

Language Access in Health Care Statement of Principles: Explanatory Guide

WRITTEN BY

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National Health Law Program

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The Coalition

The Language Access in Health Care Statement of Principles springs from the work of a broad coalition of national organizations. The coalition seeks to develop a consensus-driven agenda to improve policies and funding for access to quality health care for individuals with limited English proficiency (LEP). The impetus for this collaborative effort was provided by the issuance of Executive Order 13166 (*Improving Access to Services for Persons with Limited English Proficiency*, 2000), and the subsequent guidance developed by the U.S. Department of Health and Human Services, as health care providers and advocates for LEP communities came to recognize the advantages of identifying common goals for facilitating and improving language access.ⁱ This national coalition, coordinated by the National Health Law Program and supported by The California Endowment, represents an ongoing, constructive approach for achieving consensus on a critical health care issue.

The Statement of Principles is intended as a conceptual guide for use in achieving quality care for LEP patients by addressing issues of language access in health care at the national, state, and local levels. The Principles represent a consensus for a framework to ensure that language barriers do not affect health outcomes.

The coalition, which includes health care provider organizations, advocates, language companies, interpreters and interpreter organizations, and accrediting organizations, 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. The organizations that participated in drafting these Principles included:

American Academy of Pediatrics	Mexican American Legal Defense and Educational Fund
American Civil Liberties Union	National Association of Community Health Centers
American College of Physicians	National Association of Public Hospitals and Health Systems
American Dental Association	National Committee on Quality Assurance
American Hospital Association	National Council of La Raza
American Medical Association	National Council on Interpreting in Health Care
American Osteopathic Association	National Health Law Program
Asian American Justice Center	National Hispanic Medical Association
Asian Pacific Islander American Health Forum	National Immigration Law Center
Association of Community Organizations for Reform Now	National Partnership for Women and Families
Association of Language Companies	National Women’s Law Center
Bazon Center for Mental Health Law	Northern Virginia Area Health Education Center
California Healthcare Association	Physicians for Human Rights
Center on Budget and Policy Priorities	Physicians for Social Responsibility
Families USA	The Joint Commission
La Clinica de Pueblo	

This Explanatory Guide augments the Principles by discussing the issues considered in their development and other materials that offer support for the concepts ultimately adopted.

i Because the Executive Order and guidance both deal only with language access for LEP individuals, the coalition limited its focus to that group. The Principles therefore do not address services for those who use American Sign Language (ASL) or Braille. For similar reasons, the coalition has concentrated on language access in health care and not on the broader concept of cultural competency.

How the Statement of Principles was Developed

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 providers offer linguistically competent care, and if so, why? The answer: 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. In other words: "This is who we are and these are the patients we serve."

Coalition participants worked diligently to hone and clarify the language of the principles so that they accurately articulate the consensus positions achieved. The result is a statement that reflects a great deal of compromise and balance, but ultimate agreement on core issues.

The coalition sought to articulate the critical importance of effective communication with LEP populations in providing quality public health programs and health care services. Accordingly, it established a framework for the Statement of Principles organized around the following five domains:

Access

Quality language services facilitate entry to health services, assist in reducing health disparities and medical errors, reduce unnecessary tests, and improve accurate diagnosis and patient adherence to treatment plans. Research has shown significant differences in the health care experiences of LEP individuals who had interpreters available

and those who did not. There was also agreement that a clear statement should be articulated that competent language services are essential for effective public health and health care delivery. The coalition was emphatic, however, that more resources were needed to achieve these objectives. (Principles 1 and 2)

Funding

A paramount issue for all coalition members was the need for sufficient resources to provide effective language services to LEP populations. This issue was discussed and analyzed extensively from divergent and strongly held points of view. Although there was unanimity regarding the current lack of sufficient resources, there were diverse perspectives regarding responsibility for funding. There was sound agreement, however, that funding ultimately is a societal responsibility of all stakeholders in the health care system. (Principles 3 and 4)

Education

The coalition took a broad view of the role of education in improving access to quality health care for LEP individuals. The discussions considered the needs of patients, providers, funders, and the health care workforce. Key issues for coalition members included: informing providers about available resources in their communities; providing language-appropriate consumer education and outreach; educating states about available reimbursement mechanisms; improving data collection about LEP populations; addressing workforce issues such as diversity and appropriate training elements; and improving access to English as a Second Language instruction as an additional mechanism for eliminating language barriers. (Principles 5, 6, and 7)

Quality Improvement

It was the position of coalition members that the principles should reflect the importance of language services in achieving quality and

safety. In addition, the coalition felt that methodologies and strategies for assessing the quality of health care and health outcomes should be applied to assessing the competency of interpreters, translators, and bilingual staff. There was also general concern about the lack of national standards related to the assessment and training of those providing language services and a need to improve primary language data collection. (Principles 8, 9, and 10)

Accountability

The theme of accountability for providing language services in health care evolved from a point of view that focused on enforcement of existing laws and regulations to one that emphasizes the societal responsibility for providing these services. Advocates for enforcement joined other coalition members in framing a principle that articulates a concept of communal accountability, within which the enforcement of laws and regulations when necessary is an important tool, but not an end in itself. (Principle 11)

How the Principles Interrelate

The organizations endorsing the Statement of Principles¹ view them as an inseparable whole that cannot legitimately be divided into individual parts.² Each of the principles articulated here 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 whole.

