FEBRUARY 2010

Language Services Resource Guide

FOR PHARMACISTS

PREPARED BY

The National Health Law Program

WITH

American Association of Colleges of Pharmacy
National Alliance of State Pharmacy Associations

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The National Health Law Program

Washington, DC • Los Angeles, CA • Chapel Hill, NC

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Introduction

In 2003, the National Health Law Program convened national organizations interested in working together on language access issues. This coalition is a collaborative effort to envision and foster a health care delivery system that would better respond to the increasing diversity of our nation. The coalition joins health care providers, advocates, language services agencies, accrediting organizations, and other interested stakeholders to identify areas of consensus to improve language access for limited English proficient individuals.

The coalition developed a Statement of Principles (see Appendix A) to guide its work. The very first Principle embodies the commitment of the coalition – a recognition that the ultimate goal in the health care setting is effective communication between provider and patient. It states: "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." Other principles address issues of funding for language services, technical assistance, workforce diversity, data collection, and quality improvement.

In 2003, NHeLP, in collaboration with the National Council on Interpreting in Health Care, released the *Language Services Resource Guide for Health Care Providers*. This Guide offered an overview of materials related to providing effective language services in health care settings.

In 2007, NHeLP began working with the American Association of Colleges of Pharmacy and the National Alliance of State Pharmacy Associations to identify needed resources to assist pharmacists in identifying and providing language services. The *Language Services Resource Guide for Pharmacists* is based on the earlier guide with additions and updates related to providing language service in pharmacy settings. This guide, developed with input from AACP, NASPA and an Advisory Committee convened in March, 2009, gathers basic information about providing language services in one document. Information includes interpreter and translator associations and agencies, training programs, assessment tools, and other materials. A searchable version is available online at **www.healthlaw.org**.

We hope that this guide will aid pharmacists and pharmacies in improving language access and improving health care for their clients and patients.

Contents of this Guide

Chapter 1. Assessment of Needs and Development of a Language Services Plan

This chapter provides an overview of the issues around language access. First, it provides information on the demographics of the United States and the changing face of the limited English proficient population. It also explains concerns with relying on untrained interpreters such as family members, friends, and children in health care encounters.

Chapter 2. Assessment of Needs and Developing a Language Services Plan

This chapter offers basic steps for identifying the language services needs of a provider's client base and information about two assessment tools to help providers determine their needs (excerpts from these tools are in Appendix E and F). The chapter also includes other resources on developing language services from the Office of Minority Health, America's Health Insurance Plans, the American Medical Association, and Joint Commission Resources (an affiliate of The Joint Commission).

Chapter 3. Language Service Resource Locator

Locating language services can often be challenging. The chapter's association listing includes local, state, regional and national interpreting and translation associations. These associations can be valuable resources for pharmacists to identify available language services. A directory of language service providers follows. This directory is far from comprehensive. Attempts were made to find language services in every state. To our knowledge, only programs that provide services to the public are listed, rather than those limited to in-house service. Many unique and innovative in-house language access services also exist within various pharmacy chains, hospitals and social services settings, but since their services are not accessible by non-affiliated providers, they are not included in these listings. However, exploring whether in-house programs exist in your local communities may provide valuable information and resources as you develop your own language services.

Chapter 4. Multilingual Tools and Resources

This chapter offers a sampling of materials available to aid in providing language services, such as sources for preexisting translated patient materials, "I-Speak" cards, bilingual dictionaries, and testing resources.

Chapter 5. Promising Practices and Technology

This chapter offers examples from pharmacies that are successful in providing language services as well as an exploration of technological options to assist pharmacists.

Chapter 6. Health Care Symbols

Finding one's way through a large health care provider, such as a hospital, can be especially challenging for limited English proficient individuals. Recent developments in symbols can assist providers in helping LEP individuals navigate through the system and may be especially useful for entity's whose LEP clientele speaks multiple languages where multilingual signage may not be feasible for space or other reasons. Pictograms from U.S. Pharmacopeia and other health care symbols are included in this chapter.

Chapter 7. Brief Guide to U.S. Department of Health & Human Services Office for Civil Rights Resources

Chapter 7 is a brief guide to the U.S. Department of Health and Human Services Office for Civil Rights, particularly the resources available through its website.

Chapter 8. Glossary of Terms

The last chapter consists of a Glossary of Interpreting and Translation Terms. The glossary draws from several sources, including the glossary found in NCIHC's *National Standards of Practice for Interpreters in Health Care*, from September 2005, the California Health Interpreters Association, and ASTM International.

Appendices

The Appendices include additional information including federal laws governing language access, federal and state laws on pharmacy practice relevant to language access, how Medicaid and the State Children's Health Insurance Program can provide reimbursement for language services, work of national organizations to raise awareness of the need for improved resources and funding for language access at the federal level, and other resources.

1 Background

Contents of this Chapter

BACKGROUND:

The Research on Language Services

In a perfect world, perhaps, people would be able to communicate with each other flawlessly using a common language. In the present world, however, language services (including oral interpretation and written translation) that enable accurate communication among people who otherwise would not understand each other are an essential element for providing quality care to patients with limited English proficiency (LEP). The available evidence clearly establishes how important it is for LEP individuals to be able to communicate effectively with their pharmacists, and *vice versa*. Limited English proficiency among patients can result in the provision of substandard health care due to inaccurate or incomplete information.[1] Language barriers can also increase the cost of care.[2] They are a primary reason why LEP populations disproportionately underutilize less expensive and quality-enhancing preventive care.[3] In addition, an inability to comprehend the patient, mixed with a fear of liability, can lead some providers to avoid LEP patients altogether or, in the alternative, to order expensive, otherwise avoidable tests.[4]

Numerous studies have documented the problems associated with a lack of language services, including one by the United States Institute of Medicine, which stated that:

> *Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services. (Cites omitted.)*[5]

Over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only 2% of those who did not need an interpreter and those who needed and received one.[6]

Indeed, language barriers have been found to be as significant as the lack of insurance in predicting use of health services. Health care providers surveyed in four major metropolitan areas identified language difficulties as a major barrier to immigrants' access to health care and a serious threat to medical care quality. These providers also expressed concern that they could not get information to make good diagnoses and that patients might not understand prescribed treatment.[7] On the other hand, while Latino children generally have much less access to medical care than do white children, that gap becomes negligible when their parents' English-speaking skills are comparable to those of Whites.[8]

While the failure to address language barriers can lead to much harm, LEP individuals who through the use of competent language services *can* communicate effectively with their health care providers reap the benefits of accessing preventive care, understanding their diagnosis and condition, making informed decisions about treatment options, and following through with recommended treatments. This in turn leads to better health outcomes. In a survey by PALS for Health, 96 percent of those surveyed reported that the PALS interpretation service directly improved their health and well-being. Positive outcomes included a better understanding of health conditions (46 percent) and an ability to ask questions and get clearer answers (19 percent).[9] Another study found that LEP Latinos with hypertension and diabetes were significantly more likely to experience improved physical functioning, better psychological well-being, better health outcomes and less pain if their primary care physician could communicate with them effectively.[10] A comparison of LEP Spanish- and Portuguese-speaking patients with non-LEP patients found that the use of interpreters significantly increased the LEP groups' utilization of preventive services, office visits, and written prescriptions.[11]

The literature thus clearly demonstrates the benefits to be derived from competent language services. But that literature also demonstrates that the emphasis in the last sentence should be on the word "competent," and that, because pharmacists depend on receiving accurate information from a patient, *ad hoc* interpretation can sometimes be as harmful as no interpretation at all. Interpretation is a learned skill. While it is true that every interpreter can speak at least two languages, it does not follow that every person who can speak two languages is an effective interpreter. The ability of a provider to diagnose accurately a patient's condition can be jeopardized by unpracticed interpreters, including family and friends, who are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices.[12] *Ad hoc* interpreters may themselves be limited in their English language abilities or

unfamiliar with medical terminology, and they often succumb to the temptation to act as "language brokers" who informally mediate, rather than merely interpret information.[13]

While the above problems pertain to the use of any family member, friend or other untrained person as an interpreter, additional concerns arise when the interpreter is a minor.[14] The use of minors to interpret will frequently 1) require children to take on burdens, decision-making and responsibilities beyond their years or authority, 2) cause friction and a role reversal within the family structure, 3) call on the child to convey information that is technical and educationally advanced, and 4) undermine patient confidentiality. In short, using minors to interpret in the health care context should never be the norm, but only a last resort.

Most importantly, the lack of adequately trained health care interpreters can result in an increased risk of medical errors. One recent study revealed a greatly increased incidence of interpreter errors of potential clinical consequence when untrained interpreters were used instead of those with training.[15] Subsequent research determined that while interpretation errors of potential clinical consequence occurred in 12 percent of encounters using trained interpreters, they occurred in 22 percent of encounters in which *ad hoc* interpreters were employed.[16] Remarkably, and perhaps counter-intuitively, the latter figure was higher than the percentage of encounters in which such errors occurred (20 percent) when there was no interpreter present at all. The Office of Minority Health at the U.S. Department of Health and Human Services (HHS) has specifically recognized this phenomenon and offers an explanation for why bad interpretation can be as harmful as no interpretation:

> *The research . . . makes clear that the error rate of untrained 'interpreters' (including family and friends) is sufficiently high as to make their use more dangerous in some circumstances than no interpreter at all. Using untrained interpreters lends a false sense of security to both provider and client that accurate communication is actually taking place.*[17]

The value of competent interpreting, both to the quality of the care offered by the pharmacist and the health of the patient, is thus beyond dispute. However, the cost of competent language services is frequently cited as a reason why they are not always readily available to those who need them. Costs are certainly an important factor, and we as a nation must surely do more to ensure that the costs of providing language services do not compromise their availability and use.

A report from the Office of Management and Budget estimates that providing language services would add on average only fifty cents to the cost of a one hundred dollar health care visit.[18] An HMO-based study found that for an average cost of $2.40 per person per year language services could be provided to those who needed them. It also noted that the health plans would be able to fund the increase from savings realized in other areas.[19]

There are currently a number of innovative activities underway designed to decrease the cost of providing language services. Numerous translated materials are readily available,[20] and some hospitals and managed care plans are assembling libraries of translated forms for participating providers to use.[21] Other approaches include medical interpretation through the use of videoconferencing, remote simultaneous medical interpretation by means of wireless technology, centralized language support offices, language banks (including interpreter and translation pools) and incremental compensation programs for bilingual staff. In addition, there are an ever-increasing number of agencies and community-based organizations that provide language assistance services either on a volunteer basis or at reasonable rates.[22]

Nor is it the case that there are no resources available to help defray the cost of language services. First and foremost, some payment is available from the federal government. The Centers for Medicare & Medicaid Services within HHS has made clear that federal matching payments are available for interpreting and translation services provided to Medicaid and State Children's Health Insurance Programs applicants and enrollees.[23]

Moreover, when considering the issue of costs, those associated with a failure to provide language services must also be taken into account. As noted earlier, studies demonstrate that when language barriers are not adequately addressed, harm to patients may occur. For example, a 10-month old girl was taken to a pediatrician's office by her parents, who spoke no English. The infant was diagnosed with iron-deficiency anemia and prescribed an iron supplement. The parents took the prescription to a local pharmacy that did not provide language services, and the prescription label on the bottle was provided in English. The pharmacist attempted to demonstrate the proper dosing and administration. The prescribed dose was 15 mg per 0.6 ml (1.2 ml) daily. Fifteen minutes after the parents administered the medication to the infant, she appeared ill and vomited twice. She was taken to the emergency room where it was discovered that the parents had administered 15 ml (a 12.5-fold overdose).[24] The lack of effective communication caused serious harm to the patient and could have resulted in the pharmacist facing legal liability for the harm caused.

Most LEP individuals endure the consequences of ineffective communication in silence, or at least unheard, exactly because of their limited English proficiency. The goal is a world in which the tools to communicate effectively with LEP patients, and thereby provide them with quality health care, are available, adequately financed and regularly utilized. We hope that the information in this Guide can help inform the provision of language services and move us towards that goal.

BY THE NUMBERS:

The Growing Need for Language Services[25]

In 2008, according to the U.S. Census Bureau's American Community Survey, the foreign born population of the United States numbered almost 38 million people, or 12.5% of the population, and was increasingly disbursed throughout the country.[26] Over 55 million people speak a language other than English at home. Almost 25 million (8.6% of the population) speak English less than "very well," and for health care purposes may be considered LEP.[27]

Furthermore, 4.8% of households in the United States are linguistically isolated, that is, living in households where all members who are 14 years of age or older have at least some difficulty with English.[28] These numbers are certain to increase because of the changing demographics of the U.S. population. Between 1990 and 2000, for example, the Hispanic population increased b 57.9 percent.[29]

Today, hundreds of languages are spoken in both urban and rural areas of the United States.[30] The vast majority of non-English speakers are Spanish-speaking;[31] all told, however, over 300 different languages are spoken. Multilingualism is spreading most rapidly beyond traditional urban areas.[32]

It is critical that the growing numbers of LEP residents be able to communicate with their pharmacists. As complicated as it may be for English speakers to navigate the complex health care system, the difficulties are exacerbated for LEP individuals. Yet accurate communication ensures the correct exchange of information, allows patients to understand medication instructions, and avoids breaches of patient-provider confidentiality.[33] The literature provides many examples of the how the lack of language services negatively affects access to and quality of health care.[34]

Top Ten Languages Spoken in the United States (excluding English)

Spanish	12.2 percent
Chinese	0.8 percent
Tagalog	0.5 percent
French	0.5 percent
Vietnamese	0.4 percent
German	0.4 percent
Korean	0.4 percent
Polish	0.3 percent
Russian	0.3 percent
Italian	0.3 percent

Not surprisingly, language barriers are reflected in how LEP persons perceive their health care encounters. Among Asian and Hispanic parents, for example, those who do not speak English as their primary language rated their children's health care significantly

lower than did English speakers.[35] A recent survey across 16 cities found that three of four respondents needing and getting an interpreter said the facility they used was "open and accepting," compared to fewer than half (45 percent) of the respondents who needed but did not get an interpreter, and 57 percent who did not need an interpreter.[36] Unfortunately, providers are often not aware of the existence of language barriers. A March 2002 report by the Kaiser Family Foundation found that the majority of doctors believe disparities in how people are treated within the health care system "rarely" or "never" occur based on factors such as fluency in English or racial and ethnic background.[37]

In sum, the dramatic growth in the number of people who need language services is making it a business necessity for health care providers to address the issue. In addition, a number of federal and state laws and policies require providers that treat people enrolled in federally funded health care programs and activities to work to ensure meaningful access to services for people with LEP.[38] These laws are significant because health care is one of the most heavily federally-funded endeavors in the United States today, and providers that receive federal funds will inevitably see an increased demand for language services from consumers who do not speak English well or at all.

Why Relying on Family Members, Friends and Children is Not Advisable[39]

There is some reliance on saying that a patient's family members or friends can — or should — appropriately serve as interpreters. However, significant problems can arise from the use of family members, friends and particularly children, rather than trained professionals, as interpreters. Patients may suffer direct consequences because they do not fully understand a diagnosis or treatment. One study noted that interpreting errors by "ad hoc" interpreters — including family members and friends — are significantly more likely to have potential clinical consequences than interpreting provided by hospital interpreters.[40] Using trained interpreters can ensure confidentiality, prevent conflict of interest, and make sure that medical terms are interpreted correctly.

Adult family members or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the patient says, and may summarize information instead. They may also inject their own opinions and observations, or impose their own values and judgments as they interpret. Family members and friends who act as interpreters may themselves have limited English language abilities and may be completely unfamiliar with medical terminology. Furthermore many patients will not disclose sensitive or private information to family members and friends; providers may thus receive incomplete information that can prevent them from correctly diagnosing a condition. For example, if a battered woman is brought to the hospital by her batterer, who is then asked to interpret for her, the battered woman is not likely to reveal the scope and cause of her injuries.

Guidance from the federal Department of Health and Human Services' Office for Civil Rights recognizes the drawbacks of using family members and friends and encourages the use of trained interpreters whenever possible.[41]

While many problems can result from using adult family members and friends as interpreters, additional problems arise

when the interpreter is a minor. Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information.[42] Children who act as language brokers often influence the content of the messages they translate, which in turn affects their parents' decisions. Other concerns with using children as interpreters include:

- requiring children to take on additional burdens, such as decision-making responsibilities;
- creating friction and a role reversal within the family structure, which can even lead to child abuse;
- violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services; and
- causing children to miss school.

The potential for harm is exacerbated when providers use children to translate in gynecological or reproductive health settings. For example, in one case a provider performing an ultrasound on a pregnant LEP patient instructed the patient's seven-year-old daughter to tell her mother that the baby was stillborn. The provider only called a trained medical interpreter when the daughter became upset and refused to do the interpretation.

Further exemplifying the problems of using children as interpreters, a study of 150 Vietnamese- and Mexican-American women who are or had been welfare recipients in California found that more than half (53.3 percent) used their children to translate for them. Most used their children for communicating with schools and government agencies and filling out forms. More than half of the women who used their children as interpreters identified problems with this practice. The top four problems were:

- the child translated incorrectly;
- the child left out information;
- the information was too technical for the child; and
- the child was unable to properly translate due to limited language skills.

Several of the Mexican-American women reported that their children sometimes answered questions without first checking with them.

These potential problems should caution health care providers from relying on family members, friends and children to interpret in clinical settings, except in emergencies. The remaining chapters of this guide provide information and resources for identifying trained, competent interpreters and translators to ensure accurate communication occurs.

2 Assessment of Needs and Developing a Language Services Plan

Contents of this Chapter:

- Description of Language Services Assessment and Evaluation Tools
- Developing a Language Services Plan
- Suggested Plan for Implementing Language Services
- Other Resources

Language Services Assessment and Planning Tools

Pharmacists wishing to identify their patients' language needs and assess their existing services may wish to undertake an assessment and planning evaluation. Two freely available, detailed language services assessment and planning tools are described and excerpted below. The first is the National Council on Interpreting in Health Care's Linguistically Appropriate Access and Services: An Evaluation and Review for Health Care Organizations, published June 2002, available at **http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20-%20Linguistically%20Appropriate%20Access%20and%20Services.pdf**. The second is Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance, published by the Interagency Working Group on LEP, Civil Rights Division, Department of Justice, available at **http://www.lep.gov/selfassesstool.htm**.

While the two tools cover some of the same territory, they are presented in different styles and have different emphases. The NCIHC tool is particularly detail oriented, asking over 150 questions, with many sub-questions. Most of these questions require a yes or no answer, while a significant number ask for additional description. The tool applies a similar set of questions to the use of agency interpreters, staff interpreters, and other modes of language services, carefully tailoring each section to the subject addressed. It also provides a glossary of terms, a bibliography, and a good deal of explanatory background information and advice on its application in a readable format. Billed as an assessment, it can provide pharmacies at any level of language services development with many ideas as to what to establish, strive for, or accomplish.

