradictions and limitations of the U.S. health system.[1] The table presented below describes the situation:[1]

[5] Cohen, A., Rivara, F., Marcuse, E., Mcphillips, H., & Davis, R. (2005). Are language barriers associated with serious medical events in hospitalized pediatric patients? Pediatrics, 116(3), 575-579.

Characteristics of the Low-Skill Immigrant Population of the United States and its Health Consequences

Unauthorized Status	Low Education	Poverty	Numbers
Ineligibility for federal entitlements.	Folk beliefs and practices.	Inability to meet medical co-payments.	Significant increases in the uninsured population needing care.
Postponement of help-seeking for illness up to a crisis point.	Inability to understand and read labels in English.	Inability to meet local residence requirements.	Public health hazards due to potential spread of infectious diseases.
Erratic compliance with medical treatment and prescriptions.	Erratic compliance with medical instructions.	Erratic compliance with medical instructions.	Growing pressure on budgets and facilities of clinics caring for the poor.
	Ignorance of modern nutritional and hygienic practices.	Poor nutrition and associated chronic illnesses.	

The American Healthcare System:

The U.S. health system is dominated by an array of large institutions—public and private hospital systems—supplemented by thousands of clinics and hundreds of thousands of private practice health professionals. [1] These entitlements are anything but unqualified, and several requirements and barriers to care are confronted even by those covered. These constraints are linked to the fact that health insurance is also a market good and, hence, its quality is linked to its price, leading to different levels of access and care.[1] Those not entitled to work-related insurance or lacking membership in special categories of the population can purchase individual insurance policies, generally at a high cost. It is at this point that the definition of healthcare as a human right comes into play: as the uninsured and unable to pay cannot be left dying in the streets, a parallel safety net system has been constructed, by fits and starts, consisting of networks of

federal- and state-subsidized clinics and health programs, as well as federally mandated access to care in emergencies.[1]

Discrimination based on national origin or other protected categories in programs or activities receiving federal financial assistance has long been prohibited in the United States. To assure compliance with Title VI of the 1964 Civil Rights Act,[5] Executive Order 13166, issued in 2000, required federal agencies to develop systems to improve access to their programs and services for persons with LEP, defined as those "whose primary language for communication is not English" and who have "a limited ability to read, write, speak, or understand English." In 2003 the Department of Health and Human Services (HHS) published guidance about how to meet the provisions of the executive order by providing LEP individuals with meaningful access to federal health care programs (HHS LEP Guidance). That guidance continues to be used today. Also, the prohibitions against discrimination in health care programs were further addressed and codified in HHS regulations implementing Section 1557 of the Affordable Care Act (ACA). [3] Hospitals, clinics, and private practitioners can be compensated for caring for those lacking work-related or self-purchased insurance if these are citizens or long-term legal residents and fall under certain officially specified categories: the very old, the very young, the disabled, and the very poor.[1]

Eligibility must be documented and is checked carefully before access is granted to the various federal programs such as Medicare, Medicaid, or the network of Federally Qualified Health Clinics (FQHCs). Several states and counties have chosen to expand this safety net with programs that do not require proof of citizenship or legal permanent residence, but still, demand records documenting local residence and low or no income. Programs such as New Jersey's Charity Care or the Jackson System of satellite clinics in South Florida are examples. Persons unable to document local residence and indigence fall into the lowest tier of the safety net,

consisting of an assortment of free clinics created by private philanthropy or hospital emergency rooms when extremely ill. By law, emergency rooms must provide care in these situations, although the quality of that care varies significantly—from simply "stabilizing" the patient and sending him or her away to granting access to inpatient hospital services. Emergency rooms bill for services and their charges can be economically ruinous, leading many poor patients to avoid them even when in need.[1] Determination of whether covered entities, including physicians and practices that receive federal financial assistance, have taken the required reasonable steps to provide meaningful access to LEP individuals must be made on a case-by-case basis. Factors that will be considered include the "nature and importance of the health program or activity and the particular communication at issue" and other relevant factors including whether the entity has "developed and implemented an effective written language access plan appropriate to its particular circumstances."[3]

The differences in access, quality, and promptness of services provided by the U.S. system is stark. An ocean separates the clean halls, prompt attention, and almost doting care received by properly insured or otherwise paying patients for whose favor's hospitals compete and those carrying a charity card or no card at all. For hospitalization or specialty care, poor patients—especially those outside federal or state programs—depend on the goodwill of individual professionals.[1]

How are Limited English Proficiency (LEP) Patients protected and provided?