The Societal Context for the Principles

According to the recently released *2005 American Community Survey* of the U.S. Census Bureau, almost 52 million people speak a language other than English at home. Over 12 million speak English “not well” or “not at all” and over 23 million (8.6 percent of the population) speak English less than “very well”.³

As demographic trends continue to evolve,⁴ the prevalence, diversity and geographic distribution of languages spoken will continue to be fluid and will necessitate the ongoing assessment of language needs. Multilingualism is spreading rapidly, in rural states and counties as well as urban environments.⁵ Between 1990 and 2000, fifteen states experienced more than 100 percent growth in their LEP populations — Arkansas, Colorado, Georgia, Idaho, Kansas, Kentucky, Minnesota, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Utah and Washington.⁶

As the number of limited English-speaking residents continues to increase, so does the demand for classes in English as a Second Language (ESL). This heightened demand has led to long waiting lists for ESL classes in many parts of the country.⁷ For example, in New York State, one million immigrants need ESL classes, but there are seats for only 50,000. Meanwhile, in Massachusetts less than half of those who applied for English classes were able to enroll.⁸

Research demonstrates how the lack of language services creates a barrier to and diminishes the quality of health care for LEP

individuals.⁹ In one study, over one quarter of LEP 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 did not need an interpreter and those who needed and received one.¹⁰ Language barriers also impact access to 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.¹¹

Health care providers from across the country have reported language difficulties and inadequate funding of language services to be major barriers to LEP individuals' access to health care and a serious threat to the quality of the care they receive.¹² Although virtually all hospitals and health care systems are legally required to provide interpreter services under a variety of federal and state laws, the lack of effective and consistent funding mechanisms is a major barrier to compliance. A growing number of health care providers, advocates, and others support laws requiring payers to cover the cost of interpreters. A 2002 Office of

Management and Budget (OMB) study estimated the cost of such a requirement would be only about \$4 per patient.¹³

The increasing diversity of the country only amplifies the challenge for health care providers,¹⁴ who must determine which language services are most appropriate based on their setting, type and size, the frequency of contact with LEP patients, and the variety of languages encountered. Without adequate attention and resources being applied to address the problem, the health care system cannot hope to meet the challenge of affording LEP individuals meaningful access to quality health care.

Principle 1: 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.

Accurate and effective communication is the most fundamental component of the health care encounter between patient and provider. Language barriers frequently lead to misunderstanding, dissatisfaction, and omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. Quality health care for LEP populations requires that language services be available and provided by competent staff and that written materials be available and translated in a manner that accurately and appropriately conveys the substance of the document or sign being translated.

The development of the descriptive elements of Principle 1 was the pivotal accomplishment of the coalition in achieving consensus on the relationship of effective language services to quality health care. Initial discussions of the principles included some lack of clarity and contentiousness about the role of language services in health care. Some provider and professional associations were focused on the lack of appropriate compensation for these services, concern about unfunded mandates by federal and state agencies, and lack of expertise in this area of health care. On the other hand, patient advocate groups emphasized the need to enforce existing laws and regulations and the inadequate response of the health care community to the needs of LEP populations. The coalition eventually arrived at the conclusion that it had to identify a commonly accepted view of language services in health care.

At the suggestion of organizations representing hospitals and those involved in health care and health outcome research, general agreement developed that the quality and safety of health care is the overarching imperative that crystallizes and underlies the need for language services. Once this framing of the issue was articulated, this principle was quickly adopted by consensus.

The ideas behind this principle — quality and safety as the underpinning for language services — are well grounded in the research literature. The Institute of Medicine’s (IOM) vision for quality health care in the United States, *Crossing the Quality Chasm: A New Health System for the 21st Century*, challenged the American health system to improve its quality and cost-effectiveness of care, and its responsiveness to patient needs and values. The IOM was addressing the prevalent and persistent shortcomings in our health system’s quality of care by offering a challenge to begin a major redesign of both the delivery system and the policy strategies that shape care delivery. At the core of the IOM report were six key dimensions of quality that provide a framework for policy and practice: care should be safe; effective; patient-centered; timely; efficient; and equitable.¹⁵ Each of these dimensions is related to providing quality care to LEP individuals — effective communication is critical to providing safe, effective patient-centered care; language services must be timely and efficient (*i.e.* competent) so as not to delay treatment or negatively impact health outcomes; and the health system must equitably treat English and non-English speakers.

In addition, the coalition’s thinking reflects the position of the American Medical Association (AMA) on the role of effective patient-provider communication: “Patient-centered communication is respectful of and responsive to a health care user’s needs, beliefs, values and preferences. Defined in this way, patient-centered communication is not just about patient-doctor conversations, it is an element of any ethical, high quality health care interaction.”¹⁶

Principle 2: Competent health care language services are essential elements of an effective public health and health care delivery system in a pluralistic society.

U.S. public health and health care systems have a long history of providing care to diverse populations. Although the English language and Anglo-European culture have gained dominance, a vast diversity of culture and language has taken hold, adding to the richness and vitality of the American social landscape. Today U.S. census and other demographic sources indicate that society is becoming more pluralistic, and not just in traditional centers of immigrant growth. In a recent survey of women giving birth in the nation's public hospitals and health systems, two-thirds of the respondents were born outside of the U.S. and were extremely diverse in terms of their countries of origin, with many coming from Central and South America, Asia, the Caribbean, Africa, the Middle East, and Eastern Europe.¹⁷

Given the multitude of languages spoken in the United States, and the increasing need for language services, the issue of competency of those providing language services was a much discussed topic while drafting the Principles. While no national standards exist for health care interpreters, states and national organizations have begun taking steps in that direction. (NOTE: In Principle 9, the coalition highlights the need for mechanisms to establish competency). For example, guidance from the federal Department of Health and Human Services' Office for Civil Rights recognizes the need for quality and accuracy in the provision of language services.¹⁸ And the National Council on Interpreting in Health Care has developed a national Code of Ethics and Standards of Practice for Interpreters in Health Care which is expected to form the basis for eventual national certification of interpreters in health care. These outline basic tenets for those providing language services as developed through a national consensus-building process that included input from a nationwide network of interpreters and State and regional organizations.