The U.S. government tool is less detail-oriented and more conceptual. The assessment addresses the following four factors: the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee/recipient; the frequency with which LEP individuals come in contact with the program; the nature and importance of the program, activity, or service provided by the program to people's lives; and the resources available to the grantee/recipient and costs. A significant

amount of it is intended to provide a blueprint for those interested in designing and establishing language services by assessing preexisting services and resources and helping the institution determine what should be accomplished. In order to do this, many questions are accompanied by ideas, explanations, and suggestions.

The appendices include excerpts from each tool.

Developing a Language Services Plan

Once an assessment is completed and the needs of the pharmacist and his/her LEP patients are identified, a pharmacist may want to develop an implementation plan, often referred to as a "LEP Plan" or "Language Access Plan." This plan can identify how the pharmacy will provide language services. Having a written plan can be helpful for training, administration and budgeting. According to the HHS Office for Civil Rights, there are 5 elements of an effective language services plan:

1. **Identifying LEP Individuals Who Need Language Assistance.**
2. **Language Assistance Measures** — a description of the types of language services available, how staff can obtain those services, how to respond to LEP callers, how to respond to LEP individuals who have in-person contact with recipient staff, and how to ensure competency of interpreters and translation services.
3. **Training Staff** — identifying staff that needs to be trained regarding the recipient's LEP plan, a process for training them, and the identification of the outcomes of the training.
4. **Providing Notice to LEP Persons** — how does the pharmacy provide notice of the services that are available to the LEP persons it serves or, to the extent that a service area exists, that reside in its service area and are eligible for services.
5. **Monitoring and Updating the LEP Plan** — for example, are there any changes in current LEP populations in service area or population affected or encountered; frequency of encounters with LEP language groups; nature and importance of activities to LEP persons; availability of resources, including technological advances and sources of additional resources, and the costs imposed; whether existing assistance is meeting the needs of LEP persons; whether staff knows and understands the LEP plan and how to implement it; and whether identified sources for assistance are still available and viable.

In addition to these five elements, effective plans set clear goals and establish management accountability. Some pharmacists may also want to consider whether they should provide opportunities for community input and planning throughout the process.

The next section of this chapter outlines a **Suggested Plan for Implementing Language Services**.

Suggested Plan for Implementing Language Services[43]

Pharmacies can take the following steps to examine the language service needs of their practices and develop a strategy and plan to meet them. Having a written plan can assist all pharmacy staff in understanding how to provide language services. Other resources are also available to help providers supplement their plan. For example, the California Academy of Family Physicians has published a guide for providing language services in small health care provider settings.[44]Additionally, the Industry Collaborative Effort has developed a toolkit entitled, *Better Communication, Better Care: Provider Tools to Care for Diverse Populations*.[45]

Step 1: Designate Responsibility

Deciding how to respond to the community's and patient's language needs involves gathering information and investigating and harnessing resources. Pharmacies may want to designate a staff member who has the responsibility for its language activities. Such a designation can increase organization, efficiency, and ready access to community resources.

Step 2: Conduct an analysis of language needs.

According to guidance issued by the Department of Health and Human Services' Office for Civil Rights, the assessment of language services should balance four factors:

- The number or proportion of LEP persons eligible or likely to be encountered;
- The frequency with which LEP individuals come into contact with the program;
- The nature and importance of the program to people's lives; and
- The resources available and costs.[46]

Pharmacies can engage in a self-assessment of the languages spoken by its clients and in the community. Self-assessment tools are available at no cost. For example, the federal government provides such a tool at **www.lep.gov**.

It is important to note that collecting client data may not always provide a complete picture. If a pharmacy has a small number of LEP patients, it may be because there are few LEP patients in the service area or it could be because LEP patients do not use the pharmacy due to a lack of language services. Thus, it is important to assess not only the clients currently being served but also those eligible to be served.

To fully understand the community's language needs, the pharmacy should consider other data. Easily accessible sources can provide additional information and include the latest census data for the area served (available at **www.census.gov**), as well as information from school systems, community organizations, and state and local governments. In

addition, community agencies, school systems, religious organizations, legal aid entities, larger health care providers like hospitals, and other local resources can often assist in identifying populations that may be medically underserved because of existing language barriers.

Step 2a: Ask clients about their language needs.

The first step in determining which clients need language services is to ask them. If the pharmacy serves children or incapacitated adults, it should also ask for the language needs of the clients' parents or guardians. The pharmacy should ask not only whether the client needs language services in an oral encounter (such as counseling a client about a prescription), but also determine in which language the client prefers to receive written materials and communications (such as labels and medication information). Depending on clients' language and literacy level, the choice for language services may differ for oral and written communications.

Pharmacy staff who answer the telephone should request clients' preferred spoken and written language and document the information in the client's record and pharmacy management system. This will allow the pharmacy to plan in advance for the language needs and maximize appropriate language services for clients.

Pharmacies may want to consider using an "I Speak . . . " poster or card, which can help identify the language spoken.[47] The pharmacy can provide patients with "Language ID" cards that can be used in subsequent health care encounters.[48]

Step 2b: Maintain data on patients' language needs in medical records and management information systems.

Pharmacies should document clients' language needs in its management information system. Having this information not only will assist pharmacies in assessing clients' needs, but also in arranging for services. Pharmacies should determine if their electronic or paper records system has a specific field to collect a patient's language. If that is not the case, a pharmacy should explore whether such a field can be created or put the information in an alternate field — such a comments field. Most importantly though, all staff at the pharmacy must be trained to input a patient's language consistently so that it can be utilized by every pharmacy staff person easily.

Step 3: Identify resources in the community.

Establishing what resources are available in the community will help determine what language services to provide and how to provide them. Pharmacies should examine whether there are local language agencies that can provide in-person or telephone interpretation or written translations. Pharmacies can also contact local immigrant organizations, refugee resettlement programs, or court systems. These organizations are likely sources of information about language services in the community.

Chapter 3 includes lists of interpreter and translator associations as well as language companies who can assist with providing language services.

Step 4: Determine what language services will be provided.

Depending on clients' needs, available community resources, and the pharmacy's resources, a variety of language services may be implemented. Activities will depend heavily on the information uncovered from the self-assessment and there is no one-size-fits-all solution. As a rough guide:

- In-person, face-to-face interpreters provide the best communication for sensitive, legal, or lengthy communications.
- Trained bilingual pharmacists — pharmacists (or pharmacy techs when legally authorized to do so) who can perform the regular functions of their job in English and in the non-English language (such as a Spanish-speaking pharmacist)
- Trained bilingual non-clinical staff — either dedicated full-time interpreters or staff who serve in a dual role (e.g., pharmacy tech or cashier who can interpret when needed) — can provide consistent client interactions.
- Contract interpreters can assist pharmacies with less frequently encountered languages or when the LEP patient base is relatively small.
- Telephone and/or video interpreter services can often provide an interpreter within a few minutes and are most cost-effective for short conversations or unusual language requests.

Step 4a: Ensuring competency of individuals providing language service

The pharmacy should seek to provide the highest possible level of competency. Competent interpreters can ensure confidentiality, prevent conflicts of interest, and ensure that medical terms are interpreted correctly, thus reducing potential errors.

Bilingual individuals may not necessarily have sufficient command of both English and the target language to serve as medical interpreters. Further, oral interpretation and written translation each require specific skill sets that bilingual individuals may not possess. As stated by the Office for Civil Rights:

> "[Health care providers] should be aware that competency requires more than self-identification as bilingual. Some bilingual staff and community volunteers, for instance, may be able to communicate effectively in a different language when communicating information directly in that language, but not be competent to interpret in and out of English. Likewise, they may not be able to perform written translations." 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** (August 4, 2003).

There are assessments that can be used to evaluate language skills. For example, Pacific Interpreters conducts language competency assessments for external clients and the Industry Collaborative Effort has an Employee Skills Self-Assessment Test on its website. Moreover, if a pharmacy contracts with outside language agencies or interpreters, it should ensure the competency of those interpreters, either by requiring a certain level of training or conducting a language skills assessment. Similar precautions should be taken with telephone and video interpreter services. The pharmacy should determine what sort of education and training the interpreters have received, whether the interpreters are trained in medical terminology and ethics, and whether the company has contracted for alternative site availability in the event their service is unexpectedly interrupted.

Step 4b: Consider ways to minimize use of family members or friends.

Significant problems can arise from the use of untrained family members and friends as interpreters. One study noted that interpreting errors by ad hoc interpreters are significantly more likely to have potential clinical consequences than would services provided by trained interpreters.[49]

Family members, particularly minors, or friends often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the patient says and may summarize information instead. In some clinical encounters, patients may not disclose sensitive or private information.

A pharmacy can adopt a range of language services that minimize the use of family members and friends as interpreters. Resource and cost issues can often be reduced by making use of technological advances (such as the on-line availability of printed translated materials) and the sharing of language assistance materials and services among local pharmacies. When family members and friends are used to interpret, there can be a follow-up visit or telephone contact in the target language to confirm the important aspects of the interaction.

Step 5: Determine how to respond to LEP patients.

Pharmacies must determine how to respond to LEP clients, not only when clients visit the office but also when individuals call, both during and after normal business hours.

Step 5a: Responding in the office setting.

The first question to ask is how pharmacy staff will respond when an LEP client enters the pharmacy. Do pharmacy staff speak the languages most frequently encountered in the pharmacy? If not, how will they initially communicate with clients? Using an "I Speak . . ." poster or card can be an excellent first step in responding to clients' needs.

Once the staff ascertains the language needs of the client, the staff can make appropriate arrangements for language services. This might

include calling a telephone language line so that an interpreter is available during the interaction. It could also include requesting the appropriate bilingual staff to assist the client.

Step 5b: Responding over the telephone.

The pharmacy should also have a plan for assisting clients over the phone during normal business hours. Some questions that should be addressed are:

- Does the pharmacy have bilingual staff who can assist LEP clients over the phone?
- Does the pharmacy's automated response offer information in its prevalent languages?
- Does the pharmacy's "hold" message offer information in its prevalent languages?
- If the staff person answering the phone is not bilingual, does this person ask a bilingual staff person for assistance when speaking with an LEP client?
- Does the staff person call a telephone language line to assist in communicating with the client?

Step 5c: Responding after-hours.

After-hours communication with patients is critical to ensure clients can contact pharmacists when necessary, regardless of their language needs. Some pharmacies may be co-located in other facilities that offer extended hours so LEP clients may seek information after the pharmacy has closed. Some of the questions must be addressed include:

- If the pharmacy has an answering machine, does it include messages in the languages of the client population?
- If the pharmacy uses an answering service, does the service have bilingual employees or a plan to use a telephone language line when an LEP client calls?
- If a client can reach a pharmacist after-hours, what is the plan for a pharmacist to access language services to ensure effective communication with the client?

Step 6: Train staff

The pharmacy should train staff to understand the language plan and policies. At minimum, staff in direct client contact positions should be trained. Orientation for new employees should include information about language services. Staff members can also attend periodic in-service trainings, staff meetings, or brown bag lunches that reiterate the pharmacy's language services, access to services, and effectiveness of services. Sometimes, local community-based organizations or interpreter agencies and associations offer training programs focusing on working with an interpreter and other relevant topics. For example, training should include information on how to access telephonic interpretation, or steps to take to access language services; this information should also be posted where the pharmacy staff can always refer to it.

Step 7: Notify LEP clients of the available language services.

It is also important to communicate to the pharmacy's LEP clients that language services are available and accessible. The pharmacy should post information about its language services, translated into the prevalent languages in locations that all patients will easily see. Patient information (e.g. brochures, educational materials or pharmacy information) should be translated and contain information about the services available.

The pharmacy can also provide information about its services in the local foreign language media. It can disseminate information about its language services through local community-based organizations that work with LEP individuals.

Step 8: Periodically review and update language services.

After developing a language services plan, the pharmacy should continually evaluate and update it, as needed. The demographics of a community can shift over a relatively short period of time, necessitating different or additional language services.

Other Resources

The American Medical Association (AMA) Ethical Force Program issued a consensus report *Improving Communication — Improving Care*. The report offers guidelines and measurable expectations for health care organizations to improve communications with patients of diverse backgrounds. The report is available at **http://www.ama-assn.org/ama1/pub/upload/mm/369/ef_imp_comm.pdf**.

Joint Commission Resources (JCR), an affiliate of the Joint Commission on Accreditation of Healthcare Organizations, offers *Providing Culturally and Linguistically Competent Health Care*. This book provides tips and tools for implementing or improving systems and addressing challenging issues, such as providing for non-English speaking patients; identifying who lives in the community; developing and training staff to meet patients' cultural and linguistic needs; developing and implementing a business case for cultural and linguistic competence; and providing safe, quality patient care. This book includes case studies profiling domestic and international health care organizations that have effectively improved cultural and linguistic competency to meet the needs of diverse populations. The book is available from JCR at **http://www.jcrinc.com/Books-and-E-books/PROVIDING-CULTURALLY-and-LINGUISTICALLY-COMPETENT-HEALTH-CARE/411/**.

"A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations" is available from the U.S. Office of Minority Health. The guide is intended to help health care organizations implement effective language access services (LAS) to meet the needs of their limited English-proficient patients, and increase their access to health care. The overall purpose of this guide is to provide practical, ground-level suggestions for how health care organizations and providers can apply LAS. It is designed for hospitals and HMOs, with an eye toward addressing the needs of smaller organizations, including family practices, health clinics, and health care specialists with limited resources seeking alternative means of implementing LAS. The executive summary is available at **http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG-ExecutiveSummary.pdf**; the complete guide is available at **http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf**.

America's Health Insurance Plans (AHIP), a national association representing nearly 1,300 members providing health benefits to more than 200 million Americans, has released a compendium of resources for health insurance plans, physicians, and health care organizations. The compendium, entitled *Communications Resources to Close the Gap*, was developed as a component of AHIP's plan to build on its existing health disparities work, with a multi-faceted initiative providing technical support for health insurance plans and other health care organizations. This is the

third in a series of *Tools to Address Disparities in Health* focusing on the collection of data on race, ethnicity, and primary language; cultural competency training as a foundation to improve care; model designs for quality improvement activities to reduce disparities; and communication approaches that address the cultural diversity of America's growing racial and ethnic population. The report, and other materials on Diversity and Cultural Competency, is available at **http://www.ahip.org/content/default.aspx?bc=38|10760**.

3 Language Services Resource Locator

Contents of this Chapter:

OVERVIEW:

Locating Sources of Interpreting and Translation Services

This chapter introduces some primary sources and starting places on the road to providing language services. Provided here are directories of language service providers and language professional associations, a description of things to consider when choosing a language company, some examples of arrangements used by institutions to address language needs, and references to further reading on the subject.

Perhaps the first thing to keep in mind is an understanding that translation and interpreting are separate skills and services. Within the language professions, **interpreting** is distinguished from **translation** according to whether the message is produced *orally* (or manually), which is **interpreting**, or *in writing*, which is **translation**.[50]

Several approaches may be used to locate language services for interpreting and translation. A local, state, or regional interpreters and/or translators professional association may have a directory of available individual interpreters, translators and language companies in the area. Many of these associations' websites also offer information on language services and educational information about working with interpreters, as well as interpreter standards of practice and/or codes of ethics. The Yellow Pages of the phone book (online or in print) also lists local companies that provide language services. This chapter includes two state-by-state charts that provide the following information:

- Interpreter and Translator Associations
- Language Services Providers

Considerations when evaluating available language services

There are many different ways that pharmacists can offer language services. How you decide to offer language services will likely depend on factors including the number of languages of your patient population, the frequency of contact with these languages, and available local resources. Some pharmacists may contract with language agencies or independent interpreters to provide language services. Others may create their own interpreter services departments, which they may supplement with contract interpreters and possibly telephonic

interpreting for less common languages. Some may collaborate with similar entities to share interpreter services. Some organizations have "dual-role" bilingual staff wherein interpreting is not their primary role. These staff may be receptionists, accounting, clinical staff or others who have been trained as interpreters. In some states institutions can book interpreters through agencies contracted through the state. The state may also reimburse for services of a qualified interpreter for a Medicaid patient.

A video/DVD offered by Resources in Cross-Cultural Health Care may be helpful as well. Entitled *Communicating Effectively through an Interpreter*, it is designed to help providers in: choosing an appropriate interpreter, recognizing the signs of professional and unprofessional interpretation, working effectively with a trained interpreter, and guiding an untrained interpreter. Available at **http://www.xculture.org/catalog/index.php?cPath=22**.

For more information, you may want to consult the following publications:

Models for the Provision of Language Access in Health Care Settings by B. Downing and C.E. Roat. Santa Rosa, CA: National Council on Interpreting in Health Care 2002, **http://www.ncihc.org/mc/page.do?sitePageId=57022&orgId=ncihc**.

Linguistically Appropriate Access and Services; An Evaluation and Review for Healthcare Organizations by C.C. Anderson. Santa Rosa; National Council on Interpreting in Health Care, 2002, **http://www.ncihc.org/mc/page.do?sitePageId=57022&orgId=ncihc** (also excerpted in Appendix E)

Providing Language Services in Small Health Care Provider Settings: Examples from the Field by M. Youdelman, J. Perkins; National Health Law Program. Washington, DC: NHeLP; New York: The Commonwealth Fund, 2005, **http://www.cmwf.org/publications/publications_show.htm?doc_id=270667**.

Providing Language Services in Health Care Settings: Examples from the Field by M. Youdelman, J. Perkins; National Health Law Program. Washington, DC: NHeLP; New York: The Commonwealth Fund, 2002, **http://www.cmwf.org/publications/publications_show.htm?doc_id=221272**.

Considerations when evaluating specific language agencies

An excellent resource on choosing and evaluating a language agency is *How to Choose and Use a Language Agency*[51] from The California Endowment. Much of the following information derives from that document.