Several federal and state regulations are designed to protect LEP patients from encountering healthcare barriers. All providers who receive federal funding must abide by Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on of race, color, or national origin.[25] In 2000, President Bill Clinton issued Executive Order 13166, which reinforced the need for providers and hospitals that receive federal funding to render appropriate access and services to LEP patients.[26] Also, the *Standards for Culturally and Linguistically Appropriate Services* (CLAS)[27] were established in 2001 by the Department of Health and Human Services (HSS) Office of Minority Health.[2] These LEP-related standards include the following requirement:

> "Health care organizations [that receive federal funding] 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."[2]

A major source of confusion for many physicians is whether this HHS guidance applies to them. To clarify, the HHS CLAS standards apply to any entity receiving funds from the HHS, including physicians who participate in Medicare Part A or federally funded clinical trials or who provide treatment to certain other patient categories. Physicians enrolled only in Medicare Part B and who do not otherwise receive federal funds are not subject to the HHS requirements. [2] Individual states vary in their quantity and scope of laws related to caring for LEP patients. All states have anti-discrimination laws that at least broadly encompass Title VI, Executive Order 13166, and the CLAS standards.[6] In New Jersey, mandatory cultural competency training, including content for treating LEP patients, is required for all physicians and podiatrists before relicensure. Curricular integration of cultural competency is required in all New Jersey medical

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[6] Office of Minority Health, US Department of Health and Human Services. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*. Washington, DC: US Department of Health and Human Services; 2001. http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf. Accessed March 05, 2021.

schools. California and Washington State[30,35] require varying degrees of cultural competency training or continued medical education regarding LEP patients before physician relicensure.

Many other states currently have legislation in various stages of development involving the integration of cultural competency and LEP proficiency training for healthcare providers.[2] These many efforts, however, have not been sufficient to resolve language barriers for LEP individuals. Awareness of language law among providers has not been associated with the use of professional interpreters by providers.[6] This finding suggests that providers may still not be aware of their legal obligations to offer language access services to their LEP patients. It may also indicate that providers continue to use untrained interpreters, such as patients' family members and friends. Although federal policy for the past 40 years has mandated that meaningful language access be provided to LEP patients, this requirement has resulted in less than favorable outcomes.[7]

Qualified Medical Interpreters:

When entities are required to provide interpretation for LEP individuals, they must use the services of "qualified" medical interpreters. Unfortunately, when an interpreter appears in a clinic or hospital settings to assist during a clinician-patient encounter, most clinicians assume the interpreter is qualified to interpret. But, that's not always the case.[8] A qualified interpreter for an individual with LEP is one who "(1) adheres to generally accepted interpreter ethics

[7] Grubbs V, Chen AH, Bindman AB, Vittinghodd E, Fernandez A. Effect of awareness of language law on language access in the health care setting. *J Gen Intern Med*. 2006;21:683-688. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924696/?tool=pubmed. Accessed November 20, 2009.