The research literature also documents the problems of using incompetent interpreters. In the July 20, 2006 issue of *The New England Journal of Medicine*, Glenn Flores, M.D., describes tragic miscommunication when medical interpreters are either not available or not competent. In one case, a mother misunderstood instructions and put oral antibiotics in a child's ears. In another, a doctor not fluent in Spanish interpreted "she hit herself" as "I hit her," resulting in a mother losing custody of her children after one of them fell off a tricycle. In another case a hospital was ordered to pay a \$71 million damage award because a patient was not treated promptly for a ruptured artery. The paramedics interpreted his complaint of "*intoxicado*" as meaning that he was "intoxicated" rather than "nauseated," and the hospital delayed a neurological evaluation while doing a drug-and-alcohol workup. The patient ended up quadriplegic.¹⁹

In addition to the issue of competency, the coalition, particularly those organizations advocating for patients and community groups, expressed a grave concern for the state of U.S. public health and the lack of sufficient resources directed at the needs of LEP populations. It was critical for many of these organizations to focus not only on health care delivery but also the public health system and thus this principle addresses both.

Coalition members, particularly those from the public sector, cautioned, however, that despite ongoing advances in quality of care, persistent racial and ethnic health disparities continue to plague the U.S. health care system. It was agreed that language difficulties among the diverse LEP population likely exacerbates this problem. Yet, although the costs of increased morbidity and mortality associated with health disparities are high, the elimination of disparities is only beginning to emerge as a focus of investment in U.S. public health and health care systems.

Principle 3: The responsibility to fund language services for LEP individuals in health care settings is a societal one that cannot fairly be visited upon any one segment of the public health or health care community.

Health care in the United States is provided through a variety of public and private systems of financing, education, organization, access, provision, and oversight. The common value among the stakeholders in these systems represented in the coalition, however, is the view that effective communication is essential to access quality care, to assure patient adherence to treatment plans, and to achieve positive outcomes. Lack of effective patient-provider communication clearly has quality and safety implications because it can lead to incorrect diagnosis. Important preventive health measures may not be properly understood, implemented or adhered to. And language barriers may prevent patients from receiving complete information about treatment options. The coalition succeeded in formulating the consensus position that, whatever the health care setting, it was a societal responsibility to provide sufficient resources to facilitate effective communication, by funding both language services and ESL programs (see Principle 7).

In developing Principle 3, coalition members, in particular those representing small clinical practices, were concerned that the onus of providing language services would fall disproportionately on individual professionals and group practices. In addressing this concern and building upon Principle 2, the coalition clearly enunciated its position that language services for LEP individuals, being an essential aspect of quality health care, become a communal fiduciary and ethical responsibility that all segments of the public health and health care community have to the American public. Through Principle 3, the coalition is calling upon all health care providers, insurers,

employers, organizations, and policy makers to recognize and to commit to providing and paying for language services. The coalition envisions sufficient resources be made available to public, private, and nonprofit health care providers to enhance both access to and the quality of services by reducing language barriers.

The United States is a nation of immigrants. Organizations in the coalition that advocate on behalf of or provide health care to recent immigrants wanted this fact reflected in the principles by calling on all participants in the health care system — providers, insurers, government, employers, and patients — to share the responsibility for providing quality care for individuals from varied language backgrounds. But the coalition also considered the points of view of those who believe that the best solution is to communicate only in English. The Principles recognize, through their support for adequate ESL funding (see Principle 7), the desire and need of many LEP individuals to learn English. But all recognized that this cannot be the only response. Many LEP individuals enter the country as asylees or refugees and it takes time to learn English even if educational training is immediately available. Also, due to the complexity of the interactions, it may take longer for individuals to achieve sufficient English fluency to understand and participate in health care decision-making. The coalition concluded that this hurdle must be overcome both through education and a clear articulation of organizational policy and practice that recognize and embrace the linguistic diversity of our country.

Principle 4: 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.

Those U.S. health care providers and organizations that are focusing quality improvement efforts on addressing language barriers affecting the communities served are doing so in an environment that provides limited or no reimbursement for these types of interventions. Acknowledging this, and building on Principle 3, the coalition supports the proposition that our public, not-for-profit, and for-profit health care delivery systems should be organized and funded to respond effectively to patient linguistic diversity.

Both provider associations and advocacy organizations agreed that adopting a range of strategies to address linguistic access makes sound economic and policy sense. Public sector representatives of the coalition pointed out that, although many health care providers and organizations already have exerted leadership in the provision of language services, stable sources of funding and reimbursement are necessary to help offset the expense without sacrificing other critical imperatives. Provider associations in the coalition emphasized that since only a handful of insurers pay for language services, most of the responsibility falls to providers. For example, a recent study from the Health Research and Educational Trust found that only 3 percent of hospitals are receiving

direct payment for language services.²⁰ The provider associations pointed to the need for support in developing other resources for patients who speak English as their primary language but who have limited literacy and for improved dissemination of existing strategies to pay for language services.

In Principle 4, the coalition concludes that implementing language access in health care is difficult in light of the resource constraints facing many health providers and organizations. For instance, only fourteen states currently reimburse providers through Medicaid and the State Children's Health Insurance Program (SCHIP) for interpreter services, a basic tool in providing linguistically appropriate services.²¹ And Medicare does not reimburse such services at all, although a recent report prepared for the coalition outlines options for how Medicare could implement payment.²²

Accordingly, this Principle stresses that federal, state and local governments and health care insurers need to develop an agenda for identifying and supporting promising and effective practices for serving our linguistically diverse populations.

Principle 5: 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.

The “gold standard” for providing health care to non-English speaking individuals is to offer access to bilingual bicultural health care providers who are competent to provide services directly in a patient’s language. The coalition recognized that this goal is a long way away and thus most health care providers rely on interpreters and translators to ensure effective communication between LEP patient and provider. Yet coalition members recognized that more can — and should — be done to increase the linguistic diversity of the health care workforce. This emphasis is particularly important in direct patient contact positions so that bilingual staff in other positions is not continually pulled away to interpret. Direct contact positions include not only those involved in providing clinical care but also front office staff for scheduling and administrative assistance; technicians administering laboratory, x-ray, and other diagnostic tests; and individuals who can explain payment options and financial assistance.