There are a number of considerations regarding quality of interpreting when considering a language agency:

- *How does the agency recruit interpreters/translators?* An agency that does not maintain relationships with immigrant and refugee communities, professional interpreter organizations, and training programs may have difficulty filling an institution's needs.
- *How does the agency screen interpreter candidates?* Although it is unrealistic to expect all interpreters to have a college degree, they should be screened for proficiency in the languages they will be interpreting.
- *Does the agency require interpreters to have received professional training in interpreting?* While few interpreters will have degrees in interpreting, they should have received some form of professional training. The longer the training, the better, though 40 hours is common for basic training programs. Training should cover the interpreter role, ethics, modes, basic conversation skills, handling the flow of the session, intervening, and medical terminology, and should involve skill building and practice.
- *Does the agency require any continuing education of its employees/ contractors?* If so, how much and what sort of proof do the employees/ contract interpreters have to offer? Continuing education is important for active interpreters and may be offered by local interpreter associations, colleges, or other organizations.
- *How does the agency assess its interpreters' qualifications?* Unlike in the legal interpreting field, true certification programs for medical interpreters are rare. The situation varies by state, language, and company, but national certification opportunities are currently in development for healthcare interpreters.[52] The National Association of the Deaf and the Registry for Interpreters of the Deaf (RID) have several special certificates for sign language interpreters.
- *What code of ethics are the interpreters/ translators expected to follow?* The National Council on Interpreting in Health Care created *A National Code of Ethics for Interpreters in Health Care* which can be found at **http://www.ncihc.org/mc/page.do?sitePageId=57768&orgId=ncihc**. Prior to the NCIHC code, numerous agencies and associations produced their own codes, the most prominent being those of the Massachusetts Medical Interpreters Association (now the International Medical Interpreters Association) and the California Health Interpreters Association. An interpreter who has gone through any formal training should be aware of the principles contained in at least one of these codes of ethics.
- *What protocols are interpreters expected to use?* There are several issues involved, such as whether the interpreters use first person interpreting (preferable), do they do pre-sessions[53] with the patient and provider, do they provide cultural information to the provider to aid in a difficult session, will they advocate if necessary, and how are interpreters expected to handle difficult situations?
- *How does the agency provide long-term quality assurance for interpretation?*

- *What mechanisms does the agency have to instruct interpreters about specific policies and procedures of your institution?*
- *Does the agency specialize in any particular industry(ies)?* For example, some agencies focus on health care/medical interpreting and their interpreters will have knowledge of specialized medical terminology.
- *Available languages.* A pharmacy should consider its particular language needs. What languages are required? Which languages can the agency provide and how qualified are the interpreters who use those languages? Some agencies specialize in a specific language or group of languages, such as Asian languages, Spanish, Arabic, "hard to find" languages, or sign languages.
- *Back-up alliances.* Some agencies use other agencies to cover when they cannot provide an interpreter. Prospective users should make sure allied agencies have standards as high as the original agency.
- *Responsiveness.* An agency should be tracking and willing to share information about what percentage of requests it is able to fill. No agency can fill 100 percent of requests.
- *No-show rates.* An agency should also track how often its interpreters fail to show for appointments.
- *Connect times for telephonic interpreter services.* Average connect times of 45 seconds or less are preferable and competitive. Connect time should be counted from when the phone starts ringing to when an interpreter is on the line.
- *Special equipment requirements for telephonic interpreter services.* An institution may need specific equipment to work with a particular telephonic interpreter agency.
- *Disaster recovery system (for telephonic interpreter services)*. What happens if the phone lines go down? Some telephonic services now have alternate systems to resort to if one technology fails. This is especially important if a telephonic service will be the institution's only interpreter service provider.
- *Switching equipment (for telephonic interpreter services)*. An agency's preparedness to handle large volumes of calls will depend in part on its switching system.
- *What additional services are offered?*
- *Fees.* In-person interpreter services usually charge by the hour with a one-hour minimum, while telephonic services charge by the minute. Find out about all the fees and variations before contracting with an agency. There may be additional fees for travel and/or waiting time. Further, are there monthly minimums or is a monthly fee credited towards usage?
- *Cancellation policies.* Most agencies charge for same-day cancellations, to pay the interpreter whose time has been reserved.
- *Learn the company's history.* There are several considerations here, such as who started the agency, what are

their backgrounds, and how long has the agency been in business.

- *Industry involvement.* How is the agency involved in the development of the health interpreting field? Participation in the development of the field and awareness of the current affairs of the interpreter community suggest dedication to the field and an interest in providing the best possible service and improving the industry as a whole. A quality agency will be interested in up-to-date techniques, technology, knowledge, and ethics.
- *Key documents.* Institutions may want to ask to see a standard contract, a billing statement, and to work out details specific to the institution.
- *Get references from current clients.*
- *Request a test call from telephonic services.*

Getting Translation Right

The American Translators Association offers a guide called "Getting it Right" that offers advice on what to look for when evaluating translation services. The Guide is available at **https://www.atanet.org/docs/Getting_it_right.pdf**.

WHAT'S IN A WORD?

An Overview to Understanding Interpreting and Translation in Health Care[54]

As patient populations become increasingly diverse, hospitals and heatlh care providers often rely on interpreters and translators to ensure the provision of high quality patient-centered care to individuals with limited English proficiency (LEP). However, as the acknowledgement of the importance of language access grows, there is widespread misunderstanding of the differences between interpreting and translation. The media often use the terms interchangeably, and contribute to the perception of the general public that translators and interpreters are simply parrots, copiers, or walking dictionaries. But competent interpreters and translators must possess a specialized set of skills. Both are agents in creating understanding between people, but they do so by different means.

To frame the differences between interpreting and translation, an analogy may be helpful, keeping the end products for each in mind: An interpreter is hired and paid for the time delivering a service (that is, for the time spent interpreting between two people). This is analogous to hiring a pianist and paying for his or her time. What is not paid for, however, are the years of piano lessons, the composition of the music, the manufacture of the piano, and other factors that result in the rendition of the tune. In the case of translations, the focus is on the end product (a translated document), similar to buying a cake rather than buying the baker or the kitchen staff.

This difference is why we have deliberately used the terms "interpreting" and "translation." While the alternate terms "interpretation and translation" or "interpreting and translating" are parallel to one another, "interpreting" underscores the emphasis on the process involved in interpreting, and "translation" emphasizes the final product.

What is Interpreting?

Interpreting is the process of understanding and analyzing a spoken or signed message, and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social

context into account.[55] The purpose of interpreting is to enable oral communication between two or more individuals who do not speak each other's languages.[56]

What is Translation?

Translation is the conversion of a written text into a corresponding written text in a different language.[57]

In other words, interpreting refers to communication that is spoken, or signed, while translation refers to written communication.

A Side-by-Side Look at Interpreting and Translation

Figure 1 displays characteristics of Interpreting and Translation which demonstrate that while both share many common denominators, there are, issues unique to each.

Requisite Skills and Qualifications of an Interpreter and Translator

As you can see from Figure 1, bilingualism alone is not sufficient to be an interpreter or a translator, and the same bilingual person can not necessarily do both.

FIGURE 1

A Side-By-Side Look at Interpreting and Translation

INTERPRETING	BOTH	TRANSLATION
	Both overcome language barriers to make communication possible.	
	Both require an advanced level of proficiency in both the source and target languages.	
	Both reflect the cultural terms, expressions and idioms that bear on the meaning of the content. Both must capture any expression or nuance in meaning to maintain the impact of the original.	
	Both require special aptitudes in the language of health care terminology and health care systems.	
Interpreting is a process of understanding and analyzing a spoken or signed message, and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.		Translation is a process that requires analysis, text conversion, proof-reading, and editing.
Interpreters work "in the moment" or "live" and are compelled by the mode of interpretation. Interpreters may consult dictionaries or utilize other resources, but the time between each language exchange is only a matter of seconds and minutes.		Translators work in a different timeframe. They must read an entire text for comprehension before starting the translation and consult dictionaries and other resources for correct grammar and terminology.
Interpreters mostly work in public (in a hospital or clinic, for example).		Translators work in private, including at home.
Interpreters must be present at a specific location, i.e. onsite at a hospital or clinic, or at a location that has an individual line for telephonic or video interpreting.		Translators research the material and language to be translated; this may be done in many different locations.
Interpreters must rely on exceptional memory and note-taking skills for accuracy in verbal expression.		Translators must rely on exceptional research skills to assure accuracy in written work.

Looking for certification as a means to ensure quality in the selection of an interpreter and/or translator is not helpful: certification for health care interpreters is being developed although certification for health care translators is not available.[58]

Fortunately, other resources do exist, and have contributed significantly to the advancement of this specialized field. These include assessment tools developed by private companies, training programs that award "Certificates of Completion" or "Certificates of Attendance" to successful participants, and a general certification from the American Translators Association (ATA) for translators.

In addition, the National Council on Interpreting in Health Care (NCIHC) has developed a National Code of Ethics for Interpreters in Health Care and National Standards of Practice for Interpreters in Health Care. The ATA has developed a Code of Conduct and Business Practices for translators. These tools have proven to be vital in the development of assessment and training programs.

Given the skills required to skillfully work as either an interpreter or translator, hiring each can be challenging. Knowing which skill sets to look for as well as how to measure skills beyond language proficiency will assist human resources professionals in properly evaluating candidates for each position. In either case, having a quality control plan in place to ensure the quality of services is important for managers of language services.

Interpreting and translation are unique tasks best undertaken by trained, qualified professionals. To ensure the provision of high-quality patient-centered care to LEP individuals, hospitals and health care systems should employ proper selection, training, and ongoing assessment protocols. While some individuals may be skilled in both tasks, some are better suited to one over the other. Understanding the differences and commonalities between interpreting and translation will give administrators insight into the often "misinterpreted" field of language services.

Interpreter and Translator Associations

National Associations

National Council on Interpreting in Health Care (NCIHC)

Santa Rosa, CA
F: 707-541-0437
info@NCIHC.org
http://www.ncihc.org

The National Council on Interpreting in Health Care is a multidisciplinary organization based in the United States whose mission is to promote culturally competent professional health care interpreting as a means to support equal access to health care for individuals with limited English proficiency. Its website offers listings of state interpreter associations, working papers, and *A National Code of Ethics for Interpreters in Health Care and National Standards of Practice for Interpreters in Health Care*.

Association of Language Companies (ALC)

Arlington, VA
T: 800-338-4155; 703-418-0391
F: 703-416-0014
info@alcus.org
http://www.alcus.org

ALC is a national trade organization representing businesses that provide translation, interpretation, and language training services. (NOTE: ALC is not solely focused on health care interpreting/translating so you may need to evaluate whether its members have the appropriate expertise to meet your needs.)

American Translators Association (ATA)

Alexandria, VA
T: (703)683-6100
F: (703)683-6122
ata@atanet.org
http://www.atanet.org

ATA offers a number of online directories, including a Directory of Interpreting and Translating Services and a Directory of Language Services Companies (see **http://www.atanet.org/bin/view.pl/18756.html**). (NOTE: ATA is not solely focused on health care interpreting/translating so you may need to evaluate whether its members have the appropriate expertise to meet your needs.)

Interpreting and Translation Organizations

This chart provides information about available interpreting and translating organizations and associations. Within the language professions, **interpretation** is distinguished from **translation** according to whether the message is produced *orally* (or manually) which is interpreting, or *in writing* which is translating. Some translation-specific organizations may not be listed, as we have prioritized interpreter organizations. National associations that can provide further resources are listed on the previous page. We have provided as much information as available. Inclusion should not be considered an endorsement, as the authors have not undertaken any evaluation of these organizations' services. Email addresses listed were the most up-to-date that the authors were aware of at the time of writing and are subject to change. They are publicly available elsewhere on the internet and/or were provided through communication during the making of this document.

NOTE: These organizations often do not directly provide language services but can assist with identifying available resources including individual interpreters, translators and language agencies.

KEY: I = interpreting, T = translation,
R = Does the organization make referrals to interpreters/translators (Y = Yes, N = No)

Association	T	I	City/State	Phone	Fax	Email address	Website	R
ALABAMA								
Interpreter Association of Alabama	√	√		205-930-9173				N
ALASKA								
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle, WA	206-701-9183		info@ notisnet.org	www.notisnet.org	Y
ARIZONA								
Arizona Translators and Interpreters, Inc.	√	√	Phoenix			info@atiinc.org	www.atiinc.org	N
ARKANSAS								
Mid-America Chapter of ATA (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Shawnee Mission, KS	785-843-6034	815-846-0606	micata@gmail.com	www.ata-micata.org	Y
CALIFORNIA								
California Healthcare Interpreting Association	√	√	Sacramento	916-444-1506	916-444-1501	dschinske@ chiaonline.org	chiaonline.org	Y
Northern California Translators Association	√	√	Berkeley	510-845-8712	510-845-8712	ncta@ncta.org; president@ncta.org	ncta.org	Y

Association	T	I	City/State	Phone	Fax	Email address	Website	R
COLORADO								
Colorado Association of Professional Interpreters (CAPI)	√		Denver			trosado@coloradointerpreters.org; droberts@coloradointerpreters.org	coloradointerpreters.org	Y
Colorado Translators Association	√	√	Boulder	303-499-9622		info@cta-web.org; corinne@translatewrite.com	cta-web.org	Y
National Latino Behavioral Health Association		√	Berthoud	970-532-7210	970-532-7209	msanchez@nlbha.org	nlbha.org	N
CONNECTICUT								
Medical Interpreting Association of Connecticut	√	√	Hartford	860-535-2774			miac.us	
New England Translators Association (NETA) (Membership in CT, MA, ME, RI, VT)	√	√				info@netaweb.org	www.netaweb.org/cms	Y
DELAWARE								
Delaware Valley Translators Association (DVTA) (Membership in southeastern PA, central and southern NJ, and DE)	√	√	Coatesville, PA	215-222-0955		president@dvta.org	dvta.org	Y
DISTRICT OF COLUMBIA								
National Association of Judiciary Interpreters and Translators	√	√	District of Columbia	202-223-0342	202-293-0495	hq@najit.org	najit.org	Y
National Capital Area Chapter of ATA (NCATA) (Residence in DC not required for membership)	√	√	District of Columbia	703-255-9290			ncata.org/template/index.cfm	Y
FLORIDA								
Florida Interpreters & Translators Association, Inc.	√	√	Pinecrest	786-261-7094	305-662-8530	board@fitanet.org	intertrans.wordpress.com	N
GEORGIA								
Atlanta Association of Interpreters & Translators	√	√	Atlanta	404-729-4036		info@aait.org	aait.org	Y
Georgia Healthcare Interpreting Association, Inc.	√	√	Milton	404-422-6268	678-990-7330	info@gahia.org	gahia.org	Y
Medical Interpreter Network of Georgia		√	Atlanta	770-895-8296		info@mingweb.org	www.mingweb.org	Y
HAWAII								
Hawaii Interpreters and Translators Association (HITA)	√	√					hawaiitranslators.com	Y
Pacific Gateway - Hawaii Language Bank	√	√	Honolulu	808-851-7000	808-851-7007	myaing@pacificgatewaycenter.org	pacificgatewaycenter.org/portal/default.aspx	N
Maui Interpreters Hui	√	√	Wailkuku	808-985-8216 or 808-243-8649	808-984-8222	mary.santa_maria@doh.hawaii.gov; rachel.hecksher@doh.hawaii.org	www.mauiready.org/interpreters	Y

Association	T	I	City/State	Phone	Fax	Email address	Website	R
IDAHO								
Boise Interpreters	√	√	Boise				boiseinterpreters .com	Y
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle, WA	206-701-9183		info@notisnet.org	notisnet.org	Y
ILLINOIS								
Chicago Area Translators and Interpreters Association (CHICATA)	√	√	Chicago	312-836-0961		info@chicata.org	chicata.org	Y
Mid-America Chapter of the American Translators Association (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Shawnee Mission, KS			micata@gmail.com	ata-micata.org	Y
Midwest Association of Translators and Interpreters (MATI) (Membership in IL, IN, and WI)	√	√				MATIemail@gmail .com	matiata.org	Y
INDIANA								
Midwest Association of Translators and Interpreters (MATI) (Membership in IL, IN, and WI)	√	√				MATIemail@gmail .com	matiata.org	Y
Northern Indiana Medical Interpreters Association	√	√	LaPorte	574-647-2093 /298-2321			nimia.org	
IOWA								
Iowa Interpreters and Translators Association (IITA)	√	√	Des Moines	515-865-3873		info@iitanet.org	iitanet.org	N
KANSAS								
Mid-America Chapter of the American Translators Association (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Shawnee Mission			micata@gmail.com	ata-micata.org	Y
KENTUCKY								
South Eastern Medical Interpreters Association		√	Lexington	859-281-6086	859-254-9919	info@semia.net	semia.net	N
Western Kentucky Mutual Assistance Association	√	√	Bowling Green	270-781-8336	270-781-8136	Jennifer@wkrmaa .org	immigration refugeservices.org	N
MAINE								
Association of Maine Interpreters and Translators (AMIT)	√	√		207-422-3962 /944-3469		sbecque@ roadrunner.com or Hope_valcarcel@ hotmail.com	mainetranslators.org	Y
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√					www.netaweb.org/ cms	Y

Association	T	I	City/State	Phone	Fax	Email address	Website	R
MARYLAND								
National Capital Area Chapter of ATA (NCATA) (Residence in DC area not required for membership)	√	√	Washington, DC	703-255-9290		president@ncata.org	www.ncata.org/template/index.cfm	Y
MASSACHUSETTS								
Forum on the Coordination of Interpreter Services (FOCIS) (A statewide organization of managers of medical interpreter services departments) c/o Interpreter Services		√	Springfield	413-794-2502	413-794-5327	Tim.moriarty@bhs.org		
International Medical Interpreters Association		√	Boston	781-801-6898	866-806-4642	iarocha@imiaweb.org	imiaweb.org	Y
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√					www.netaweb.org/cms	Y
MICHIGAN								
Michigan Translators/ Interpreters Network	√	√	Novi	313-882-0386		info@mitinweb.org	mitinweb.org	Y
MINNESOTA								
Upper Midwest Translators and Interpreters Association	√	√	St. Paul	651-746-9467		Pres@umtia.org; VP@umtia.org	umtia.org	Y
MISSOURI								
Mid-America Chapter of the American Translators Association (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Shawnee Mission, KS			micata@gmail.com	ata-micata.org	Y
Missouri Interpreting & Translation Services	√	√	Innsbrook	636-745-2161	636-745-0029	esardina@centurytel.net		Y
MONTANA								
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle, WA	206-701-9183		info@notisnet.org	notisnet.org	Y
NEBRASKA								
Mid-America Chapter of the American Translators Association (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Shawnee Mission, KS			micata@gmail.com	ata-micata.org	Y
Nebraska Association for Translators and Interpreters	√	√	Omaha	402-598-4186 /610-3107	402-502-7649	nati@natihq.org; jbonet@cox.net	natihq.org	Y
NEVADA								
Nevada Interpreters and Translators Association	√	√	Reno	775-772-9319	775-636-6567	president@nitaonline.org	www.nitaonline.org	