[8] Flores G, Abreu M, Barone CP, Bachur R, Lin H. Errors of medical interpretation and their potential clinical consequences: a comparison of professional versus ad hoc versus no interpreters. *Ann Emerg Med*. 2012; 60:545–55.

principles, including client confidentiality; (2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and (3) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology."[9] Federal regulations and guidance do not require interpreters to be licensed or certified. The use of certified interpreters is required in some states,[10] however, and HHS considers certification helpful to establish competency.[11]

Certified medical interpreters have a high level of fluency in 2 or more languages, have been trained in the ethics and role of a medical interpreter, study medical terminology, and can facilitate the flow of a patient-clinician medical visit—including making clinic visits shorter than when telephonic or uncertified in-person interpreters are used.[12] In contrast to "trained" interpreters, certified interpreters have participated in a formal medical interpreter education program and have passed written and oral examinations in medical interpreting. Just like medical professionals, they have a code of professional standards and ethics among which includes accuracy, confidentiality, and impartiality.[3] Currently there are only 2 national organizations in

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[9] Nondiscrimination in Health Programs and Activities, Qualified interpreter for an individual with limited English proficiency. *81 Fed Reg at 31468; 45 CFR § 92.4*. Accessed Mar 2021

[10] Washington State Department of Social and Health Services, Financial Services Administration. *Language Testing and Certification Program*. https://www.dshs.wa.gov/fsa/language-testing-and-certification-program Published 2017. Accessed Mar 2021.

[11] Guidance to Federal Financial Assistance Recipients, Selecting language assistance services, Considerations relating to competency of interpreters and translators. https://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf *68 Fed Reg at 47316*. Published Aug 8, 2003. Accessed Mar 2021.

[12] Fagan M, Diaz J, Reinert SE, Sciamanna CN, Fagan DM. Impact of interpretation method on clinic visit length. *J Gen Intern Med*. 2003;18:643–638.

the United States that provide formal certification of medical interpreters: The National Board of Certification for Medical Interpreters[13] and the Certification Commission for Healthcare Interpreters.[14] Whenever possible, clinicians and health systems should seek to use the services of interpreters who are certified by these organizations.[3]

It is not appropriate to rely on health care staff to interpret unless they are "qualified bilingual/multilingual staff"—defined as individuals who meet the requirements listed in the table below.[15] Practices and health systems covered by the regulations cannot require patients to provide their interpreters.[16] The use of minor children accompanying a patient to serve as interpreters is also prohibited except in emergencies involving "an imminent threat to the safety or welfare" of the patient when no qualified interpreter is available.[17] Also, adults accompanying the patient cannot be used as interpreters absent emergency conditions or where the patient specifically requests that the accompanying individual interprets and "reliance on that adult for such assistance is appropriate under the circumstances."[18] Definition of a Qualified Interpreters[9,15]

[13] The National Board of Certification for Medical Interpreters. http://www.certifiedmedicalinterpreters.org/ Accessed Mar 2021.

[14] Certification Commission for Healthcare Interpreters. http://www.cchicertification.org/ Accessed Mar 2021.

[15] Nondiscrimination in Health Programs and Activities, Qualified bilingual/multilingual staff. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities#page31467 *81 Fed Reg at 31467, 31470; 45 CFR § 92.4*. Accessed Mar 2021.

[16] Nondiscrimination in Health Programs and Activities, Restricted use of certain persons to interpret or facilitate communication. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-andactivities#page-31470 *81 Fed Reg at 31470; 45 CFR § 92.201(e)(1)*. Accessed Mar 2021.

[17] Nondiscrimination in Health Programs and Activities, Restricted use of certain persons to interpret or facilitate communication. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-andactivities#page-31470 *81 Fed Reg at 31470; 45 CFR § 92.201(e)(3)*. Accessed Mar 2021.