The discussion also noted that, similar to Principle 2, the competency of bilingual individuals should also be considered. As the Office for Civil Rights noted in its LEP Guidance, self-identification as bilingual is not necessarily indicative of an individual’s ability to interpret or translate. Thus concomitant with ensuring linguistic diversity, it is vital that bilingual individuals have sufficient competency to interpret, translate or provide services directly in a non-English language.²³

In formulating Principle 5, the coalition reflects the research pointing to a link between health outcomes for minorities and LEP populations and the lack of bilingual and minority providers.²⁴ The coalition’s concern for linguistic diversity in the health care workforce is bolstered by the findings of the Sullivan Commission on Diversity in the Healthcare Workforce that racial, ethnic,

and linguistic minorities are not present in significant numbers. For example, African Americans, Hispanics and American Indians combined make up more than 25 percent of the U.S. population but represent less than nine percent of nurses, six percent of physicians, five percent of dentists, and similarly low percentages of other health professions. The Commission’s report speaks to the imbalance in the makeup of the U.S. health care workforce and how it contributes to the gap in health status and the impaired access to health care experienced by a significant portion of the population.²⁵

In elaborating on the implications of Principle 5, the coalition cited the need for increasing recruitment and training of health professionals from diverse linguistic backgrounds. There are a variety of effective workforce development programs. Some of the concepts, as suggested by a focus group of public hospital CEOs, which could be included are:

- Increasing or dedicating funding for health professions training programs and recruitment of bilingual individuals;
- Exploring standardized medical interpreter training, testing and/or assessment for bilingual individuals intending to provide interpreting services (NOTE: the National Council on Interpreting in Health Care has published national practice standards for health care interpreters);
- Determining what workforce training and education programs should be offered to staff in the area of linguistic competence; and
- Collaborating with other providers and organizations on the funding and implementation of workforce training and education programs for staff serving linguistically diverse populations.²⁶

Principle 6: 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.

In drafting Principle 6, the coalition supports development of organizational agendas and infrastructures for facilitating and promoting quality health care for our diverse communities. This includes establishing priorities for training staff and educating constituents that guide the systems and management of a hospital, clinic, or physician practice. The core concept behind this strategy is: providing health care in a linguistically competent manner for diverse communities is not a discrete project, program, or initiative but provides a context for all aspects of care for a diverse community. This directly relates to an environment conducive to positive health outcomes cited in Principle 5.

The ideas enunciated in Principle 6 are characterized by thinking about staff development and constituent education in terms of their relationship to, and impact on, quality and safety of health care for the community served. It includes valuing and promoting care that is characterized by initiating, integrating, and assuring linguistically competent practices throughout the organization's programs and operations related to training and education. For example, in addition to ensuring interpreters and translators have the appropriate skills and education, it is also important that all staff — clinical and non-clinical — know how to access language services and when and how to work with interpreters and translators.

By including an educational component of promoting effective language services, the coalition reflects the view that engaging staff, consumer, family, and community participation in the planning and delivery of services is essential to meet the needs of LEP populations. This view requires developing and maintaining productive linkages and partnerships with other health care providers, community agencies, and resources. Educating staff and constituents requires an assessment of community needs and effective community engagement. In addition, it is based on the belief that the community is not just a recipient or consumer of health care but is a real partner in identifying needs, establishing priorities, developing programs, and promoting effective health care for all.

In follow-up discussions about the principles, the coalition formulated some practical steps that could be undertaken to implement the intent of Principle 6:

- Identify methods for assessing best practices for a variety of settings and language services, *e.g.* in-person, telephonic, after-hours and available resources;
- Develop tools or protocols to evaluate effectiveness of programs;
- Create and implement education at health care professional schools (see for example the American Association of Medical Colleges curriculum²⁷);
- Explore development of continuing education programs.

Principle 7: 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.

English as a Second Language (ESL) is a basic component of instructional programs for LEP individuals, often integrated within a broader curriculum. ESL instruction includes the development of listening, speaking, reading, and writing in addition to the development of social communication skills and academic language proficiency. Access to ESL instruction is one effective way of reducing limited English proficiency in the U.S. population.

In developing this principle, provider associations highlighted that in health care, as in every other aspect of American life, the ability to understand and communicate effectively in English is desirable for successful interactions and outcomes. They stated that English is the *de facto* language of the United States and those with limited English skills should embrace personal responsibility and motivation to learn English. Other members emphasized that time to acquire adequate English skills and resources to provide educational programs are needed to attain this ideal and that in no way should we disparage language learning and multilingualism. The coalition agreed that all individuals have the right to preserve and foster their linguistic and cultural origins, whether their native tongue is English or another language. Further, coalition members representing patient advocate and provider

associations voiced the need for ESL instruction for foreign health care workers who are recruited by U.S. hospitals and health systems. These workers occupy virtually every health care occupation and are routinely called upon to communicate with other staff and patients. Providing English language instruction to these workers can also increase the availability of bilingual health professionals who can provide services in non-English languages and/or potentially assist (after training and assessment) with interpretation and translation (see Principle 6).

While the coalition recognized the need for ESL instruction as an additional mechanism for eliminating the language barriers to health care, few opportunities are readily available. Urban areas, in particular, reflect a demand for adult ESL resources that far outpaces the supply, with extensive waiting lists for persons wishing to attend available programs.²⁸ It takes children two to five years to become socially adept in a second language, and while research is limited for adults, the expectation is that it will normally take them even longer.²⁹

Principle 7 is a call for more effective strategies for increasing the availability of and funding for ESL instruction, as well as for fostering an inclusive environment for all linguistic groups.

Principle 8: 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.