Association	T	I	City/State	Phone	Fax	Email address	Website	R
NEW HAMPSHIRE								
New England Trained Interpreters Association		√	Dover	603-742-1967	866-325-1997	info@netiaonline.org	netiaonline.org	Y
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√					www.netaweb.org/cms/	Y
NEW JERSEY								
Delaware Valley Translators Association (DVTA) (Membership in southeastern PA, central and southern NJ, and DE)	√	√	Coatesville, PA	215-222-0955		president@dvta.org	dvta.org	Y
NEW MEXICO								
New Mexico Translators and Interpreters Association	√	√	Albuquerque	505-352-9258		uweschroeter@comcast.net; lopezfam@cybermesa.com	cybermesa.com/~nmtia	Y
NEW YORK								
Association of Medical Interpreters of New York		√	New York	212-844-8555		aminyinfo@yahoo.com; aminyinfo@aminy.org	aminy.org	N
Multicultural Association of Medical Interpreters	√	√	Utica	315-732-2271/214-5003	315-732-2360	info@mamiinterpreters.org	mamiinterpreters.org	Y
Spanish Action League	√	√	Syracuse	315-475-6153	315-474-5767	execassistant@laligaonline.com	spanishactionleague.com/programs-interpretation.html	N
New York Circle of Translators (NYCT)	√	√	New York			president@nyctranslators.org	www.nyctranslators.org/index.shtml	Y
NORTH CAROLINA								
Carolina Association of Translators and Interpreters	√	√	Chapel Hill	919-698-0721		catiweb@pobox.com; catiadmin@catiweb.org	catiweb.org	Y
OHIO								
Northeast Ohio Translators Association	√	√	Solon			president@notatranslators.org	notatranslators.org	Y
OKLAHOMA								
Mid-America Chapter of the American Translators Association (MICATA) (Membership in AR, IA, IL, KS, MO, NE, OK)	√	√	Shawnee Mission, KS			micata@gmail.com	ata-micata.org	Y
OREGON								
Associated Linguists of Oregon	√	√	Beaverton	503-914-1119			oregontranslation.com/alo.php	N
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle, WA	206-701-9183		info@notisnet.org	notisnet.org	Y
PENNSYLVANIA								
Delaware Valley Translators Association	√	√	Coatesville	215-222-0955		membership@dvta.org	dvta.org	Y

Association	T	I	City/State	Phone	Fax	Email address	Website	R
RHODE ISLAND								
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√					www.netaweb.org/cms/	Y
SOUTH CAROLINA								
Carolina Association of Translators and Interpreters	√	√	Chapel Hill	919-698-0721		catiweb@pobox.com; catiadmin@catiweb.org	catiweb.org	Y
TENNESSEE								
Tennessee Association of Professional Interpreters and Translators	√	√	Nashville	615-824-7878		info@tapit.org	www.tapit.org	Y
TEXAS								
Austin Area Translators and Interpreters Association	√	√	Austin	512-731-5266		mediaz@austin.rr.com; president@aatia.org	aatia.org aatia.net	Y
El Paso Interpreters and Translators Association (EPITA)	√	√	El Paso			info@metroplexepita.org	www.metroplexepita.org	Y
Houston Interpreters and Translators Association (HITA)	√	√	Houston	281-731-3813			hitagroup.org	Y
Metroplex Interpreters and Translators Association	√	√	Dallas	817-417-4747		info@dfw-mita.com	ttp://dfw-mita.com	Y
Texas Association of Healthcare Interpreters and Translators	√	√	Houston			tahit07@yahoo.com	tahit.us	Y
UTAH								
Utah Translators and Interpreters Association	√	√	American Fork	801-492-1226 /359-7811	801-359-9304	katyab@xmission.com; JCAlleman@aol.com		Y
VERMONT								
New England Translators Association (NETA) (Membership in CT, MA, ME, NY, RI, VT)	√	√					www.netaweb.org/cms	Y
VIRGINIA								
National Capital Area Chapter of ATA (NCATA) (Residence in DC area not required for membership)	√	√	Washington, DC	703-255-9290		president@ncata.org	www.ncata.org/template/index.cfm	Y
WASHINGTON								
Northwest Translators and Interpreters Society (NOTIS) (Membership in AK, ID, MT, OR, WA)	√	√	Seattle	206-701-9183		info@notisnet.org	notisnet.org	Y
WISCONSIN								
Midwest Association of Translators and Interpreters	√	√				matiemail@gmail.com	matiata.org	Y

Language Service Providers

The following directory contains both nonprofit and commercial providers of interpreting and translation services. Though all the agencies have experience providing language services in health care or related areas, inclusion does not constitute an endorsement of an agency's services, as we have not undertaken any evaluation of the providers included herein. Effort has been made to seek and list language service providers in every part of the United States, but availability of quality resources varies from place to place. The directory is far from comprehensive but should provide an idea of what is available and the types of organizations to seek. Many additional high quality services and resources exist across the United States; the Yellow Pages of the phone book (online or in print) lists local companies that provide language services. While inclusion here does not constitute an endorsement, neither does absence imply anything particular about an agency not listed.

A note about certification and training

There are currently no national health care interpreter certification standards and no consensus on standards for training for interpreters in health care.[59] A pharmacy should seek to find out what assessments an agency conducts with its interpreters and what interpreter training/education qualifications the interpreters hold.

Nonprofit sources

Nonprofit organizations providing interpreter and translation services include state and local governmental public health departments, college and university-based programs, faith-based charities, refugee resettlement agencies, mutual assistance associations, a variety of independent community-based service organizations, and cooperative efforts between multiple partners. Innovative efforts are being executed throughout the country in which organizations are finding ways to address their communities' unique needs. In this directory we have tried to list only organizations that extend language services to outside users in the community.

Faith-based nonprofits such as Catholic Charities and Jewish Vocational Services play a large and varied role in providing services to the underserved in many communities, and exist in every state. The

level of language services provided by these organizations varies. Some have a highly skilled interpreter and translation services department that serves the community, including health care needs, while others only provide interpreters to refugees during their period of resettlement services. Several are listed in this directory, but many are not. Check local offices for information on whether they provide language services.

Refugee resettlement agencies, which help new refugees who arrive in the United States with little money and few belongings adjust to their new environment and find housing, work, food, health care and fulfillment of other basic needs, sometimes provide interpreter services. In some areas, such agencies may be the only organizations equipped to assist LEP persons in accessing health care and social services. Refugee resettlement agencies, contracted by the U.S. government, may be part of faith-based charities, a university, local or state government program, or community-based organizations.

Mutual assistance associations exist in many states and communities. They may be community-based organizations providing services and advocacy to a specific or more broadly defined clientele. When an immigrant community begins to develop in a locale, members sometimes form mutual assistance organizations to help support each other. Some provide language services ranging from a single or a few languages and English to many languages, and even offer interpreter training.

A variety of other community-based organizations are involved in providing interpreter and translation services across the United States. Some maintain language banks providing volunteer or paid interpreters and translators. Standards of training and skill vary.

Other sources of language services are collaborative projects and multi-partner organizations in which stakeholders such as public health departments, hospitals, community-based organizations, faith-based charities, schools, or other organizations pool their resources to provide language services, training, advocacy, and support.

In addition to the resources mentioned above, some larger health systems — such as hospitals or managed care organizations — have in-house interpreter/translation programs but may be willing to share resources or consider partnerships to expand availability and lower costs. Hospitals that put a high priority on linguistically appropriate care may become deeply involved in their local communities, conducting or partnering on health initiatives intended to address a particular refugee, immigrant, ethnic, or underserved community's health needs.

Commercial sources

Commercial interpreting and translation businesses exist across the country. They may provide telephonic or face-to-face interpreting, or both, as well as document translation. While many firms list language services in health and medical-related fields amongst their experience, potential clients should

investigate whether an individual company would make a good match for their need to provide culturally appropriate language services in health care settings. Determine whether the language company has provided specific training on medical and health care terminology and interpreting in clinical settings for their employees or similarly evaluated their contractors. Some commercial services specialize in medical interpreting, requiring certification where available and providing specialized in-house training. Health systems may make up the bulk of such firms' clientele. Like nonprofit sources, the number of choices and level of quality may vary significantly from place to place. Many companies can work outside their home base, especially in telephonic services and translation. Helpful considerations for choosing a language agency are described earlier in this chapter.

Interpreting and Translation Services

This chart includes information on agencies that provide interpreting and/or translation services but should not be viewed as an exhaustive list as many additional agencies/companies provide these services. You may want to check your local telephone directories for additional companies. We have provided as much information as available. Inclusion should not be considered an endorsement, as the authors have not undertaken any evaluation of these organizations' services.

NOTE: email addresses were up-to-date at the time of writing but are subject to change. They are publicly available elsewhere on the internet or were provided through communication during the making of this document.

KEY:

Services Offered categories:
Transl = translation
F2F = Face-to-Face/In-person Interpreting
OPI = Over-the-phone Interpreting
Vid = Video Interpreting
Transc = Transcription
Train = Training
Test = Testing

Status column:
N = nonprofit community-based organization
C = commercial
G = government
U = university or college

Region column:
I = International
N = National
S = Statewide
R = Regional (i.e. multiple states)
L = Local Community Only

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
ALASKA														
Alaska Immigration Justice Project Language Interpreter Center	√	√	√		√	√	√	N	Anchorage	Phone 907-257-2457 Fax 907-257-2450	barb.jacobs@akimmigrationjustice.org	akijp.org	S	Arabic, Bosnian, Cebuano, Chinese, Croatian, Czech, Danish, Farsi, Hmong, and Ilocano
ARIZONA														
CyraCom	√		√	√	√	√	√	C	Tucson	Phone 800-713-4950 Fax 520-745-9022	rschneider@cyracom.com	cyracom.com	N	More than 150 different languages

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
CALIFORNIA														
Agnew Multilingual	√	√		√	√	√		C	Westlake Village	Phone 805-494-3999 Fax 805-494-1749	i.agnew@agnew.com	agnew.com	N	Most languages
California State University Fullerton Extended Education						√		U	Fullerton	Phone 657-278-3123 Fax 657-278-5445	vmartinez@fullerton.edu	www.csufextension.org/interpretation/	L	Spanish, Vietnamese
Fluency, Inc.		√						C	Carmichael	Phone 800-522-7512 Fax 916-487-7088	Bill@gofluently.com	gofluently.com	R	Regional solutions to tracking, managing and paying for on-site interpreting
Global Clinical Research Solutions	√	√				√		C	Chula Vista	Phone 240-246-4174 Fax 619-591-9391	tbalsamo@globalclinicalrs.com	globalclinicalrs.com	I	Spanish, French
ISI Translation Services	√	√	√	√	√	√	√	C	North Hollywood	Phone 818-753-9181 Fax 818-753-9617	gpr@isitrans.com	isitrans.com	I	ISI works with the languages of the LEP communities of the United States.
Language Line Services	√	√	√	√	√	√	√	C	Monterey	Phone 831-648-7436 Fax 831-648-7436	dhansman@languageline.com	languageline.com	I	Over 170 languages representing more than 99.9% of the interpreter requests we receive from over 20,000 clients
Lexicon I	√	√	√					C	Newbury Park	Phone 805-504-0622 Fax 866-212-5134	pbroughton@lexiconintl.com	lexiconintl.com	N	Over 187 languages
Lingua Solutions, Inc.	√				√	√		C	Studio City	Phone 800-508-2484 Fax 818-743-7411	info@linguainc.com	linguainc.com	N	Over 40 languages served, including all major European & Asian
Professional Interpreting, LLC	√	√						C	City of Industry	Phone 626-330-0794 Fax 626-934-9131	maria@professionalinterpreting.com	professionalinterpreting.com	S	All languages
Spoken Translation, Inc.		√						C	Berkeley	Phone 510-843-9900 Fax 510-843-1388	mark.seligman@spokentranslation.com	spokentranslation.com	I	English <> Spanish now; more to come

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
CALIFORNIA (CONTINUED)														
SSG/PALS for Health & ALAS para tu Salud	√	√				√	√	N	Los Angeles	Phone 213-553-1818 Fax 213-553-1822	anital@palsforhealth.org	palsforhealth.org	L	Armenian, Cambodian (Khmer), Chinese (Cantonese, Mandarin, Taiwanese, Teo-Chew), Indonesian, Japanese, Korean, Russian, Spanish, Thai, and Vietnamese
COLORADO														
Spring Institute for Intercultural Learning	√	√				√		N	Denver	Phone 303-831-4151 Fax 303-831-4250	drizvanovic@springinstitute.org	interpreternetwork.org	S	Over 85 languages (Asian, African, Middle Eastern, Eastern and Western European)
CONNECTICUT														
Eastern Area Health Education Center, Inc	√					√		N	Jewett City	Phone 203-671-4685 Fax 860-760-6230	rosado@easternctahec.org	easternctahec.org	R	
Mijoba Commun-ications, LLC	√					√	√	C	North Stonington	Phone 860-535-2774 Fax 860-535-2774	nadesha@mijobacommunications.com	mijobacommunications.com	L	Spanish, Portuguese, Italian, French
DISTRICT OF COLUMBIA														
La Clinica del Pueblo	√	√	√			√		N	Washington	Phone 202-464-0157 Fax 202-328-3560	iisschot@lcdp.org	lcdp.org/template/index.cfm	S	Spanish, Portuguese, French, Amharic, Tigrinya, Arabic, Mandarin, Cantonese
Language Innovations	√	√	√	√	√			C	Washington	Phone 202-349-4180 Fax 202-349-4182	bfriedman@languageinnovations.com	languageinnovations.com	I	Practically all languages served.

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
FLORIDA														
Optimal Phone Interpreters			√					C	Lake Mary	Phone 866-380-9410 Fax 321-214-2049	info@callopi.com	callopi.com	N	Over 200 Languages
PRIZMA Language Services, Inc.	√	√	√	√	√			C	Weston	Phone 954-217-9654 Fax 954-217-8246	contact@prizmalanguageservices.com	prizmalanguageservices.com	S	70 languages: all languages spoken in Americas, Western and Eastern Europe; Russian and other former Soviet Union's languages, Arabic, Farsi, major Asian languages, Hindi and other languages of India, Japanese
GEORGIA														
International Communications Resources	√		√	√	√			C	Pine Mountain	Phone 404-259-0004 Fax 706-663-0311	cFranco.Translation@gmail.com	icrcommunications.com	I	Spanish
ILLINOIS														
Cross-Cultural Interpreting Services of Heartland Alliance	√	√	√			√	√	N	Chicago	Phone 773-751-4094 Fax 773-506-9872	ccis@heartlandalliance.org	heartlandalliance.org/ccis/	N	36 languages for face to face interpreting, 70 for document translation and over 100 for telephonic interpreting
DuPage Federation - Language Access Resource Center	√	√	√			√		N	Villa Park	Phone 630-290-7893 Fax 630-516-1306	LARC@dupagefederation.org	dupagefederation.org	L	Albanian, Arabic, Burmese, French (African), German, Kurundi, Lithuanian, Mandarin, Persian/Farsi, Polish, Portuguese (Brazilian), Russian, Slovak, Somali (Mai Mai), Spanish, Swahili, Ukrainian, Urdu

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
ILLINOIS (CONTINUED)														
Healthcare Language Services, LLC	√	√				√		C	Chicago	Phone 312-467-0630 Fax 312-467-0612	kt@healthcare language services.com	www. healthcare language services.com/ welcome.htm	L	Arabic, Spanish, Polish, Russian, Lithuanian, French, Mandarin, Cantonese, American Sign Language, Burmese, Urdu, Hindi
International Language Services, Inc.	√	√	√					C	Chicago	Phone 773-525-8590 Fax 773-525-8591	bsnook@ ilschicago.com	www.ilschicago. com/ILS/home. htm	I	30+ spoken, 80+ written
Metaphrasis Language & Cultural Solutions, Inc.	√	√	√		√	√	√	C	Chicago	Phone 815-464-1423 Fax 815-464-1747	info@ metaphrasislcs .com	www. metaphrasislcs. com/ metaphrasis/ prod/index.html	S	Over 20 languages for on-site and 160 for telephone
Professional Translation Services, LLC	√	√			√			C	Villa Park	Phone 630-802-9679 Fax 630-530-2306	kate.jan@att. net		I	Polish
INDIANA														
Central Indiana Interpreting Service, LLC	√								Morgantown	Phone 812-597-0283	interpreter@ ciis.us	ciis.us		Spanish, French, Portuguese, Korean, Arabic, Turkish, Sango, Ukranian, Yakoma, Ukranian, Galician, Chinese, Mandarin
CulturaLink, Inc.	√	√	√	√	√	√	√	C	Indianapolis	Phone 888-844-1414 Fax 888-433-1313	yrobles@ theculturalink .com	theculturalink .com	N	Most languages
Gema Aparicio Translation Services	√	√	√			√		C	Fort Wayne	Phone 260-750-6783 Fax 260-625-6622	aparicio4@ gmail.com		R	Spanish
IOWA														
International Translation Services, Inc.	√	√	√		√	√		C	Des Moines	Phone 641-751-1147 Fax 630-566-1174	Sparks.Olga@ gmail.com		S	Arabic, Laotian, Russian, Sudanese, Liberian, Vietnamese, Ukrainian, German, French, Chinese, Japanese – Total over 50 languages

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
KENTUCKY														
In Every Language	√	√	√					C	Louisville	Phone 502-213-0317 Fax 502-413-6011	clients@ ineverylanguage .com	ineverylanguage .com	R	Multiple--varies by states--generally the FIGS, as well as African languages
LOUISIANA														
REACH NOLA						√		N	New Orleans	Phone 504-342-2940 Fax 504-342-2508	katrinabadger@ reachnola.org	reachnola.org	S	Any language, with focus on Spanish, Vietnamese and Portuguese
MAINE														
Catholic Charities RISinterpret	√	√	√		√			N	Portland	Phone 207-523-2700 Fax 207-774-7166	risinterpret@ ccmaine.org	ccmaine.org/ risinterpret	S	Over 40 languages, including many lesser-dispersion east-African languages such as Acholi, Amharic, Dinka, Lingala, Kinyarwandan, Nuer, Somali, Swahili, and Zande
MASSACHUSETTS														
Acacia Languages	√	√	√	√	√	√	√	C	Greenfield	Phone 413-774-4008	al@acacia languages.com	acacialanguages .com/ indexfrnoielg. html	I	Spanish, Italian, English, French
American Translation Partners, Inc.	√	√	√	√	√		√	C	Raynham	Phone 888-443-2376 Fax 508-823-8854	scott@ american translation partners.com	american translation partners.com	I	Over 200 language pairs of translation and a plethora of languages covered by consecutive and simultaneous interpreters
Central MA Area Health Education Center, Inc.	√	√	√			√	√	N	Worcester	Phone 508-756-6676 Fax 508-756-9825	jlcalista@ cmahec.org	cmahec.org	N	Spanish, Portuguese, Vietnamese, Russian, Khmer, Haitian Creole, Chinese, Polish, Swahili, Twi, Kirundi, Nepali, Korean, Italian, Burmese, Albanian, Arabic, French