[18] Nondiscrimination in Health Programs and Activities, Restricted use of certain persons to interpret or facilitate

Qualified Interpreter for an Individual With Limited English Proficiency	Qualified Bilingual/Multilingual Staff
An individual who, via a remote interpreting service or on-site presence: Adheres to generally accepted interpreter ethics principles, including client confidentiality Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology	A member of a covered entity's workforce who is designated by the covered entity to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the covered entity that he or she: Is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology Is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages

Finally, covered entities are also required to post notices of nondiscrimination and include "taglines" in the appropriate languages on specified documents and signs that alert individuals with LEP to the availability of language assistance services.[19] Examples of a sample notice of nondiscrimination and taglines in over 60 languages are available free on the HHS website.[20]

Different Options for LEP patients and their costs:

Physicians in small practices often cite cost as a barrier to using trained interpreters[21] and indeed, costs can be considerable—though they vary from state to state.[22],[23] They also vary depending on whether a practice uses in-person face-to-face interpreters, telephonic interpreters,

communication. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-andactivities#page-31470 *81 Fed. Reg. at 31470; 45 CFR § 92.201(e)(2)*. Accessed Mar 2021.

19 Nondiscrimination in Health Programs and Activities, Notice requirement. https://www.federalregister.gov/documents/2016/05/18/201611458/nondiscrimination-in-health-programs-and-activities#page-31469 *81 Fed Reg at 31469; 45 CFR § 92.8*. Accessed Mar 2021.

20 US Department of Health and Human Services. *Translated Resources for Covered Entities*. https://www.hhs.gov/civil-rights/forindividuals/section-1557/translated-resources/index.html?language=es Accessed Mar 2021.

21 Caring for patients with limited English proficiency: the perspectives of small group practitioners.
Gadon M, Balch GI, Jacobs EA
J Gen Intern Med. 2007 Nov; 22 Suppl 2():341-6.

22 National Center for State Courts. *Language Access Programs by State*. http://www.ncsc.org/Services-and-Experts/Areas-ofexpertise/Language-access/Resources-for-Program-Managers/LAP-Map/Map.aspx Accessed Mar 2021.

23 American Medical News. *Picking your best option for patient interpretation services*. Published Aug 5, 2013. Accessed Mar 2021.

or video remote interpreting.[3] The options are In-person Interpreters, Telephonic interpreters, and video remote interpreting (VRI).

In-Person Interpreters: If using a face-to-face interpreter provided through a language translation service, costs are generally in the range of $45–$150 per hour, often with a minimum time requirement (e.g., 2-hour minimum).[23] Costs can vary, however, depending on the language involved. For example, in an area where many Spanish-language interpreters are available, the cost is often lower than in areas where few are available. The costs for an interpreter of languages that are rarely spoken, in contrast, can be more. Costs for an independent interpreter who is not affiliated with a language service provider can also be more.[3]

Telephonic Interpreters: Many medical providers use telephonic language services to provide immediate language assistance, and this approach costs less than face-to-face interpreters. Telephonic interpreters are paid by the minute, but there can be a set-up charge along with volume minimums or monthly minimums that vary between services. A typical cost is in the range of $1.25–$3.00 per minute,[23] varying between companies and varying with the time of day and language.[3]

While telephonic interpreting is convenient, less costly, and in some situations the only available option (particularly in practices with patients speaking multiple languages), it can sometimes be suboptimal.[24] Problems cited with telephonic interpretation include inadequate clarity of sound, the inability of the interpreter to respond to visual cues from the patient and clinician, and cultural barriers in which some patients are not comfortable speaking with an unknown

[24] Lost in Translation.
Rush R
N Engl J Med. 2016 Feb 4; 374(5):407-9.

voice.[25],[26] A face-to-face interpreter, rather than telephonic interpreting, is particularly important in mental health settings, for communicating with patients who are hard-of-hearing, for patient education that includes visual components, and when communicating with children.[27]

Video Remote Interpreting: Video remote interpreting (VRI) is a video telecommunication service that uses devices such as web cameras or videophones to provide language services via a remote/off-site interpreter. Video remote interpreting has long been used for sign language interpreter services. Like telephonic interpreters, VRI can be used when qualified or certified interpreters are not available for face-to-face interpretation. The Department of Health and Human Services has developed standards for use of VRI that are listed in the table below.[28]