In formulating Principle 8, coalition members from hospital organizations and agencies involved with quality improvement and accreditation stressed the need to take advantage of proven quality improvement strategies to assess and evaluate the care provided to LEP populations. These groups pointed out that the provision of culturally competent services — of which language services are one part — recognizes and responds to differing health-related beliefs and values, disease incidence and prevalence, and treatment efficacy seen across diverse populations. Viewing language services as an integral aspect of quality and safe health care contributes to positive outcomes for patients (including satisfaction); the provision of appropriate preventive services, diagnoses, and treatments; increased adherence to prescribed treatments; and improved health status. The coalition concurred that quality improvement initiatives need to be broadened to focus on how the presence or absence of effective language services impacts the quality and safety of health care and the elimination of disparities.

The provider's ability to communicate with a patient is a *sine qua non* of quality health care, which evaluation mechanisms and organizations should take into account. More research is necessary to identify methods and metrics specific to measuring the quality of language services. Initial work in this area is being undertaken by

Speaking Together: National Language Services Network, a project funded by the Robert Wood Johnson Foundation to identify quality measures and create performance benchmarks for language services.³⁰

Another promising example relates to the role of health information technology (HIT). HIT offers potential for improving quality generally if implemented to support providers' management of linguistically competent patient care, could also directly contribute to reductions in health disparities. To maximize the impact of quality improvement initiatives in this area, policymakers and funders could encourage and support adoption of HIT for improving language services among public and non-profit providers who may otherwise lack the necessary capital.

Another report that reflects the concepts underlying this Principle is the *2005 National Healthcare Disparities Report* (NHDR), a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and among priority populations. It recognizes the importance of quality measures as a method of reducing health disparities related to language barriers (among other factors). The report highlighted four key themes: disparities still exist; some disparities are diminishing; opportunities for improvement remain; and information about disparities is improving.³¹

Principle 9: Mechanisms should be developed to establish the competency of those providing language services, including interpreters, translators and bilingual staff/clinicians.

As discussed in Principle 2, the coalition recognized that in recent years, health care organizations have made significant progress in providing effective language services, but the lack of competent interpreters remains a critical issue for serving LEP patient populations. The coalition concluded that one of the key elements in overcoming this barrier is the need for consistent definitions of the characteristics, skills, and role of a competent health care interpreter, translator, or bilingual staff/clinician. Existing inconsistency has increased the potential for inaccurate patient communication having both clinical and financial consequences. In this regard, coalition members representing small physician practices and professional organizations expressed concern regarding the lack of standards (national or state) to guide recruitment, training and assessment of interpreters, translators, and bilingual staff. The coalition emphasized the need for resources to enable evaluation of language competency with protection from liability and responsibility for assessing skills.

Provider associations in the coalition suggested that there should be an exploration of the multiple ways language services can be provided and how those providers can be trained and assessed regarding the level of services they are asked to perform, ranging from basic to complex interactions. For example, individuals with a basic command of a language other than English might be able to assist with scheduling or completing a facility's forms but only those with fluency and demonstrated competency in interpreting should interpret during the clinical encounter. Coalition members also suggested that it would be helpful to develop a decision tree for providers to help determine when to use varying levels/skills of interpreters/bilingual clinicians/bilingual staff.

In addition to the issue of training and assessment, some organizations in the coalition, particularly those involved in workforce development, raised concerns about establishing a health care interpretation or translation "profession" which could imply requirement of an advanced degree or certificate, a requirement that would not account for certain complex issues. For example, some competent bilingual individuals may not have the educational background required for admittance to secondary education, or there may be difficulty in developing adequate programs or assessment requirements for certain languages for which there is a limited demand. Another significant concern relates to the exclusionary effect that it may have by limiting the number of available interpreters and translators, thus diminishing – rather than enhancing – access to health care. The coalition agreed that paramount in any discussion of establishing competency standards for health care interpreting and translation is the recognition that this area of health care is still evolving.

Also referenced in Principle 2, a key organization that has emerged as a leader in this critical area is the National Council on Interpreting in Health Care (NCIHC). In 2005, NCIHC developed the first national standards of practice for health care interpreters. The standards are intended to enhance professionalism in the field of health care interpreting, thereby improving quality of care, reducing errors, and promoting effective communication. Just as clinical protocols provide for quality and consistency of medical practice, these standards provide guidance as to what is expected of interpreters and what constitutes good practice. The standards also provide a common base of understanding of the health care interpreting profession, thus improving the quality of interpreter services across the United States and addressing some of the key issues raised by the coalition.³²

Principle 10: Continued efforts to improve primary language data collection are essential to enhance both services for, and research identifying the needs of, the LEP population.

With the IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, clearly documenting that racial, ethnic, and language-based disparities still exist, measurement and outcomes have become critical for assessing the effectiveness of health care. Recognizing this, the coalition articulated Principle 10 to emphasize that data are key elements in tracking language needs and in developing effective programs for addressing them within a quality improvement framework.³³

Many advocacy organizations stressed the vital importance of data collection to identify and plan for language needs as well as to identify disparities caused by language barriers.³⁴ These organizations sought language in the principles that would underscore the need for mandatory data collection. But some provider associations felt that certain essential questions still needed to be addressed to improve data collection, particularly regarding information management systems. For example, there are a variety of ways providers currently obtain primary language data — some request a patient’s primary language, others ask patients in what language they would prefer to receive services, and others collect separate data to distinguish between a patient’s oral and written language needs. In addition to questions about how to collect primary language data, other data questions exist, such as:

- What performance measures and data sets are needed to monitor culturally and linguistically competent practices in an organization?
- How can performance data be collected and analyzed in an accessible, timely, and cost-effective manner?
- What systems are in place to use data effectively to ensure the maximum impact of financial and human resources dedicated to quality care for diverse LEP populations?

This principle reflects the compromise that data collection is important but more research is needed to identify the most effective collection methods and data sets so that the data can be effectively utilized.