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
MASSACHUSETTS (CONTINUED)														
Cross Cultural Communication Systems, Inc.	√	√				√		C	Woburn	Phone 781-729-3736 Fax 781-729-1217	cccsinc@cccsorg.com	cccsorg.com	N	Over 50 languages with offices in New Hampshire and Texas
Global Link Translations	√	√	√		√	√		C	Springfield	Phone 413-737-1888 Fax 413-737-0188	jessica@gltranslations.com	gltranslations.com	N	All Languages for Translation - Most languages for Interpreting
MAPA Translations & Language Solutions	√	√	√	√	√	√	√	C	Framingham	Phone 508-309-6309 Fax 508-309-6303	drita@mapatranslation.com	mapatranslation.com/home.html	I	All mainstream languages
MICHIGAN														
Bromberg & Associates, LLC	√	√	√		√	√		C	Hamtramck	Phone 313-871-0080 Fax 888-225-1912	info@BrombergTranslations.com	bromberg translations.com	I	Over 150 languages
Interpreter Network	√	√	√	√		√	√	C	Grand Rapids	Phone 616-285-3701 Fax 616-285-3703	srettig@interpreternetwork.net	interpreternetwork.net	S	Over 38 languages (Spanish, Bosnian, Somali, Vietnamese, etc) including ASL
Voices For Health, Inc.	√	√	√		√	√		C	Grand Rapids	Phone 616-233-6505 / 800-VFH-3347 Fax 616-233-6522	info@voicesforhealth.com	voicesforhealth.com	N	Over 40 languages on-site in Michigan; over 150 languages over-the-phone nationwide
MINNESOTA														
Dialog One, LLC	√	√	√	√	√	√	√	C	Saint Paul	Phone 651-379-8600 Fax 651-379-8510	rfonts@dialog-one.com	dialog-one.com	N	Over 170 languages and dialects
Pillsbury United Communities	√	√	√					N	Minneapolis	Phone 612-767-9186 Fax 612-767-3709	cabrerac@puc-mn.org	www.pucia.org	S	Multiple languages
University of Minnesota						√	√	U	Minneapolis	Phone 612-625-0591 Fax 612-626-1800	ccepti@umn.edu	www.cce.umn.edu/Program-in-Translation-and-Interpreting	N	Spanish, Russian, Somali, English-others on request
MISSOURI														
Jewish Vocational Service	√	√				√		N	Kansas City	Phone 816-471-2808 Fax 816-471-2930	canders@jvskc.org	www.jvskc.org	S	Arabic, Bosnian, Burmese, Somali, Spanish, Russian, Vietnamese, Others

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
NEBRASKA														
Creighton University	√	√						U	Omaha	Phone 402-280-2890 Fax 402-280-1268	kimbegley@creighton.edu		L	Spanish
NEVADA														
Executive Translations, Inc.	√	√	√					C	Las Vegas	Phone 702-562-7963 Fax 702-437-3966	info@exetranslations.com	exetranslations.com	N	Spanish
NEW HAMPSHIRE														
Cross Cultural Communication Systems, Inc.	√	√				√		C	Nashua	Phone 781-729-3736 Fax 781-729-1217	cccsinc@cccsorg.com	cccsorg.com	N	Over 50 languages with offices in New Hampshire and Texas
So. NH AHEC		√				√		N	Raymond	Phone 603-895-1514 x 5 Fax 603-895-1312 x 5	fgdinu@snhahec.org	snhahec.org	R	We have a list of trained free lanced interpreters speaking 36 languages, on our website
NEW JERSEY														
New Brunswick Community Interpreter Project (RWJMS)	√	√				√		N	New Brunswick	Phone 732-235-9535 Fax 732-235-9720	h.dallmann@umdnj.edu	rwjms2.umdnj.edu/community_programs/new_brunswick_interpreter_program.htm	L	Spanish
The Language Center	√	√	√		√			C	East Brunswick	Phone 732-613-4554 Fax 732-238-7659	marymajkowski@thelanguagectr.com	thelanguagectr.com	N	All languages
Translation Plus Inc.	√	√	√	√	√	√	√	C	Hackensack	Phone 201-487-8007 Fax 201-487-8052	info@translationplus.com	translationplus.com	I	Services available in all languages
NEW MEXICO														
Russian Consulting Services	√	√							Albuquerque	Phone 505-248-0876 Fax 505-248-0876	lioudmila alexeenko@comcast.net			Russian
Translations La Rosa	√								Albuquerque	Phone 505-980-6356	info@translations larosa.com	translations larosa.com		

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
NEW YORK														
Langalo Inc.	√	√				√		C	New York	Phone 646-867-1988 Fax 212-248-2038	contact@ langalo.com	langalo.com	N	Spanish, Portuguese, French, and other languages are available
LifeLinks			√	√				C	New York	Phone 212-714-2476 Fax 212-714-2906	akalb@lifelinks .net	lifelinks.net	I	ASL and most spoken languages
MEJ Personal Business Services Inc	√	√	√	√	√	√		C	New York	Phone 212-426-6017 Fax 646-827-3628	support@ mejpbs.com	mejpbs.com	N	Over 140 languages
NORTH CAROLINA														
Fluent Language Solutions	√	√	√	√		√	√	C	Charlotte	Phone 704-532-7446 Fax 704-532-7429	cheryl@ FluentLS.com	fluentls.com	N	American Sign Language and over 70 spoken languages for onsite consultation & training
Rosario Incorporated	√	√	√			√		C	Winston-Salem	Phone 336-659-6883 Fax 336-659-6161	sandra@ rosarioinc.com	rosarioinc.com	S	Spanish
OHIO														
ASIST Translation Services, Inc.	√	√	√	√	√	√	√	C	Columbus	Phone 614-451-6744 Fax 614-451-1349	Susan@ ASIST translations .com	asisttranslations .com/index .html	I	Over 2,000 language combinations
Freelance Interpreter/ Translator	√	√	√	√	√			C	Columbus	Phone 413-535-0618 Fax 614-220-0151	nev.ibrahim@ gmail.com		R	Arabic
International Institute of Akron, Inc	√	√				√		N	Akron	Phone 330-376-5106 Fax 330-376-0133	translation@ iiakron.org	iiakron.org	L	Arabic, Burmese, Chinese, Gujarati, Karen, Laotian, Mon, Nepali, Punjabi, Russian, Serbo-Croatian, Spanish, Vietnamese + 20 more
Language Access Network	√			√		√		C	Columbus	Phone 614-355-0900 x 906 Fax 614-221-1717	ecastro@ columbus.rr .com	languageaccess network.com	N	Spanish, Somali, French, Arabic, Mandarin, Portuguese, American Sign Language

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
OREGON														
Certified Languages International	√	√	√				√	C	Portland	Phone 800-362-3241 Fax 503-450-1913	kevinc@certified languages.com	certified languages.com	I	173 of the top languages spoken in the United States
Pacific Interpreters, Inc.	√	√	√					C	Portland	Phone 800-324-8060 Fax 503-445-5501	sales@pacific interpreters.com	pacific interpreters .com	N	180+ Languages
Passport To Languages	√	√	√	√	√	√	√	C	Portland	Phone 800-297-2707 or 503-297-2707 Fax 503-297-1703	robin@passport tolanguages .com	passport tolanguages .com	N	More than 130 languages
PENNSYLVANIA														
Flanagan	√	√	√		√			N	Erie	Phone 814-452-3935 Fax 814-452-3318	jflanagan@interinsterie.org	interinsterie.org	S	Arabic, Nepalese, Burmese, Eritrean, Dinka, Mai-Mai, Spanish, French, Bosnian, Russian, Sudanese
Interpreting & Translation Services of n/w Pa.	√	√	√					C	Erie	Phone 814-864-5318 Fax 814-866-7400	mcorapi@verizon.net		L	Russian and Ukrainian
Nationalities Service Center	√	√		√				N	Philadelphia	Phone 215-893-8400 Fax 215-735-8715	dhuynh@nscphila.org	nationalities service.org	L	Over 50 languages available: Spanish, Russian, Chinese, Korean, Indonesian, Italian, Ethiopian, French, African dialets, etc.
Phoenix Language Services	√	√				√	√	C	Philadelphia	Phone 215-632-9000 Fax 215-632-9300	bill.martin@plsi.net		L	Multiple
SOUTH CAROLINA														
AccuLingua Communica-tions & Consulting Services, LLC	√	√				√	√	C	Greenville	Phone 864-616-7380 Fax 864-322-5049	acculingua@bellsouth.net		N	Spanish, Vietnamese, Haitian-Creole

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
TENNESSEE														
P & L Translations	√				√			C	Nashville	Phone 615-460-9119	info@pandltranslations.com	www.pandltranslations.com	N	Most European and Asian languages
TEXAS														
Accessible Signs		√		√				C	Houston	Phone 713-263-9670 Fax 713-263-9737	coordinator@accessiblesigns.com	accessiblesigns.com/Accessible_Signs/Home.html	S	Sign language and foreign languages
Translation Source	√	√	√	√	√	√	√	C	Houston	Phone 713-465-0225 Fax 281-966-1869	camilo@translation-source.com	translation-source.com/index.html	I	All languages
VERMONT														
Vermont Refugee Resettlement Program	√	√	√			√		N	Colchester	Phone 802-654-1706 Fax 802-655-4020	jrose@uscrivt.org	vrrp.org	R	Approximately 40 languages served
VIRGINIA														
Northern Virginia Area Health Education Center (NV AHEC)	√	√			√	√				Phone 703-549-7060 Fax 703-549-7002	info@nvahec.org	www.nvahec.org	R	
WASHINGTON														
CTS LanguageLink	√	√	√	√	√	√	√	C	Vancouver	Phone 360-433-0437 Fax 800-513-7273	info@ctslanguagelink.com	www.ctslanguagelink.com	N	Over 200 languages
Flores & Associates Language Services	√		√		√	√		C	Seattle	Phone 206-915-9825	interpreters@aol.com		N	Spanish
Systematech	√	√	√	√				C	Wenatchee	Phone 509-293-5488 Fax 509-888-0996	adrake@systematechinc.com	systematechinc.com	N	Spanish, Russian, ASL, Vietnamese. Cantonese, Mandarin and Korean coming soon

Organization	Services Offered							Status	City	Phone / Fax	E-mail address	Website	Region	Languages Served
	Transl	F2F	OPI	Vid	Transc	Train	Test							
WISCONSIN														
Connecting Cultures, Inc.	√	√	√			√		C	Little Chute	Phone 920-687-0407 Fax 920-687-0371	rashelle@connecting-cultures.com	connecting-cultures.com	L	Spanish, Hmong, Somali
Equalingua LLC	√	√	√			√		C	West Allis	Phone 414-588-6441	info@equalingua.net		R	Spanish
International Institute of WI	√	√	√			√		N	Milwaukee	Phone 414-225-6220 Fax 414-225-6235	aldurtka@iiwisconsin.org	iiwisconsin.org	S	Up to 50 languages
SWITS, Ltd.	√	√	√	√	√	√	√	C	Delavan	Phone 262-740-2590 Fax 262-740-2592	saulart@swits.us	swits.us/	R	All spoken languages including American Sign language
Universal Translation	√	√	√					C	Appleton	Phone 920-734-1702 Fax 920-734-1703	info@universal-translation.com	universal-translation.com/home.html	S	Hmong and other Southeast Asian Languages
WYOMING														
El Puente		√	√			√		N	Jackson	Phone 307-739-4544 Fax 307-739-4742	elpuente@wyoming.com		L	Spanish

Training for Interpreters

Training programs for interpreters may be useful to health care providers in different ways. If a health care provider has bilingual staff (or plans to hire them), the provider may want to require training to ensure staff is competent to provide interpretation and/or translation. If a health care provider is seeking an interpreter/translator, either to hire as staff or as an independent contractor, individuals who have completed a training programs may be better suited to meet the needs of LEP patients. For information on training programs, see **http://www.imiaweb.org/education/trainingnotices.asp**.

There is currently no consensus on a meaning of adequate training for interpreters in health care. While some training programs provide a certificate of completion, a certificate of attendance, or an undergraduate certificate, this is not to be understood as certification. "Certificate program," for example, does not equal certification. The National Council on Interpreting in Health Care is developing National Standards for Training, a project expected to be completed by the end of 2010. For more information, see **http://www.ncihc.org**.

Some language companies offer language testing to determine the bilingual skills of interpreters, translators, and/or bilingual staff that may sometimes be used to interpret/translate. These assessments can be helpful to identify whether individuals have sufficient fluency in both languages but often cannot assess whether a person is competent to interpret.

4 Multilingual Tools and Resources

Contents of this Chapter:

Overview

This chapter provides a sampling of materials available to aid in providing language services, such as sources for preexisting translated patient materials, I-Speak cards and bilingual dictionaries. Many of these are available for free on the internet and can be customized to meet the needs of a variety of health care providers.

"I Speak" Cards/Posters

"I Speak" cards/posters are a handy tool for patients and providers for identifying a patient's language. The cards/posters features the same information printed in English and the patient's language.

The cards/posters can be as simple as saying "I Speak ____" or can add additional information about how to request an interpreter, patient's rights, and other details. Sometimes, nonprofit organizations or government agencies may distribute I Speak cards that patients will bring to a health care provider's office. It is thus important that staff that interacts with patients is familiar with these cards. Some providers also have the cards and/or posters available in their offices to assist in identifying the language needs of patients.

The U.S. Department of Commerce, Bureau of the Census offers an Identification Flashcard written in 38 languages which can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities. This flashcard can be posted so that LEP patients can scan the list, indicating to staff the language for which they will need an interpreter. **http://www.lep.gov/ISpeakCards2004.pdf**.

As another example, the California Civil Rights Bureau provides an "I Speak" card in Spanish, Laotian, Russian, Cambodian, Chinese, Farsi, Korean, Vietnamese, Hmong, Arabic, Armenian and Hmong. "I Speak" cards can be given to patients to keep on hand. It is available at **http://www.dss.cahwnet.gov/civilrights/PG584.htm**. A practical feature of this card is the civil rights information in both languages, reminding the patient and providers of the patient's right to language services. For example, the Spanish card states:

(Front)

Hello, my name is _____.

I speak limited English. I need competent language assistance in Spanish to have full and effective access to your programs.

Under Title VI of the 1964 Civil Rights Act, public agencies are obligated to provide competent language assistance to limited-English-proficient individuals. Social and health service agencies may call HHS' Office for Civil Rights at 1-800-368-1019 for more information. Food Stamp and WIC agencies may call USDA Office of Civil Rights at 1-888-271-5983. All other agencies may call U.S. Department of Justice, Civil Rights Division, at 1-888-848-5306.

(Back)

Hola, mi nombre es _____.

Hablo muy poco inglés. Necesito ayuda en español para poder tener acceso completo y efectivo a sus programas.

Bajo el Título VI del Decreto de Derechos Civiles de 1964, las oficinas públicas están obligadas a roporcionar ayuda competente, en su propio idioma, a las personas con limitaciones en el inglés. Para más información, las oficinas de servicios sociales y de salud pueden llamar a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos (HHS) al 1-800-368-1019. Las oficinas de estampillas para comida y del Programa de Nutrición Suplemental Especial para Mujeres, Bebés y Niños (WIC) pueden llamar a la Oficina de Derechos Civiles del Departamento de Agricultura de los Estados Unidos (USDA) al 1-888-271-5983. Todas las otras oficinas pueden llamar a la División de Derechos Civiles del Departamento de Justicia de los Estados Unidos al 1-888-848-5306.

Multilingual Health Resources and Translated Health Promotion Materials

This section provides a sample listing of sources for preexisting translated health materials.

The Massachusetts Department of Health Office of Minority Health's document Best Practice Recommendations for Hospital-Based Interpreter Services provides the following introduction on the definition and characteristics of quality translation:

> *Translation is often confused with interpretation. It is important to understand that these are different activities requiring separate skills sets. Translation is the conversion of written text from one language into another, while interpretation involves the spoken word. Properly translated written materials can be critical to ensuring effective communication in the medical settings such as in the case of obtaining informed consent, establishing advanced directives, and issuing discharge instructions and prescriptions.*
>
> *Clearly identifying the target audience is the first step and most important step in developing an effective translation. This decision involves determining the literacy level, the cultural concepts, and the regional language variations that are to be incorporated into the translation.*
>
> *The goals of translation include assuring reliability, completeness, accuracy, and cultural appropriateness. Reliability is achieved when nothing is omitted and nothing is added to the original message. Accuracy is achieved when a text is free of spelling and grammatical errors. Cultural appropriateness is achieved when the message of the text is meaningful and appropriate for the target culture.*[60]

There are far more resources available than those listed here. We have tried to include sites with a variety of resources from recognized sources, but we have not evaluated the quality of any of the translations. Evaluating preexisting translated materials for quality can be difficult to impossible depending on the circumstances. In many cases, the health worker providing the patient with materials will be unfamiliar with the patient's language and unable to directly assess quality. At the very least, consider the source. Can you discern who translated and produced the material? Does it seem reputable? Does it come from an agency dedicated to providing quality care to LEP people, or a reputable translation company accustomed to doing culturally appropriate medical translations?

Types of resources listed in this section include:

- Site with multilingual health materials on multiple topics
- Mental health sites
- Sites concentrating on specific topics such as cancer, health issues of specific populations, and sites with translations in only one language other than English

Sites with multilingual health materials

Medline Plus
http://www.nlm.nih.gov/medlineplus/languages/languages.html
Dozens of easy-to-read patient education materials in multiple languages.

The Medline Plus Multiple Languages page offers translated materials in 46 languages that have been evaluated as high quality.

Refugee Health Information Network (RHIN®)
http://www.rhin.org/
Offers multilingual information for health professionals, refugees, and asylees (in print, audio, and video formats).

New Routes to Community Health
http://newroutes.org/
Provides a new approach for improving the health of immigrants through immigrant-created media. They recently released videos in Chinese on the following topics:

- Getting an Interpreter (In Chinese with English Subtitles)
  http://newroutes.org/node/29723
- How To Read a Prescription Label (In Chinese with English Subtitles)
  http://newroutes.org/node/29924
- How To Read a Prescription Label (In Chinese with Chinese Subtitles)
  http://newroutes.org/node/29927
- What If My Drugs Are Too Expensive? (In Chinese with English Subtitles)
  http://newroutes.org/node/29931
- What If My Drugs Are Too Expensive? (In Chinese with Chinese Subtitles)
  http://newroutes.org/node/29932

The 24 Languages Project
http://library.med.utah.edu/24languages/
Over 200 health brochures in 24 languages from the Utah Department of Health and the University of Utah.

Diversity Health Institute Clearinghouse (Australia)
http://203.32.142.106/clearinghouse/
Health education resources translated into multiple languages (click on Resources from the left-side menu).

Utah Department of Health, Center for Multicultural Health
http://www.health.utah.gov/cmh/multilinguallibrary.htm.
The Multilingual Library offers health in 38 languages on a variety of topics.

Ethnomed
http://ethnomed.org
This is a site produced by Harborview Medical Center in Seattle which frequently adds patient education materials in various languages. It is particularly strong on Southeast Asian and East African languages and health topics especially relevant to these populations, and provides health-issue-specific cultural information such as material on traditional East African dental care, nutritional how-to materials from a Vietnamese American diabetes project and many other topics.