Health and Human Services' Standards for Video Remote Interpreting

Video remote interpreting (VRI) shall be provided with a qualified interpreter for an individual with limited English proficiency. When using VRI, the health program or activity shall provide:
Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication
A sharply delineated image that is large enough to display the interpreter's face and the participating patient's face regardless of the patient's body position
A clear, audible transmission of voices
Adequate training to users of the technology and other involved individuals so that they can quickly and efficiently set up and operate the video remote interpreting 44

Costs of VRI involve expenses for equipment and for the interpreter service. Costs for equipment can vary widely, depending on whether a practice simply uses a laptop or desktop computer or a more sophisticated setup using cameras, speakers, and microphones. Commonly cited costs for

[25] Saint-Louis L, Friedman E, Chiasson E, Quessa A, Novaes F. *Testing New Technologies in Medical Interpreting*. Somerville, MA: Cambridge Health Alliance; 2003. http://www.challiance.org/Resource.ashx?sn=CommunityAffairstnthndbk Accessed Mar 2021.

[26] National Association of Judiciary Interpreters and Translators. *NAJIT Position Paper: Telephone Interpreting in Legal Settings*. https://najit.org/wp-content/uploads/2016/09/Telephone-Interpreting-1.pdf Published Feb 27, 2009. Mar 2021.

[27] Kelly N. Telephone interpreting in health care settings: some commonly asked questions. *American Translators Association Chronicle*. http://www.atanet.org/chronicle/feature_article_june2007.php Published Jun 2007. Accessed Mar 2021.

[28] Nondiscrimination in Health Programs and Activities, Video remote interpreting services. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities#page31470 *81 Fed Reg at 31470-31471; 45 CFR § 92.201(f)*. Accessed Mar 2021.

VRI interpreter services can range from as little as $1.95 per minute to as much as $3.49 per minute, sometimes with a minimum number of minutes (e.g., 15 minutes) per session.[29],[30]

The Cost:

In some cases, the cost of interpreter services will be reimbursed or covered by a patient's federally funded medical insurance. Medicaid and CHIP programs in at least 14 states and the District of Columbia will reimburse providers or language service agencies for the cost of interpreter services involved in a covered patient's care.[31],[32]

In those states cost should not be an obstacle to clinicians providing interpreters for Medicaid and CHIP patients, though clinicians in some states must cover the upfront costs and then seek reimbursement from the state program. Using billing code T-1013 along with the CPT code that is appropriate for the clinical encounter is one option for claiming reimbursement for these services.[33] Although not specifically required to do so, states are also permitted to "claim federal matching funds for the costs of…. oral interpretation as administrative expenses or as a medical assistance-related expense."[31]

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[29] Interpreters Unlimited. *Video remote interpreting rates*. http://inter-pretersunlimited.com/pricing/video-remote-interpretation/ Accessed Mar 2021.

[30] Interpreters Unlimited. *Video remote interpreting rates*. http://inter-pretersunlimited.com/pricing/video-remote-interpretation/ Accessed Mar 2021.

[31] Department of Health and Human Services. *Increased federal matching funds for translation and interpretation services under Medicaid and CHIP*. https://www.medicaid.gov/federal-policy-guidance/downloads/sho10007.pdf Published Jul 1, 2010. Accessed Mar 2021.

[32] How can states get Federal funds to help pay for language services for Medicaid and CHIP enrollees (Revised January 2010)? *National Health Law Program*. http://www.healthlaw.org/component/jsfsub-mit/showAttachment?tmpl=raw&id=00Pd0000006EH2XEAW Published 2010. Accessed Mar 2021.

[33] Medicaid Administrative Claiming. Translation and interpretation services. *Medicaid.gov*. https://www.medicaid.gov/medicaid/financing-and-reimbursement/adminclaiming/translation/index.html Accessed Mar 2021.