The importance of data collection has been emphasized recently by The Joint Commission. In 2006, The Joint Commission implemented a new accreditation standard that required the notation of a patient’s language in the patient record.³⁵ In addition, recent studies by the National Public Health and Hospital Institute (NPHHI) and Health Research and Educational Trust indicated that the majority of U.S. hospitals are already actively engaged in data collection, at least for some segment of their patient populations.³⁶ However, despite its availability, very few hospitals are using the data in quality improvement initiatives or even as a management or marketing tool. The NPHHI study pointed out that more attention needs to be given to developing systems for capturing the most complete and accurate information on patients, but that the field of disparities research should nonetheless proceed using the data currently available.³⁷

The Health Research and Educational Trust’s web-based toolkit for collection of race, ethnicity and primary language information (www.hretdisparities.org) is one example of the efforts to improve primary language data collection intended by Principle 10. This toolkit is helping hospitals collect accurate information from patients to meet regulatory, accreditation and local community demands, and to monitor quality of care by linking to clinical measures and targeting appropriate interventions to specific groups.³⁸

Principle 11: 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.

All stakeholders in the health care community fulfill important roles in, and share responsibility for, eliminating language access barriers to quality health care, as evidenced by the preceding principles. They reflect a vision of developing and funding shared resources available to public, private, and nonprofit sectors of health care to enhance access to quality services for addressing language barriers. With responsibility and resources, however, comes accountability for providing or facilitating the provision of those services.

This principle originally arose out of concerns about enforcement. In the view of many of the advocacy organizations, LEP individuals often do not receive language services because implementation and enforcement of existing laws have been inadequate. In the context of other principles these groups wanted to ensure that any new funding (see Principles 3 and 4) was coupled with enforcement. They see such a requirement as entirely consistent with the concept of personal responsibility that formed part of the foundation for Principle 7, which recognizes the value of learning English if there are sufficient resources available to do so. Yet for many of the provider associations, a focus on enforcement detracted from the positive steps of many of their members to provide language services. Others were concerned that noncompliance might, in some cases, arise from lack of knowledge rather than lack of concern. They felt that an emphasis on enforcement in those cases could be counter-productive,

and that affirmative measures, such as education about the need to provide language services, could achieve the same result in a more positive manner and more quickly. In addition, framing the issue as “enforcement” put the onus primarily on providers without recognizing that other entities, such as government agencies that ought to assist with the provision of financial and technical resources, also had to be part of the solution.

This debate was resolved when one of the provider organizations suggested focusing on accountability rather than enforcement. All quickly agreed that it is results, and accountability for achieving those results, that matter. Enforcement is merely one tool available to ensure that the money being spent accomplishes its intended purpose. Accountability, though, is a broader concept, one that includes among other things an affirmative responsibility to meet the needs of LEP individuals and clinical staff, both of whom often need assistance in determining how best to overcome language barriers.

The group highlighted that language services must be available as a “matter of course” to reemphasize the concept embodied in Principle 1 that accurate communication is a sine qua non of quality health care, and accurate communication is not possible for LEP individuals without competent language assistance. The Principle envisions a health care system in which an LEP patient with a heart murmur would no more be treated without necessary language services than he or she would be without a stethoscope.

In calling for accountability from all stakeholders, this principle contemplates a system-wide approach to quality health care, delivered through a system in which all stakeholders are accountable for developing and utilizing appropriate strategies and interventions. This shared responsibility will result in a valuable synergy of resources, improve health care system performance, and contribute to the sustainability of quality health care for all populations.

The concept of real accountability finds support in the National Standards on Culturally and Linguistically Appropriate Services (CLAS), developed by the U.S. Department of Health and Human Services in 2001. CLAS provides an organization and logic for providing quality health care to linguistically diverse communities within a framework of accountability. Standard 1 encapsulates the concept of accountability for providing care that includes access to language services: “Health care organizations should ensure that patients/ consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.”³⁹

The moral underpinnings of the concept of accountability are reflected in and supported by the American Medical Association’s report from its Ethical Force Program (Consensus Report: Improving Communication – Improving Care), which recognizes that the health care community holds unique ethical obligations to meet the

health care needs of the communities they serve. These obligations create a social covenant between health care organizations and their communities. One key tool for fulfilling their social covenants and meeting their ethical obligations is patient-centered communication. The AMA report cites several professional codes, guidelines, and standards for health care organizations that hold that patient-centered communication is vital for health care organizations to provide ethical, high quality care. These ethical obligations include:

- Maintaining and protecting health care users’ autonomy (decision-making, preferences, needs, and values);
- Assuring quality care;
- Maintaining equity among health care users.

The AMA report states that none of these ethical obligations can be fully achieved without patient-centered communication for all communities served.⁴⁰

Finally, Principle 11 reflects the reality that government at all levels has an obligation to provide financial support for the provision of language services, and not just require others to provide them. In short, Principle 11 is premised on the conviction that open and accurate communication is an essential component of quality health care, and that such communication is not possible for LEP patients without competent language services.

Final Comments

In developing these Principles, the coalition is keenly aware that health care organizations, government leaders, and providers are being challenged by the growing diversity of the communities they serve and the need to continuously improve the quality and safety of care. These challenges, however, point to a critical need for facilitating, documenting, and disseminating practical and cost-effective strategies that respond to the linguistic health care needs of all communities. The coalition is calling upon all stakeholders – providers, insurers, government, employers, and patients – to collaborate in developing and implementing strategies for quality health care within a framework that recognizes:

- The relationship between effective language services and quality health care;
- The societal responsibility for funding effective language services; and,
- The accountability of all stakeholders, including government, for providing or facilitating effective language services.