Healthy Roads Media
http://www.healthyroadsmedia.org
This is a collaboration of several North Dakota agencies, this site provides multimedia health information in several formats, in English, Spanish, Vietnamese, Arabic, Somali, Bosnian, Russian, Hmong, and Khmer.

Multicultural Health Communication Service (New South Wales, Australia)
http://www.health.nsw.gov.au/mhcs/languages.html
Offers hundreds of translated health promotion documents in 62 languages.

NOAH: New York Online Access to Health
http://www.noah-health.org
This site provides a bilingual English and Spanish website providing hundreds of online health promotion brochures in English and Spanish as well as starting to provide materials in other languages.

SPIRAL: Selected Patient Information Resources in Asian Languages
http://www.library.tufts.edu/hsl/spiral.
This site is collaboration between South Cove Community Health Center and Tufts University. It offers documents on 27 topics in seven Asian languages and explains its selection criteria.

Mental Health

Geriatric Depression Scale
http://www.stanford.edu/~yesavage/GDS.html
This site provides the original English version and translations in Chinese, Danish, Dutch, French, German, Greek, Hebrew, Hindi, Hungarian, Icelandic, Italian, Japanese, Korean, Lithuanian, Malay, Portuguese, Rumanian, Russian, Spanish, Swedish, Thai, Turkish, Vietnamese, and Yiddish. Includes sources where available, and a disclaimer.

Harvard Program in Refugee Trauma (HPRT) Mental Health Screening
http://www.hprt-cambridge.org/Layer3.asp?page_id=33
Three screenings are available in multiple languages: The Hopkins Symptom Checklist-25, Harvard Trauma Questionnaire, and a simple screen for depression. Free registration is required for access. The program's site offers other refugee health resources in addition to the screenings.

Mental Health Instruments in Non English Languages: Research Literature on Multilingual Versions of Psychiatric Assessments Instruments
http://www.vtpu.org.au/resources/translated_instruments/
Victorian Transcultural Psychiatry Unit, Australia
This extensive bibliography lists literature on over 60 assessment instruments in various languages and includes a table showing the languages in which many are available. Not full text.

Mentasana.com
http://healthinmind.com/Spanish/default.htm
(Health in Mind.com in English, **http://www.healthinmind.com/english/default.html**)
Offered in Spanish and English and voluntarily authored by clinical psychologists, Healthinmind.com/Mentasana.com, presents mental health information in medium register language with a structure based on the DSM-IV. A typical entry contains a description of a disorder and a few recommended books and links. In addition, there's information for families, information about getting services, emergencies, latest news, and more. Not everything is offered in both languages.

Multicultural Mental Health Australia translated information
http://www.mmha.org.au/find/fact-sheets
This Australian database indexes a variety of resources, some internal to its parent organization, most external. Some are available via the internet, others by mail, some are free, others are not. Each resource has its own record in the system, with contact information, URL, citation or whatever relevant information is required to lead the user to the source.

National Institute of Mental Health Publicaciones en Español
http://www.nimh.nih.gov/health/publications/espanol/index.shtml
Detailed Spanish language patient education documents about common conditions such as depression, schizophrenia, panic disorder, anxiety disorder, bipolar disorder, and others. The publications run between 20 and 50 pages, some are available in English also, some are available in PDF and html while others are only offered in html.

Women's Health

Asian Pacific Islanders Women's Health
http://www.apanet.org/~fdala/
Information on cervical and breast cancer screenings in Samoan, Cambodian, Laotian, Chinese, Vietnamese, Korean, and Thai.

National Women's Health Information Center
English: **http://www.4women.gov/**
Spanish: **http://www.womenshealth.gov/espanol/**
U.S. Government-approved women's health information. The English site also links to a few Chinese language resources.

REPROLINE - Reproductive Health Online
http://www.reproline.jhu.edu/index.htm
This site offers materials, in English, Spanish, French and Russian. These are high-quality, well illustrated documents, but they are most suitable for an educated audience.

HIV/AIDS and STDs

CDC National Prevention Information Network
http://www.cdcnpin.org/scripts/search/matlSearch.aspx
HIV, TB, and STD prevention information in multiple languages.

State Family Planning Administrators
http://www.ourbodiesourselves.org/uploads/pdf/stdlist.pdf
A list of STD/HIV patient education materials for linguistically diverse populations offers various materials in up to 30 languages.

Cancer

Asian and Pacific Islander Cancer Education Materials Tool
http://www.cancer.org/apicem
This tool provides links to participating Web sites that have Asian or Pacific Islander education materials on their Web sites. The materials referenced here have been screened by the participating websites for medical accuracy and cultural relevance. Materials are available in Khmer, Chamorro, Chinese, Hawaiian, Hmong, Ilokano, Korean, Samoan, Tagalog, Tongan and Vietnamese, as well as English-language materials culturally tailored for Native Hawaiian populations. Additional languages and topics will be added as more materials become available.

Cancer Resources in Languages Other than English
Cancerindex.org
http://www.cancerindex.org/clinks13.htm
Mostly European languages and Japanese.

Diabetes

Diabetes Australia Multilingual Internet Resource
http://diabetesaustralia.com.au/Resources/Multilingual/
Materials on numerous diabetes subjects in English, Arabic, Hindi, Chinese, Croatian, Serbian, Thai, Vietnamese, Ukrainian, Turkish, Italian, Greek, Malaysian, and Indonesian.

Diabetes y la Nutrición
(Spanish language Diabetes Nutrition Series)
National Institute of Diabetes & Digestive & Kidney Diseases
http://www2.niddk.nih.gov/HealthEducation/EnEspanol/default
Information on diabetes, kidney disease and related topics in Spanish.

National Diabetes Education Program
http://www.ndep.nih.gov/
Diabetes brochures in Spanish and Asian languages.

Other

Emergency Multilingual Phrasebook
British Red Cross, with advice and funding from the Department of Health, 2004.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4073230
The Emergency Multilingual phrasebook, produced and updated by the British Red Cross Society is translated into 36 languages. It covers the most common medical questions and terms to help first contact staff communicate with patients who do not speak English and make an initial assessment while an interpreter is contacted.

Immunization Action Coalition Free Print Materials
http://www.immunize.org/catg.d/free.htm#resourcematerials
Materials on various vaccinations, immunization concerns, and communicable diseases.

Immunization Action Coalition
http://www.immunize.org/vis/
Vaccine Information Statements (VISs) in 47 languages.

National Asian Pacific Center On Aging
http://www.napca.org/
Materials on Medicare, Medicaid, managed care, and long-term care in Chinese, Korean, Tongan, Vietnamese, Samoan, and Tagalog. Click on "Help for Health" on the right-hand menu.

National Dissemination Center for Children with Disabilities
http://www.nichcy.org/Pages/Publicaciones.aspx
NICHCY site in Spanish. It's not readily apparent how they derive this acronym from the organization's full name. The site offers information regarding many childhood disabilities in Spanish.

Suc Khoe La Vang (Health is Gold)
http://www.suckhoelavang.org/main.html
This Vietnamese health organization is connected with the University of California San Francisco who have done anti-tobacco work in the Vietnamese community.

Spanish specific and English/Spanish

CDC en Español /Centers for Disease Control and Prevention
http://www.cdc.gov/spanish/
The English and Spanish sites aren't identical but there's plenty of material on the Spanish site.

Centro Nacional de Diseminación de Información para Niños con Discapacidades
National Dissemination Center for Children with Disabilities
http://www.nichcy.org/Pages/Publicaciones.aspx
NICHCY site in Spanish. The site offers information regarding many childhood disabilities in Spanish.

Healthfinder en Español
http://www.healthfinder.gov/español/
Consumer health site from the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. The alphabet along the bottom takes the user to far more subjects.

Institutos Nacionales de la Salud/ National Institutes of Health
http://salud.nih.gov/
National Institutes of Health in Spanish (United States)

Medicinatv
http://salud.medicinatv.com/
Spanish language site that links to 10,000 health-related sites.

MEDLINEPlus Espanol
http://medlineplus.gov/spanish/
MEDLINEPlus.gov is a bountiful source of authoritative and up-to-date health information from the world's largest health library, the National Library of Medicine. The Spanish version, which is less extensive than the English one, includes content on drug information, a medical encyclopedia with illustrations and diagrams, a dictionary, current health news, and over 175 interactive slideshow tutorials with sounds and pictures.

Easy-to-Read Health Resources
MEDLINEPlus.gov
http://nnlm.gov/hip/easy.html
http://www.nlm.nih.gov/medlineplus/spanish/easytoread/all_easytoread.html
Dozens of easy-to-read patient education materials, mostly in English but many available in Spanish.

Mentasana.com
http://healthinmind.com/Spanish/default.htm
(Health in Mind.com in English, **http://www.healthinmind.com/english/default.html**)
Offered in Spanish and English and voluntarily authored by clinical psychologists, Healthinmind.com/Mentasana.com, presents mental health information in medium register language with a structure based on the DSM-IV. A typical entry contains a description of a disorder and a few recommended books and links. In addition, there's information for families, information about getting services, emergencies, latest news, and more. Not everything is offered in both languages.

National Center for Farmworker Health
http://www.ncfh.org/?pid=154
This link accesses ten nicely-illustrated bilingual downloads, originally developed for use as a patient education tool to supplement and enhance existing teaching methods in migrant health centers and in outreach programs.

National Institute of Mental Health Información en Español
http://www.nimh.nih.gov/health/publications/espanol/index.shtml
Detailed Spanish language patient education documents about common conditions such as depression, schizophrenia, panic disorder, anxiety disorder, bipolar disorder, and others. The publications run between 20 and 50 pages, some are available in English also, some are available in PDF and HTML while others are only offered in HTML.

Bilingual Dictionaries and Glossaries, Online, In Print, and Other Formats

Sources for bilingual dictionaries and glossaries

California Health Interpreters Association (CHIA) list of online multilingual medical glossaries
http://chiaonline.org/content/view/72/124/

InTrans Book Service
http://intransbooks.com/
InTrans Book Services specializes in books for interpreters and translators, mostly in the Spanish and English language pair.

Schoenhof's Foreign Books
http://www.schoenhofs.com/
Extensive selection of multilingual medical and general dictionaries from around the world.

Cross Cultural Health Care Program
http://www.xculture.org/catalog/index.php?cPath=24
Offers a Guide to Common Medications as well as medical glossaries available in 18 languages translated by professionals & reviewed by MDs.

Bibliography of bilingual dictionaries and glossaries

There are also numerous health-related, general, and other specialized bilingual dictionaries. A list of these is available in the *Language Services Resource Guide for Healthcare Providers*, http://www.healthlaw.org/images/stories/issues/ResourceGuideFinal.pdf at 83.

5 Promising Practices & Technology

Contents of this Chapter:

Overview

This chapter offers information and suggested practices for identifying many possible ways to provide language access in pharmacy settings. The activities described clearly demonstrate that one size does not fit all when it comes to providing language services. Rather, the nature, scope, and delivery approach will vary from pharmacy to pharmacy, depending on the numbers of LEP patients, number of languages spoken, and resources of the pharmacy. However, by borrowing and tailoring the activities already under way and exploring the use of available technology, pharmacies can make great strides toward improving health care access.

While determining appropriate language services will depend on individual circumstances, pharmacies have an array of options that can be tailored to meet the needs of their LEP patients. Based on practice type (stand-alone or co-located within a larger facility or system), setting, size, and location, pharmacies can choose from services including hiring bilingual pharmacists or staff, using in-person or telephone interpreters, coordinating with other pharmacies to share resources and costs, and partnering with larger health care entities or systems.

Promising Practices for Providing Language Access Services in Pharmacies[61]

Research conducted by Priti N. Patel, PharmD, BCPS & Emily M. Ambizas, PharmD, Department of Clinical Pharmacy Practice, St. John's University College of Pharmacy and Allied Health Professions

With additional information added by Mara Youdelman & Sarah Lichtman Spector, National Health Law Program

Introduction

According to research from the American Medical Association, 42% of Americans did not understand the instructions to "take medication on an empty stomach".[62]

Numerous pharmacy organizations have recognized the need for effective communication in pharmacy settings, which would include language services for LEP patients. The American College of Clinical Pharmacy (ACCP) has published a white paper providing an overview of cultural competence in healthcare, especially in the pharmacy profession.[63] They have defined cultural competency as "the effective delivery of culturally and linguistically appropriate service in cross-cultural settings." The paper recognizes that "[t]he failure to understand patients and their culture could impede pharmaceutical care" and "[d]evelopment of cultural competence in pharmacy practices has the potential to increase effectiveness of drug therapy and favorably affect health outcomes."[64]

The Academy of Managed Care Pharmacy (AMCP) has a similar position on pharmacist-patient communication. As stated in its policy digest, ". . .patient education is a fundamental element of pharmaceutical care." In addition, AMCP states

> The pharmacist has a professional obligation to provide patients with accurate, understandable information that will foster positive health care outcomes, pharmacists must recognize the unique needs of each individual patient or patient population. Therefore, the pharmacist must exercise professional judgment in determining the best way to deliver essential patient information: verbally, in writing, electronically, through use of pictographs or through the internet or through a caregiver or guardian.[65]

The American Society of Health System Pharmacists (ASHP) states that pharmacists should ensure "effective communication with patients and among providers." Information should be adapted "to fit patients' language skills and primary languages, through the use of teaching aids, interpreters, or cultural guides if necessary."[66]

Effective language services include both oral and written communication. Oral communication with LEP patients can be achieved by using competent bilingual pharmacists who can provide information directly in non-English languages as well as competent interpreters. Translation of written materials can assist LEP patients in understanding usage, dosage, warning labels and side effects.

The remainder of this chapter provides some examples of promising practices. This list is not exclusive and the authors have not evaluated these practices for accuracy. Additional information is also included in the next section of this chapter related to technological opportunities to provide language services.

Translated Materials

Providing materials in non-English languages is one way to assist LEP pharmacy patients. Examples of some of the materials available include:

- RiteAid offers prescription labels nationwide on 11 languages — Rite Aid pharmacists can now provide labels in English, Spanish, French, Arabic, Korean, Chinese, Japanese, Hindi, Polish, Russian or Portuguese.[67] It also RiteAid offers a brochure entitled "Language Interpretation Service" which provides, in multiple languages, a short instruction for patients to point to their language so pharmacists can identify what language services are needed. In addition, it partners with a language agency to provide over-the-phone interpreting in its New York stores.[68]
- A "talking" medicine bottle includes a microchip on which a pharmacist can record instructions, in any language, that the patient then can play back. This is being used by Kaiser Permanente as well as other pharmacies.[69]
- Polyglot Systems, Inc. (Durham, NC) offers a program called Meducation, an internet-based tool that helps pharmacists communicate with LEP patients by speaking to patients, printing written medication instructions, and visually demonstrating complex medications. It supports seven languages, including English — with over 30 languages currently being planned.[70]
- The American Colleges of Clinical Pharmacy publishes "Pediatric Medication Education Text/Texto Educativo de Medicamentos Pediatricos" which provides information sheets in both English and Spanish on 340 commonly prescribed pediatric drugs.[71]
- The Hesperian Foundation developed "Where there is No Doctor", which is available in English and Spanish. The book contains an extensive section (the Green pages) on medicines: by class, by name, usage instructions, warnings, patient instructions on administration, etc. The content is written and vetted by pharmacists and qualified translators.[72] It also allows organizations to translate the book into other languages and lists these on its website.
- Virginia Pharmacists Association partners with Virginia Healthy Pathways and the Virginia Department of Health to develop materials for patients whose primary language is not English.

- Nebraska Pharmacists Association provides patient advocacy groups with a list of pharmacies in Nebraska who are able to provide patient information (med guides, counseling, prescription labels) in multiple languages.
- Nationwide Children's Hospital (Columbus, OH) developed a picture library to help explain the use of medicines. This program, Mediglyphs: A Visual Health Literacy System, is a web-based educational tool made up of an array of pictograms illustrating medication-specific instructions. An interdepartmental collaboration between the Nationwide Children's Hospital Pharmacy and Nationwide Children's Hospital Section of Ambulatory Pediatrics, begun in 2002. The project is a database of pictograms that explain the use of medications and are customized for each patient and prescription. The goal of the project is to increase parent adherence to instructions when administering medications to their children, thereby reducing medication errors. To date, the databank consists of asthma-related medication pictograms, including inhaler use instructions, and pictograms for simple medication instructions (for example, amoxicillin). A community health literacy website is scheduled to launch in spring 2010. This website will contain resources including professional development, asthma education toolkit, patient education resources and links for health care providers. Visit **www.nationwidechildrens.org** for more information.
- The Pharmacy Services Support Center and the American Pharmacists Association (PSSC-APhA) collaborated on a program that developed materials to help Vietnamese and Latino populations understand drug related information.
- **www.NYCLanguageRx.org**, developed by the New York Academy of Medicine, offers a search function to identify pharmacies that can provide services in non-English languages.

Oral Interpretation

Offering oral interpreting for LEP patients can assist pharmacists in communicating with their patients and, when the state has requirements to counsel patients, in meeting these requirements. Some of the promising practices in providing interpreting:

- Walgreens offers interpreting in at least 14 languages and connects its bilingual pharmacists to speak to patients in other Walgreens pharmacies when needed. It also offers translated labels in 14 languages.[73]
- Kaiser Permanente (Mid-Atlantic region) offers an over-the-phone interpreting service with specially trained and certified staff to communicate with plan members. The organization will provide training and education materials for any of its staff members who are interested in becoming part of this service.
- RiteAid offers telephonic interpretation in 175 languages in all of its stores nationwide under contract with a language agency.[74]

- Language Access Networks provides real time video interpretation for LEP patients in pharmacies located in Ohio, Michigan, New Jersey, and New York. The company also provides a document translation service in collaboration with a language agency. This subscription-based service is available to any interested party, including pharmacies, hospitals, and other healthcare providers.
- **www.NYCLanguageRx.org**, developed by the New York Academy of Medicine, offers a search function to identify pharmacies that can provide services in non-English languages.

Continuing Education

There are starting to be greater opportunities to learn about language access and cultural competency through continuing education. The following table offers information on available courses. In addition, a new continuing education course on this topic is being developed and is expected to be available through APhA in mid-2010.