States in Which Medicaid/CHIP Programs Will Reimburse Health Care or Language Service Providers for the Cost of Interpreter Services

District of Columbia
Hawaii
Iowa
Idaho
Kansas
Maine
Minnesota
Montana
New Hampshire
New York
Utah
Vermont
Virginia
Washington
Wyoming

In addition to reimbursement, some states have adopted other systems to keep the cost of interpretation from falling on individual health care providers. For example, Arizona's Medicaid program requires each contracted managed care organization to provide free interpretation services.[34] By calling the patient's contracted plan, individual health care providers can then obtain free telephonic interpretation services on an as-needed basis at no cost to the provider or patient.[3] Additionally, other states and providers have centralized telephonic language services to reduce costs.[35] The Department of Health and Human Services encourages covered entities to work together and with professional associations to develop the most cost-effective delivery programs for language assistance services,[36] suggesting approaches such as the use of

[34] Arizona Health Care Cost Containment System (AHCCCS). *Contractor Operations Manual, Chapter 400 – Operations. 405 - Cultural Competency, Language Access Plan, and Family/Patient Centered Care*. https://www.azahcccs.gov/shared/downloads/acom/acom.pdf Revised Feb 2017. Accessed Mar 2021.

[35] Washington State Health Care Authority. *Billers and providers; interpreter services*. http://www.hca.wa.gov/billers-providers/programs-andservices/interpreter-services Accessed Mar 2021.

[36] Nondiscrimination in Health Programs and Activities, Alternative Approaches. https://www.federalregister.gov/d/2016-11458/page31413 *81 Fed Reg at 31413-14*. Accessed Mar 2021.

communication technology and sharing language assistance materials and services (e.g., telephonic interpreter services could be shared between Medicaid programs in different states).[36]

Finally, HHS has reminded qualified health insurance issuers of their obligation as a condition of certification to implement a quality improvement strategy that "provides increased reimbursement or other incentives for the implementation of activities to reduce … health care disparities, including through the use of language services." [37]The Department of Health and Human Services "encourage(s) health insurance issuers to structure their health plan payment structures to consider health providers' expenses in providing language assistant services."[37]

Conclusion:

Regardless of the federal and state requirements for language assistance or whether federally funded state programs provide the reimbursement, providing appropriate interpretation services is a basic and key component of good patient care for individuals with LEP. Indeed, both the Institute of Medicine and the Joint Commission recognize the need for effective

[37] Nondiscrimination in Health Programs and Activities, *Alternative Approaches*. https://www.federalregister.gov/d/201611458/page-31414 81 Fed Reg at 31414. Accessed Mar 2021.

communication as an important aspect of high-quality care.[38],[39] Besides enhancing the quality of care and avoiding poor health outcomes for patients, there are potential negative consequences for health care providers that do not provide appropriate language assistance services.[3] Providing the best care to patients, complying with legal requirements, and developing and implementing a language access plan will assist clinicians in helping their patients stay safe and healthy. A language access plan that involves professional medical interpreters will provide better health outcomes, ethical patient care, improved patient satisfaction, and reduce costly repeat visits by patients who don't understand what clinicians are asking or telling them about their medical problems.[40],[41]

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[38] Wilson-Stronks A, Lee K, Cordero C, Kopp A, Galvez E. *One Size Does Not Fit All: Meeting the Needs of Diverse Populations*. Oakbrook Terrace, IL: The Joint Commission; 2008. http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm Accessed Mar 2021.

[39] Smedley B, Stith A, Nelson A, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2002. https://www.nap.edu/catalog/10260/unequal-treatment-confronting-racial-and-ethnic-disparities-in-healthcare Accessed Mar 2021.

[40] o professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Karliner LS, Jacobs EA, Chen AH, Mutha S*
Health Serv Res. 2007 Apr; 42(2):727-54.

[41] Betancourt JR, Renfrew MR, Green AR, et al. *Improving patient safety systems for patients with limited English proficiency: a guide for hospitals*. Rockville, MD: Agency for Healthcare Research and Quality; 2012. AHRQ Publication No. 12-0041. http://www.ahrq.gov/sites/default/files/publications/files/lepguide.pdf Revised Sep 2012. Accessed Mar 2021.