Appendix

ENDORISING ORGANIZATIONS (FEBRUARY 2010)

Aetna	Asthma and Allergy Foundation of America
Allergy and Asthma Network Mothers of Asthmatics	Bazelon Center for Mental Health Law
American Academy of Family Physicians	California Association of Public Hospitals and Health Systems
American Academy of Pediatrics	California Health Care Safety Net Institute
American Academy of Physician Assistants	California Healthcare Association
American Association of Colleges of Pharmacy	California Healthcare Interpreting Association
American Association of Physicians of Indian Origin	California Primary Care Association
American Civil Liberties Union	Catholic Charities USA
American College of Obstetricians and Gynecologists	Catholic Health Association of the US
American College of Physicians	Center for Medicare Advocacy
American Counseling Association	Center on Budget and Policy Priorities
American Hospital Association	Center on Disability and Health
American Medical Association	Certification Commission for Healthcare Interpreters
American Medical Student Association	Children's Defense Fund
American Nurses Association	Community Health Councils (CA)
American Psychiatric Association	Cross-Cultural Communications, LLC
American Psychological Association	Cuban American National Council
American Public Health Association	District of Columbia Language Access Coalition
Asian American Justice Center	District of Columbia Primary Care Association
Asian Pacific Islander American Health Forum	Families USA
Association of Asian Pacific Community Health Organizations	Family Voices
Association of Clinicians for the Underserved	Greater N.Y. Hospital Association
Association of Community Organizations for Reform Now	HIV Medicine Association
Association of Language Companies	Indiana Latino Institute, Inc.
Association of University Centers on Disabilities	Institute for Diversity in Health Management
	Institute for Reproductive Health Access
	International Medical Interpreters Association

The Joint Commission
La Clinica del Pueblo
Latino Caucus, American Public Health Association
Latino Coalition for a Healthy California
Latino Commission on AIDS
Leadership Conference on Civil Rights
Medicare Rights Center
Mental Health America
Mexican American Legal Defense and Educational Fund
Migrant Legal Action Program
Molina Healthcare, Inc.
National Alliance of State Pharmacy Associations
National Asian American Pacific Islander Mental Health Association
National Asian Pacific American Families Against Substance Abuse
National Asian Pacific American Women's Forum
National Association of Community Health Centers
National Association of Mental Health Planning and Advisory Councils
National Association of Public Hospitals and Health Systems
National Association of Social Workers
National Association of Vietnamese American Service Agencies
National Center for Law and Economic Justice
National Committee for Quality Assurance
National Council of Asian and Pacific Islander Physicians
National Council of La Raza
National Council on Interpreting in Health Care
National Family Planning and Reproductive Health Association
National Forum for Latino Healthcare Executives
National Health Law Program
National Immigration Law Center
National Hispanic Medical Association
National Latina Institute for Reproductive Health
National Latino AIDS Action Network (NLAAN)
National Medical Association
National Partnership for Women and Families
National Respite Coalition
National Senior Citizens Law Center
National Women's Law Center
Northern Virginia Area Health Education Center
Northwest Federation of Community Organizations
Out of Many, One
Physicians for Human Rights
Presbyterian Church (U.S.A.) Washington Office
Service Employees International Union
SisterSong Women of Color
Reproductive Justice Collective
Society of General Internal Medicine
Summit Health Institute for Research and Education
USAction
Washington Community Action Network

Endnotes

- 1 Those organizations that have endorsed the Principles are listed in Appendix A. An updated list is available at <http://www.healthlaw.org/link.cfm?5837>.
- 2 The drafters included a statement explaining the expected use of the Principles: "It is anticipated that the Principles will be disseminated to other interested stakeholders, Congressional and Administration staff, and the media to raise awareness of this issue and to support policies consonant with these principles. However, endorsement of the 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."
- 3 U.S. Bureau of the Census, *2005 American Community Survey: Table 16004*, available at http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts.
- 4 For example, from 1990–2000, the "top ten" countries of origin of immigrants residing in the United States changed significantly. In 1990, the top ten were Mexico, China, Philippines, Canada, Cuba, Germany, United Kingdom, Italy, Korea, and Vietnam. In 2000, while the top three remained the same, three countries fell off the top ten; the remaining changed to India, Cuba, Vietnam, El Salvador, Korea, Dominican Republic, and Canada.
- 5 See P. Kilborn and L. Clemetson, *Gains of 90's Did Not Lift All, Census Shows*, NEW YORK TIMES, A20 (June 5, 2002) (finding the immigrant population from 1990–2000 increased 57 percent surpassing the century's great wave of immigration from 1900–1910 and moving beyond larger coastal cities into the Great Plains, the South and Appalachia).
- 6 1990 and 2000 Decennial Census. Limited English Proficiency refers to people age 5 and above who report speaking English less than "very well."
- 7 See, J. Tucker, *Waiting Times for Adult ESL Classes and the Impact on English Learners*, NALEO Educational Fund (October 2006), available at <http://renewthevra.civilrights.org/resources/ESL.pdf>. See also, National Center for Education Statistics, *Issue Brief: Adult Participation in English-as-a-Second Language Classes* (May 1998), citing Bliss (1990); Chisman (1989); Crandall (1993); U.S. Department of Education (1995); Griffith (1993).
- 8 S. Sataline, *Immigrants' First Stop: The Line for English Classes*, The Christian Science Monitor (August 27, 2002).
- 9 See, G. Flores, M. Barton Laws, S.J. Mayo, et al., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, Pediatrics (2003), 111(1): 6–14; T. K. Ghandi, H.R. Burstin, E.F. Cook, et al. *Drug Complications in Outpatients*, Journal of General Internal Medicine (2000), 15:149–154; D.K. Pitkin, D.W. Baker, *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>.
- 10 See D. Andrulis, N. Goodman, and C. Pryor, *What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency*, The Access Project (April 2002), available at http://www.accessproject.org/adobe/what_a_difference_an_interpreter_can_make.pdf.
- 11 E.g. J. Bernstein et al., *Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up*, Journal of Immigrant Health, Vol. 4 No. 4 (October 2002); I.S. Watt et al, *The Health Care Experience and Health Behavior of the Chinese: A Survey Based in Hull*, Journal of Public Health Medicine, 129 (1993); S.A. Fox and J.A. Stein, *The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups*, 29 MED. CARE 1065 (1991).
- 12 Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii–iii (February 2001) (prepared by L. Ku and A. Freilich, The Urban Institute, Washington, DC), available at <http://aspe.hhs.gov/hsp/immigration/caring01/index.htm>. See also Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 71–72 (2002) (describing recent survey finding 51 percent of providers believed patients did not adhere to treatment because of culture or language but 56 percent reported no cultural competency training).