Table 1: Continuing Education Programs

Title	Provider	Format	# Contact Hours Provided	Relevant Learning Objectives and Other Information About the Program
Improving Medication Safety for Limited English Proficient New Yorkers	St. John's University College of Pharmacy and Allied Health Professions	Live	3.0	The program involved several learning techniques, including discussion in pairs, discussion as a whole group, and lectures. Two instructors were faculty of the college of pharmacy and one was from the New York University Center for Immigrant Health. • Define cultural competency • Describe demographics of NYC immigrant population • Discuss health disparities experienced by the immigrant population • Discuss language barriers and their impact on healthcare • Formulate strategies for overcoming linguistic access barriers • Discuss difficulties pharmacists may face when trying to incorporate such strategies
Providing Pharmacy Care to Patients with Low English Proficiency (also pharmacy technician CE)	National Pharmaceutical Association, Inc.	Live	1.0	• Identify patients with low English proficiency • Enumerate particular obstacles for the LEP patient • Work effectively with an interpreter • Apply governmental and professional standards for working with LEP patients • Identify resources to facilitate communication with LEP patients
Unified Health Communication: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency	American Pharmacists Association	Home study	5.0	• Explain that a unified approach to health communications includes addressing limited health literacy, cultural differences, and limited English proficiency (LEP) • Identify patients with different levels of health literacy (including limited health literacy) and evidence of appropriate communication with these patients • Identify evidence of culturally competent care • Identify behaviors that contribute to effective patient-provider communication with LEP patients • Apply a unified health communication approach to interactions with patients with limited health literacy, LEP, and/or cultural differences

Using Technology to Address LEP Patient Needs

Authored by Bill G. Felkey, professor emeritus of healthcare informatics,
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Introduction to Technology and Information Principles in Pharmacy Practice

In comparison to all other healthcare providers, the profession of pharmacy was one of the earliest adopters of computer technology in direct support of its mainstream practice. This has been true ever since community pharmacists were purchasing practice management system hardware the size of refrigerators while manually changing out nine inch floppy disks to make their operations more effective.

Because your computer systems give you access to global information resources, you'll probably be surprised at how much is available for helping you overcome language barriers with patients. You have a choice between seeking commercial products that aggregate LEP resources for a broad range of languages or you can identify and evaluate resources that exist in the public domain to solve the same problems. Instructions from reputable sources that are written at a literacy level suitable for patients can be identified and selected for use in your practice. These resources may range from relatively sparse availability to those that can offer high quality in both content and format of presentation. Technology can present written text on screen and on printouts that can contain both words and illustrations supporting the written text. The use of audiovisual resources would allow for video instruction and pre-recorded demonstrations to be utilized in addition to live demonstrations done at the point of care. The use of a live or telephonic interpreter with the patient and any family or other caregivers who accompany the patient into the pharmacy would assist in the next level of learning. Asking patients to role-play or simulate their medication regimen behaviors using a clock face or pictograms could potentially further impact learning and retention according to the literature.

It is useful to evaluate any technology under consideration for addressing specific problems in any healthcare setting by comparing it to the STEEEP (Safe, Timely, Effective, Efficient, Equitable, Patient-Centered) principles described by the Institute of Medicine. These are recommended to be used as evaluation dimensions for any proposed improvement in healthcare systems.[75] Using STEEEP, information needs to be reliable and this usually means that the information comes from a credible source. And information should arrive in a timely manner and be able to be verified from multiple sources when necessary.[76]

The rest of this chapter explores available resources for translated information relevant to pharmacy settings.

PHARMACY MANAGEMENT SYSTEMS

The hub of all pharmacy operations in the community setting typically takes place in the pharmacy management system. The typical community pharmacy system supports English and Spanish for labels, auxiliary labels and patient medication monographs. Companies like Walgreens can produce labels in 14 different languages and also support patient leaflets and their telephone interactive voice response (IVR) menus in both English and Spanish. Some IVR systems cover as many as 6 languages in their telephonic interface for patients.

Pharmacists frequently asked the question, "What's the very best information appliance for me to purchase to support my communication and information needs in my practice?" To make a point, think of the answer to the question, "if you are going to take a trip would you go through Duluth Minnesota?" Individuals generally answer yes or no immediately, depending upon where the particular pharmacist might live. We eventually get to the definitive answer, "It depends on where you're going." It always helps to know where you are going first and then how you will get there follows.

Once you know where you are going, there are several considerations for evaluating whether your pharmacy practice management system adequately addresses the needs of patients who are LEP. Whether you are upgrading or considering replacing your pharmacy practice management system, getting the answers to the following questions could be part of your selection criteria:

- Can prescription vial labels be printed in multiple languages using multiple fonts for normal and robotically dispensed medications?
- Can auxiliary labels be printed in multiple languages using multiple fonts for normal and robotically dispensed medications?
- Can the system print a line drawing and/or description of the medication being dispensed in multiple languages using multiple fonts?
- Can patient advisory leaflets be printed in multiple languages using multiple fonts?
- Can patient advisory leaflets be customized by the system to include specific patient instructions in multiple languages using multiple fonts?
- Does the system communicate with Web pages in multiple languages for the purpose of online refill requests generated by patients who are LEP?
- Does the system store and alert pharmacists and staff to the language preference of patients who are LEP?
- Does the system integrate with supportive technology such as interactive voice response systems that operate in multiple languages?
- Do software updates reflect immediate changes in the multiple language features of the system another part of the management system take place?
- Can the system generate adherence and persistence related messages in multiple languages using multiple fonts to patients who are LEP?

- Can documents presented by patients who are LEP be scanned and attached to patient's profile in the pharmacy management system?
- Does the system offer flexible workflow design to allow additional support requirements that impact privacy considerations and help accomplish the integration of additional technology support for addressing LEP challenges?

You should examine all of the approaches available to you for assisting patients who are LEP. Then, knowing where you are going, you can determine which information appliances will help you accomplish your goals. Keep in mind that the best solutions are sensitive to your workflow and that the best technology solutions allow you to use them close to where your workflow takes you. For example, many of the counseling rooms of the past that were 30 feet away from the prescription department turned into break rooms or additional storage spaces because they were not integrated into the pharmacy's workflow. It is similar with information appliances that they will best be used when they can be easily accessed and matched the level of visibility needed with the proper level of privacy assured.

If you determine the access that you will need to work with LEP patients, this will dictate how and if you will use a computer screen at the point of care that both you and your LEP patients can see. For example, you can swivel a single display or you can have two displays available for showing information. Portable information appliances can be used in the front end of your pharmacy for displaying information or helping you communicate. Information kiosks that are self-service in their design are another option. Building a web presence that mirrors the resources you have in your pharmacy can help people after-hours to find answers to their questions.

Examples of Pharmacy Management Systems and Ancillary Applications that support multiple languages include:

- RxTran, **http://www.RxTran.com** (12 languages including Spanish, French, Vietnamese, Italian, Polish, Korean, Russian)
- Scriptpro, **http://www.scriptpro.com** (6 languages)
- Telemanager Technologies Interactive Voice Response, **http://www.telemanager.com** (5 languages)
- Voicetech Interactive Voice Response, **http://voicetechinc.com** (4 languages)
- QS/1, NRx **http://www.qs1.com/nrx.html** (French, Spanish)
- JASCORP JASRx, **http://www.jascorp.com/JASRx.aspx** (Spanish)
- BestRx, **http://www.bcsbestrx.com/** (Spanish available for drug education materials)
- FSI, **http://www.fsirx.com/** (Spanish, expanding into other languages by mid-2010)

NOTE: There are many more systems to consider. Computertalk, a pharmacy technology journal, lists additional systems and resources online in their April Buyers Guide issue. See **http://computertalk.com**.

HEALTH ON THE NET FOUNDATION CERTIFICATION

So what are the reliable websites on health information available in multiple languages that you can trust for use with patients? There is a nongovernmental organization called Health On the Net Foundation that certifies health websites. Their logo on a website indicates that the Web material has been actively evaluated and certified for use by patients and healthcare professionals.

Located at **http://www.hon.ch/**, the site actively evaluates the content of websites to assure that health content is authoritative, complements (but does not replace) the role of health professionals, protects the privacy of users, provides attributions for sources of information used, uses evidence-based approaches to back up the content, is transparent by making the presentation of material accessible and the site provides e-mail contacts for follow-up as well as containing a financial disclosure and clearly distinguish advertising policies.

One of the resources available on the site is called HONsearch. For example, a search for the drug "simvastatin" produced resources in English, French, German, Spanish, Portuguese, Russian, Italian, Polish, and Chinese. A total of 6500 websites carried the HONcode certification imprimatur at the time of this writing. Although other agencies offer evaluation criteria for health information websites, it is important to distinguish between those that allow websites to self evaluate their content versus those who actively and externally evaluate these websites. Clicking on the logos for certifying organizations will usually take you to their site which would then describe their accreditation process.

TRANSLATED MATERIALS FROM TRUSTED SOURCES

Lexicomp offers translated materials for Medication and Conditions (up to 18 languages). Their online patient language medication and diagnosis content including conditions, diseases, and procedures are available for access and printing in both PC and Mac formats. The fonts necessary for printing up to 18 languages are usually stored on the operating system of the end user computer but may require installation. The leaflets are written at approximately a 5th grade level and can be printed on 1–2 pages.[77]

On-line search engines are capable of finding Web resources such as patient medication leaflets or manufacture package inserts. For example, Google identifies materials in up to 45 languages and its advanced search component yields the ability to find website information in any of the 45 languages listed. A search for "simvastatin" information in German resulted in over 75,000 page hits including a German version of Wikipedia and a WebMD type site called Netdoktor.de. Netdoktor is also available in several other European and Scandinavian languages.

The obvious next question is how trustworthy, accurate, valid, and reliable will the information

found be for use in your practice? Many of the pharmaceutical companies distributing medication in the United States are headquartered in other countries. It should be reasonable that the other language translation publications coming from these already trusted sources should be of high quality. Resources coming from government entities should also be higher on your list as potential resources to evaluate for further consideration.

Chapter 4 contains a list of some sources for translated materials.

MACHINE TRANSLATION

Machine translation refers to the use of a computer program to automatically translate information from one language to another. At this point in time, neither free nor commercial machine translation programs provide sufficiently accurate translations to rely upon for use with LEP patients.

As long ago as the 1990's, a team of researchers at Auburn University's Harrison school of pharmacy tested commercial software that had the purpose of translating text from one language to another. At the time, their research client was United States Pharmacopeia. They produced patient leaflets in both English and Spanish. To do this work, they employed seven Spanish speaking pharmacists. On one of the team's client visits, they were asked to demonstrate the new software to see if it could take the place of the human translators or at least supplement their efforts. Every one of the USP leaflets told patients what to do if they missed a dose of their medicine. When the research team was asked to put an English version of the text into the software, the system mistranslated "miss" (as in miss or skip a dose) into Spanish as "Senorita" (e.g. "Miss" used as a title).

In another technology experiment, the Auburn research team involved French-Canadian pharmacists in another translation exercise involving the then most popular search engine, AltaVista. In this exercise, the researchers placed the text from English language patient leaflets into the translation module of AltaVista and then activated the program to translate the leaflets to French. The feedback received from the French speaking pharmacists was that the results were only about 95% accurate. Some of the sentences generated were unintelligible in French while others changed the meaning of original language in such a way as to potentially bring harm to the patient who would have followed the directions given. The team concluded that 95% accuracy would expose patients to unacceptable risk. It was also determined that significant healthcare experience was needed to judge whether a translation fully conveyed the original meaning in the translated text. Lay translators may struggle with both the terminology used and have misconceptions and/or a lack of precision in their translations.

Current on-line translation software still exhibits many of these same problems. While it may be tempting to utilize these free resources, the output of the translation engine can potentially produce serious errors that directly result in causing harm to patients. It is recommended that any use of

any on-line software translation be directly supported by a qualified translator of the relevant language to carefully proofread the output and that the qualifications of the individual include healthcare experience sufficient to assure that the health-related nuances of the language be considered. Doing your own trials by translating text from other language websites back to English should allow the examination of some of the potential problems that exist in this process.

MEDICAL IMAGES AND VIDEO

Commercial products that use combinations of multiple language text and narration, still images and videos are available to assist in patient education processes.

ADAM offers an online consumer health information library. Their encyclopedia can be accessed free of charge due to companies, like Pfizer, placing it on their website for unlimited access use. The company will also make private label versions of their products for use on a pharmacy website. Their health solutions include visualized reference libraries, interactive decision support tools, and specialty tools to include illustrated patient education handouts in both English and Spanish.[78]

In addition, the Blausen Human Atlas provides a 3D human figure, visually supported medical glossary, still images and videos supported by text and narration in 13 languages. This product can run in both desktop and iPhone application modes and is available for use in a variety of other information appliances. For example, a picture of the brain can have a Spanish legend with each information point producing Spanish text upon moving the cursor over the discussion point.[79]

Figure 2. Anatomically correct illustrations can help explain medical conditions and medication related issues to patients in their own language. Using illustrations rather that real images of the body can also avoid patient issues with fainting and squeamishness. (used with permission of Blausen Communication)

Figure 2

In addition to commercial options, search engines can provide diagrams and videos that can — if validated for accuracy — be helpful when communicating with LEP patients. For example, Google offers an images search engine that can help identify illustrations of human anatomy in either line drawing or realistic color forms to supplement your communication. All that is necessary is to copy and paste these illustrations into a folder on the desktop of your computer for use at the point of care. Also, many pharmacy drug information software packages contain image libraries

of medications that can be used to create customized medication dosing calendars to assist patients in their dosing regimens.

And YouTube offers numerous video clips addressing how to do various healthcare procedures although you should view the videos and evaluate their accuracy prior to usage with your clients. For example a search on the term "nebulizer" yielded 417 video segments from a variety of different sources. Searching for the word "inhaler" yielded 1,420 results. Doing the same searches in Google videos resulted in 781 videos for "nebulizer" and 3,390 results for "inhaler." Using the advanced search feature would allow searching for videos in other languages. Results were fairly spotty for language coverage of demonstration videos other than in English but it may be desirable to capture and replay self recorded materials that can be utilized multiple times and thus preclude the need to pay for extended translator services for use of demonstration material in each episode of care.

One of the challenges you will face is determining how to integrate the resources you identify into your workflow. For example, if your community has a significant community of Vietnamese speakers, you may want to prepare and collect information resources in Vietnamese. You and your staff might find it appropriate to use a low-cost desktop computer that contains a folder for these resources that you evaluate and preselect as being useful to the specific patient population and the problems they are encountering with their medication taking behavior in your pharmacy. You can do this for each of the LEP populations who you frequently serve in the pharmacy. In this way you would assure that your patients only find the "good" information available on the Internet.

ADDITIONAL CHALLENGES

One of the major challenges for designing technology solutions to address the problems associated with the hundreds of languages being spoken in the United States is a lack of standardization and interoperability that exists in every level of healthcare.

CONCLUSION

It is difficult to imagine a future scenario where technology will be employed to a lesser extent in pharmacy practice. While the challenges to achieve and trust natural language processing using computers for all patient communication is still daunting, there still remains continual progress toward this goal. Technology can make you more efficient and effective when it is readily available, but the adoption of these resources into your practice requires careful consideration. You should evaluate ways to improve the comprehensive consumer experience of your practice for all patients and hopefully, you will continue to discover new technology resources to assist you in this process.

6 Health Care Symbols

Contents of this Chapter:

Overview[80]

One way that pharmacies can assist LEP patients is to utilize pictograms, signage and symbols to assist with understanding. Pictograms can help pass on important information to patients with a lower level reading ability and LEP patients. Multilingual signs can directly assist speakers of your most frequently encountered languages. But if your pharmacy frequently encounters a variety of languages, having multiple translated signs may not be realistic because of special, financial, or other constraints such space limitations and the need to meet ADA requirements. Symbols can function as a universal language understandable by speakers of a variety of languages and may be a useful alternative to multilingual signs.

USP developed a series of pictograms that can be utilized in pharmacy settings. These pictograms are reproduced in this chapter but also accessible from USP's website. And Hablamos Juntos ("We Speak Together"), a project of the Robert Wood Johnson Foundation, undertook a project to develop symbols for use in health care settings. Their website includes a wealth of information about symbols including 28 health care symbols, information on how to implement usage of these symbols, tool kits, a best practice workbook, and frequently asked questions. While not all are relevant to pharmacy settings, we are including all 28 symbols as some pharmacies housed within larger entities may find the broader list useful.

The following pages, reprinted with permission from USP and Hablamos Juntos, provide pictograms and initial information about symbols. Hablamos Juntos is in the final phases of testing 24 additional symbols; user testing of symbols in actual application is critical to ensure that they will be widely understood. This work is being conducted by Hablamos Juntos and the Society for Environmental Graphic Design with the support of the Robert Wood Johnson Foundation. Much more information is available on their website, **www.hablamosjuntos.org**.

Pictograms from USP

U.S. Pharmacopeia developed a Pictogram Library that offers standardized images to convey medication instructions, precautions, and/or warnings to patients and consumers. As stated by USP, "Pictograms are particularly helpful in passing on important information to patients with a lower level reading ability and patients who use English as a second language."

The pictograms may be downloaded from **http://www.usp.org/audiences/consumers/pictograms/form.html**.

In addition to the Pictograms, USP offers additional resources which may be useful to addressing language services in pharmacy settings. USP will soon be releasing a new standard (General Chapter <17>) that addresses prescription container labeling. This General Chapter was developed by USP's Health Literacy and Prescription Container Labeling Advisory Panel under the aegis of its Safe Medication Use Expert Committee. In addition, General Chapter <1265>, Written Prescription Drug Information — Guidelines, discusses information related to consumer leaflets.

1.

Take by mouth

2.

If you have questions, call the number © 1997 USPC

3.

Take 2 times a day with meals

4.

Take 2 times a day

5.

Take 1 hour before meals

5a.

6.

Take 1 hour after meals

6a.

7.

Take 2 hours before meals

7a.

8.

Take 2 hours after meals

9.

Place drops in nose

10.

Wash hands/Place drops in nose/Wash hands again

11.

11a.

12.

Do not store near heat or in sunlight

13.

Take 4 times a day, with meals and at bedtime

14.

Take 3 times a day with meals

15.

Take 4 times a day

16.

Take 3 times a day

17.

Do not store medicine where children can get it

18.

Take with meals

19.

Do not take with meals

20.

Store in refrigerator

21.

Are you taking any other medicines?

22.

Take at bedtime

23.

Do not take with milk or other dairy products

24.

This medicine may make you drowsy

25.

Insert into vagina

26.

Wash hands/Insert into vagina/Wash hands again

27.

Insert into rectum

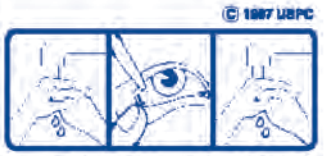
28.

Wash hands/Insert into rectum/Wash hands again

29.

Place drops in lower eyelid

30.



Wash hands/Place drops in lower eyelid/Wash hands again

31.

Place drops in ear

32.

Wash hands/Place drops in ear/Wash hands again

33.

Do not break or crush tablets or open capsules

34.

Do not take if pregnant

35.

Are you pregnant or do you plan to become pregnant?

36.

Do not take if breast-feeding

37.

Are you breast-feeding?

38.

Take with glass of water

39.

Shake well

40.

Do not drink alcohol while taking this medicine

41.

Wash hands

42.

Call your doctor

43.

Chew

44.