- 13 G. Flores, *Language Barriers to Health Care in the United States*, *New England Journal of Medicine*, Volume 355:229–231, Number 3 (July 20, 2006), available at <http://content.nejm.org/cgi/content/full/355/3/229>.
- 14 For the purposes of this document, “providers” includes health care institutions such as hospitals and nursing homes; managed care organizations; insurers; and individual clinicians and practitioners.
- 15 Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001).
- 16 Ethical Force Program™ Oversight Body, the Institute for Ethics at the American Medical Association, An Ethical Force Program Consensus Report, *Improving Communication – Improving Care: How Health Care Organizations Can Ensure Effective, Patient-Centered Communication with People from Diverse Populations* (2006), available at <http://www.ama-assn.org/ama/pub/category/11929.html>.
- 17 M. Regenstein, L. Cummings, and J. Huang, *Barriers to Prenatal Care: Findings from a Survey of Low-Income and Uninsured Women Who Deliver at Safety Net Hospitals*, prepared for the March of Dimes, National Public Health and Hospital Institute, Washington DC (October 2005), available at http://www.naph.org/Template.cfm?Section=Books_and_Monographs&template=/ContentManagement/ContentDisplay.cfm&ContentID=6658.
- 18 See HHS Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, available at <http://www.hhs.gov/ocr/lep/revisedlep.html>.
- 19 G. Flores, *op. cit.*
- 20 R. Hasnain-Wynia, J. Yonek, D. Pierce, R. Kang, and C.H. Greising, *Hospital Language Services for Patients With Limited English Proficiency*. Health Research and Educational Trust/American Hospital Association (October 2006), available at http://www.hretdisparities.org/hretdisparities_app/index.jsp.
- 21 National Health Law Program, *Medicaid/SCHIP Reimbursement Models for Language Services-2005 Update*, available at <http://www.healthlaw.org/link.cfm?5837>.
- 22 L. Ku, *Paying for Language Services in Medicare: Preliminary Options and Recommendations*, Center on Budget and Policy Priorities (October 2006), available at <http://www.healthlaw.org/link.cfm?5837>.
- 23 See HHS Office for Civil Rights, *op. cit.*
- 24 D. Andrulis, N. Goodman, and C. Pryor, *op. cit.*
- 25 L.W. Sullivan, *Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce* (2004), available at http://www.calendow.org/reference/publications/pdf/workforce/TCE0920-2004_Missing_Person.pdf#search='sullivan%20commission%2C%20missing%20person'.
- 26 E. Martinez, *et. al.*, *Serving Diverse Communities in Hospitals and Health Systems From the Experience of Public Hospitals and Health Systems*, Executive Summary, National Public Health and Hospital Institute, prepared the U.S. Department of Health and Human Services, OPHS Office of Minority Health, Washington, DC (June 2004), available at http://www.naph.org/Template.cfm?Section=Books_and_Monographs&template=/ContentManagement/ContentDisplay.cfm&ContentID=6681.
- 27 See *Cultural Competence Education for Medical Students – Assessing and Revising Curricula*, available at www.aamc.org/meded/tacct/culturalcomp.pdf. Additional materials are available at www.aamc.org/meded/tacct/start.htm.
- 28 House Committee on Education and the Workforce, Subcommittee on Education Reform, *Hearing on Examining Views on English as the Official Language*, submitted by C. Amoroso (July 26, 2006).
- 29 M. Burt, *Issues in Improving Immigrant Workers’ English Language Skills*, National Center for ESL Literacy (December 2003).
- 30 More Information on the Speaking Together: National Language Services Network is available at <http://www.speakingtogether.org>.
- 31 Agency for Healthcare Research and Quality, *National Healthcare Quality Report*, Rockville, MD (2005), available at <http://www.ahrq.gov/qual/nhqr05/nhqr05.htm>.
- 32 More information on the National Council on Interpreting in Health Care is available at <http://www.ncihc.org>.
- 33 Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002).
- 34 R.T. Perot and M. Youdelman, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices*, The Commonwealth Fund (September 2001), available at <http://www.cmwf.org>.

- 35 More information on The Joint Commission's standards and research on language services in health care is available at <http://www.jointcommission.org/HLC>.
- 36 M. Regenstein and D. Sickler, *Race, Ethnicity, and Language of Patients: Hospital Practices Regarding Collection of Information to Address Disparities in Health Care*, National Public Health and Hospital Institute, prepared for The Robert Wood Johnson Foundation, Washington DC (January 2006), available at <http://www.rwjf.org/research/researchdetail.jsp?id=2411&ia=133>; R. Hasnain-Wynia, J. Yonek, D. Pierce, R. Kang, and C.H. Greising, *Hospital Language Services for Patients With Limited English Proficiency*. Health Research and Educational Trust/American Hospital Association (October 2006), available at http://www.hretdisparities.org/hretdisparities_app/index.jsp.
- 37 M. Regenstein, *op cit*.
- 38 R. Hasnain-Wynia and D.A. Pierce, *A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients*, Health Research and Educational Trust (February 2005), available at <http://www.hretdisparities.org>.
- 39 U.S. Department of Health and Human Services, OPHS Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care – Executive Summary*, Washington, DC (March 2001), available at <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>.
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