Dilute with water

45.

Dissolve in water

46.

Dissolve under the tongue

47.

This medicine may make you sleepy

48.

Do not chew

49.

Do not take at bedtime

50.

Do not drive if this medicine makes you sleepy

51.

Do not freeze

52.

Do not refrigerate

53.

Do not shake

54.

Do not share your medicine with others

55.

Do not smoke

56.

Do not swallow

57.

Drink additional water

58.

Use this medicine as a gargle

59.

Get emergency help

59a.

Get emergency help

60.

For hypertension (high blood pressure)

61.

Injection

62.

Do not use additional salt

63.

For lung/respiratory problems

64.

Do not give medicine to babies

65.

Do not give medicine to children

66.

Remove foil from suppository before inserting into rectum

67.

Take in the morning

68.

Take with milk

69.

Avoid too much sun or use of makeup

70.

Do not take other medicines with this medicine

71.

Inhaler

72.

If this medicine makes you dizzy, do not drive

73.

Check your pulse

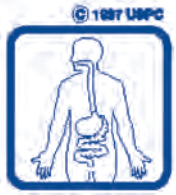
74.

For headaches

75.

For heart problems

76.



For stomach/ intestinal problems

77.

Nasal spray

78.

Read the label

79.

Wear medical alert

80.

Flammable

81.

Poison

Symbols for Use in Health Care

Hablamos Juntos, an initiative of The Robert Wood Johnson Foundation, was launched to eliminate language barriers and improve the quality of health care for people with Limited English Proficiency (LEP). In a research endeavor with JRC Design, they examined the history and usage of visual symbols as communication tools in health care settings throughout the world.

The research showed that symbols can be a effective communications tool, particularly for LEP individuals. Further, a thoughtful, well-designed symbol system could assist English speakers as well as LEP people of many languages and cultures.

The symbols shown on this poster are the results of rigorous design and testing. It is a system with broad aesthetic, as well as practical, appeal.

Symbols are not the panacea for a poor signage system, nor will they solve wayfinding issues. But they can be part of a viable and dynamic system that can assist all people, regardless of their reading skill level, to feel more comfortable and confident within a health care facility.

Hablamos Juntos
We speak together.

THE ROBERT WOOD JOHNSON FOUNDATION

JRC DESIGN

segd

Frequently Asked Questions on Symbols[81]

1. Why would I use symbols in my sign system?
2. Where can I get the symbols for use on signs?
3. How much does it cost to use the symbols?
4. Can I change the symbols?
5. Our signage is poor, will adding these symbols help?
6. What does wayfinding mean?
7. I don't see some symbols that I need. Why not?
8. Why were these referents chosen to develop symbols?
9. How were the symbols designed?
10. What is the significance of ≤87 and >87 to the testing?
11. Did all the symbols in this set receive scores >87?
12. Will there be additional symbols developed?
13. Can I use these symbols as a logo for my medical business?
14. Our facility could use the symbols, but some of the referents differ from our terminology. Can we still use the symbols?

1. **Why would I use symbols in my sign system?**

   A picture is worth a thousand words. Health facilities are struggling to meet federal laws requiring signage in the languages of their patients. Because health care facilities serve patients that speak many different languages, meeting the wayfinding needs for these patients can not be done well with typical signs. Multilingual signs can be expensive and difficult to accommodate in most wayfinding programs. Research has shown that symbols are an effective means of communication for people with Limited English Proficiency (LEP) regardless of their primary language.

2. **Where can I get the symbols for use on signs?**

   The health care symbols developed through Hablamos Juntos can be downloaded from this website, as the complete group in PDF. That means they can be opened and read in Adobe Acrobat Reader, as well as most vector-based software programs such as Adobe Illustrator, Corel Draw, AUTOCAD, etc. Vector-based software will allow the symbols to be accessed and used for other applications such as signs.

3. **How much does it cost to use the symbols?**

   The symbols and any materials developed to aid in their use are free. Upon completion of the initial set, the symbols were designated as public domain, thanks to the grant of the Robert Wood Johnson Foundation.

4. **Can I change these symbols?**

   No. Although these symbols are free and permission is not needed to use them, but the images have been protected by the Robert Wood Johnson Foundation under United States copyright law. The value of the symbols is in their ability to convey the information they were designed to convey. This comes with the public's ability to recognize they symbols' intended meaning. Modifications or changes to the symbols works against this important goal.

5. **Our signage is not very good, will adding these symbols help?**

   The symbols are meant to be adaptable and to be used in any signage system, but were designed as complete images to follow the recognized DOT standards. Image within a rounded corner square and proportioned negative space around them. They were also designed to be used in the reverse. When using the symbols in either positive or negative form, you should follow best practices for contrast and size for the environment and ADA guidelines.

   ADA guidelines state that when symbols are used to identify a space (wall mounted identification sign), they must be within a designated 6" field; that field can be any shape, but must provide a separation from everything else around it. That shape is not specifically dictated to the one around these symbols. For example, California's Unified Building Code (UBC) requires

the use of a circle and triangle with the women's and men's symbols to identify restrooms. So if using different shapes, careful consideration should be used so not to create confusion as to the meaning of the symbol and/or the shape it is in.

6. What does wayfinding mean?

Wayfinding is the method for providing consistent and overt information that can guide a person to their destination. This information can be through maps and signs, clues embedded in the architecture or through the use of color, pattern and texture in the interior design of a facility. Wayfinding is more than signs. It is the practice of looking at navigating your facility from a visitor's perspective, understanding why your visitors are there and using this information to design information and clues to help guide your visitors to their destinations.

7. I don't see some symbols that I need. Why not?

Symbols are a universal language, which means the language of health care symbols needs to be learned. Based on research conducted for the project, having too many symbols would create challenges in learning what each symbol means. By starting with a small set of symbols users can begin learning this new language. Over time it is envisioned that new additional symbols will be added.

8. Why were these referents chosen to develop symbols?

The health care symbols include 28 referents commonly found in health facilities. These were identified as priority terms through surveys conducted in the ten Hablamos Juntos demonstration sites. A survey containing over 200 terms in nearly 60 categories was given to hospital administrators, staff, social workers and others in health facilities participating in the Hablamos Juntos demonstrations located throughout the country. Respondents were asked to select the top 30 terms representing locations visitors most frequently used in their facilities. The results were tabulated, and the top 30 terms overall were determined. To learn more go to **About Symbols**.

9. How were the symbols designed?

All the health care symbols were designed for this project. You may find elements you've seen before. This is because initially, existing symbols were collected and associated with one or more of the references included in the project. These existing symbols were analyzed for the concepts used to represent the referent. A team of designers with expertise in health care, symbol and graphic design, selected existing symbols or designed new ones. Over 600 symbols were evaluated or created for the project. Through a survey method, successfully used in many different countries and adopted by the International Organization for Standardization (ISO), symbols

were tested for comprehensibility with four language groups. To learn more about the survey tool click **here**.

In the Comprehension Estimation survey, for each referent, five or six symbols were displayed and survey responders were asked to estimate the percent of the population that spoke their language would comprehend the symbols to mean the referent. Three rounds of surveys were conducted in ten states; bilingual survey administrators and interpreters were used to reach limited English speaking respondents. Ultimately, nearly 300 persons, from four language groups (English, Spanish, Indo European and Asian languages) took part in the surveys. After each round, symbols that received scores greater than 87 were retained and retested for potential use in the final symbol set. Symbols that tested less than 87 were modified and retested or discarded depending on the rating. To learn more about how symbols were developed go to About Symbols.

10. What is the significance of ≤87 and >87 to the testing?

The symbols were tested through a well-known survey method call Comprehension Estimation testing. This method has been used in many different countries and adopted by the International Organization for Standardization (ISO) because it produces consistent and reliable results. The instrument has the accepted threshold of greater than 87 percent as a measure of effectiveness. In other words, symbols that achieve a rating of greater than 87 percent are found to be comprehended by a vast majority. To learn more about how symbols were developed go to **About Symbols**.

11. Did all the symbols in this set receive scores >87?

No. 17 symbols had at least one symbol that achieved scores greater than 87. When more than one symbol for the same referent achieved this threshold, the design team had options to select the strongest symbols for inclusion into the set. Most often, those turned out to be the symbols receiving the highest scores. Eleven symbols did not reach the threshold. These were generally referents with no single or common meaning such as oncology, or less commonly understood referents such as diabetes. The symbols selected for these referents were informed by the test results and rely on features that worked well in the higher rated symbols. To learn more about how symbols were developed go to **About Symbols**.

12. Will there be additional symbols developed?

Hablamos Juntos with demonstrations in ten states offered a unique opportunity that will be expensive to replicate. The Society for Environmental Graphic Design (SEGD) is evaluating the possibility of continued health care symbol design through the proven testing procedures, but no official program has been established.

13. Can I use these symbols as a logo for my medical business?

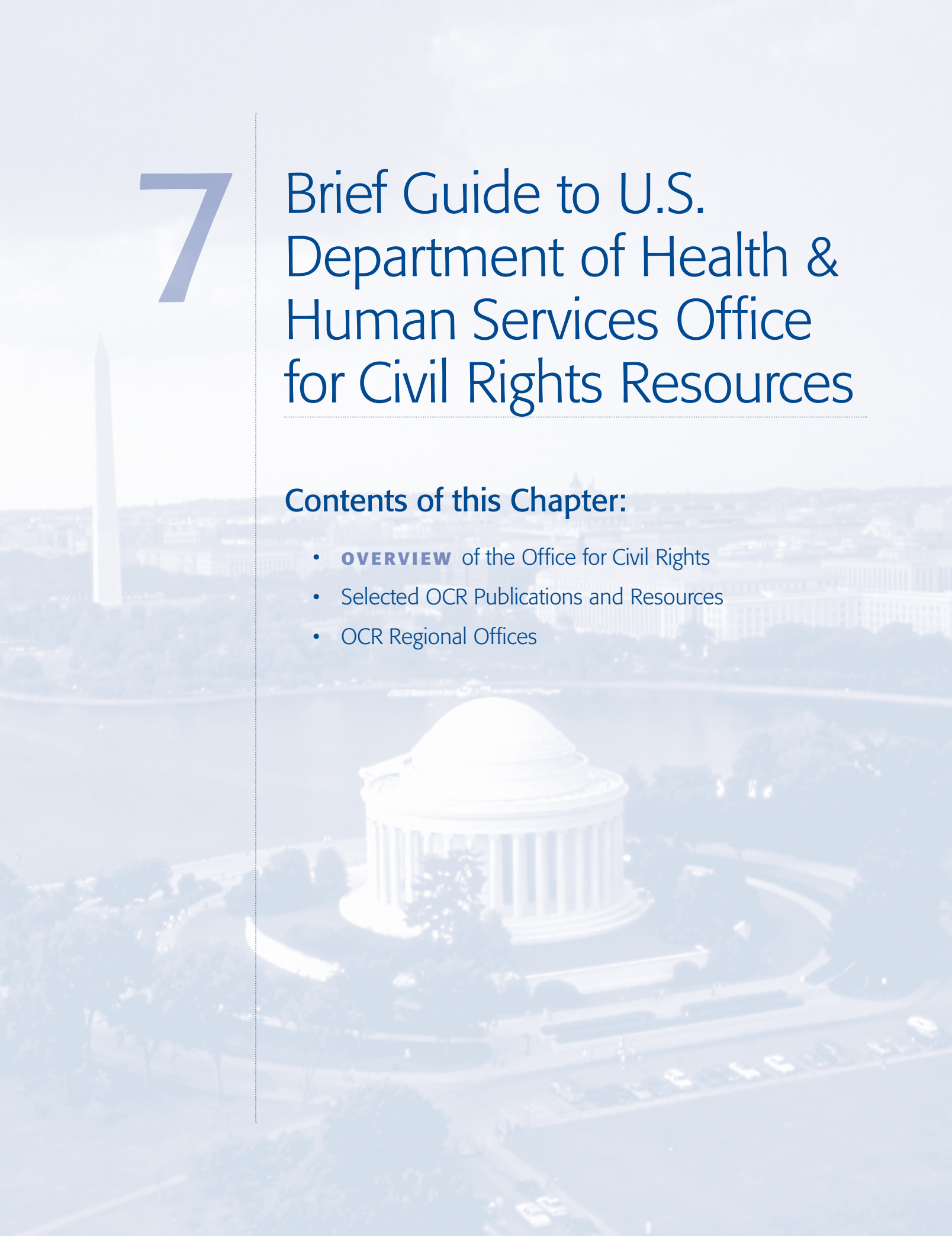
The power of symbols comes with linking the image to the concept. These symbols were developed for use as wayfinding tools. To the degree that symbols help communicate specific destinations, medical services or health activities we anticipate the use of symbols will go beyond their original purpose. However, using them as a logo or for marketing purposes is not recommended.

14. Our facility could use the symbols, but some of the referents differ from our terminology. Can we still use the symbols?

Yes. Public education is the key to success. Symbols can be used with referents that are closely related (X-Ray, Imaging, Radiology). These symbols were developed and tested to link a referent with a concept and image. Definitions were made as simple as possible while still conveying the basic meaning. Substituting a similar referent and definition can be successful with public education. Keep in mind that translations for major language groups are available only for the original referents and definitions used in the testing.

7 Brief Guide to U.S. Department of Health & Human Services Office for Civil Rights Resources

Contents of this Chapter:



Overview[82]

The Office for Civil Rights (OCR) is part of the federal Department of Health and Human Services (HHS). Located within the HHS Secretary's Office, OCR's purpose is to ensure that users of Health and Human Services programs have equal access and service quality in those programs as protected by federal civil rights legislation. In addition to its headquarters office in Washington DC, OCR operates 10 regional offices.

OCR offers technical assistance to health care providers who need help in determining how to provide language services to their patients. OCR has primary responsibility within HHS for oversight of language access and national origin discrimination. The OCR regional offices are available for consultation and can also conduct on-site trainings. In addition, OCR investigates complaints filed against federal fund recipients for failing to provide language services.

The following pages provide a summary of OCR's services and resources and how to access them. With the exception of some explanatory notes, this information is all available from OCR's web site. Much of it is also available from regional offices, which are listed near the end of this chapter.

The OCR website provides a wealth of information for both consumers and the programs covered by its jurisdiction.

Resources include but are not limited to:

- fact sheets providing general information about OCR in multiple languages
- fact sheets demystifying patients' rights in multiple languages
- medical provider certification for receiving federal Medicare funds
- text of federal regulations and guidance memoranda, including the LEP Guidance
- instructions and "frequently asked questions" on how to file civil rights complaints
- glossary of related terms

Selected OCR Publications and resources

1. **Limited English Proficiency Video**
   http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/

   This online 36-minute video provides a brief introduction to the legal issues around interpreting as well as excellent demonstrations of why professional interpreters' services are necessary in health care, their role, and how to utilize a trained medical interpreter. This compelling video is free and can be watched on a computer screen. It can be found on the OCR home page on the left-hand menu.

2. **Civil Rights Clearance for Medicare Provider Certification**
   http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/

   This section features numerous documents that aid providers and institutions in achieving compliance with civil rights law in various aspects of care, in order to be Medicare providers. Resources include but are not limited to:

   - OCR information request form and HHS Form 690 (Assurance of Compliance Form)
   - Technical assistance/ legal information on:
     - nondiscrimination policies
     - communication with LEP patients
     - auxiliary aids for persons with disabilities
     - age discrimination, and requirements
     - requirements for facilities with 15 or more employees
   - Regulations and guidance such as
     - Title VI of the Civil Rights Act: 45 CFR Part 80
     - Limited English Proficiency (LEP)

   Note: Medicare is solely funded by and providers are certified to serve Medicare patients through the federal government, while Medicaid is a joint federal-state funded and administered program where each state determines who may be a Medicaid provider. That is why this section of OCR's resources pertains to Medicare and not Medicaid.

3. **Filing a HIPAA privacy complaint**
   Information on filing a HIPAA privacy complaint can be found in a fact sheet at: **http://www.hhs.gov/ocr/privacy/hipaa/complaints/**

   Other HIPAA information includes sample contracts for businesses; consumer information, some of it in Spanish and easy-to-read English; "frequently asked questions"; a listserv to join; and links to related sites.

4. **Civil rights fact sheets for consumers**

   English: **http://www.hhs.gov/ocr/civilrights/complaints/index.html**

   Other Languages: **http://www.hhs.gov/ocr/civilrights/index.html**

   OCR provides these fact sheets in multiple languages—Chinese, English, Korean, Polish, Russian, Spanish, Tagalog, and Vietnamese. A separate web page is dedicated to each language. The English, Polish, Spanish, and Tagalog pages are in HTML, while the Chinese, Korean, Russian, and Vietnamese pages are PDF files, requiring Adobe Acrobat Reader to view. All contain hyperlinks to multiple translated documents. The following are available in most of the languages:

   - How to file a Discrimination Complaint with the Office for Civil Rights
   - Know Your Civil Rights
   - Your Rights under Title VI of the Civil Rights Act of 1964
   - Your Rights under Section 504 of the Rehabilitation Act
   - Your Rights under the Americans with Disabilities Act
   - Your Rights under Section 504 and the Americans with Disabilities Act
   - Your Rights under the Community Service Assurance of the Hill-Burton Act
   - Your Rights as a person with HIV infection or AIDS
   - Your Rights under the Age Discrimination Act
   - How to File a Health Information Privacy Complaint with the Office for Civil Rights
   - Limited English Proficiency (LEP) Know Your rights brochure

5. **Civil Rights Complaint FAQ**

   A Frequently Asked Questions document about filing a civil rights complaint is available at **http://www.hhs.gov/ocr/civilrights/faq/index.html**. This FAQ provides answers to common questions about topics such as details of the complaint process, how various situations are handled, what information is needed from the inquiring person, limitations on the types of complaints investigated, what to expect, other federal agencies that handle civil rights and discrimination issues, and other topics.

OCR Regional Offices[83]

Health care providers seeking technical assistance from OCR in assessing and implementing language services should contact their regional office for assistance.

Region	Manager, Email, Web[60]	Phone and fax	Address
Headquarters Washington, DC	Georgina C. Verdugo, Director OCRMail@hhs.gov www.hhs.gov/ocr/index.html	**T:** 800-368-1019 **TDD:** 800-537-7697	Office for Civil Rights U.S. Department of Health and Human Services (OCR DHHS) 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, DC 20201
Region I — Boston (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)	Peter Chan, Regional Manager	**T:** 617-565-1340 **F:** 617-565-3809 **TDD:** 617-565-1343	OCR DHHS Government Center J.F. Kennedy Federal Building — Room 1875 Boston, MA 02203
Region II — New York (New Jersey, New York, Puerto Rico, Virgin Islands)	Michael Carter, Regional Manager	**T:** 212-264-3313 **F:** 212-264-3039 **TDD:** 212-264-2355	OCR DHHS Jacob Javits Federal Building 26 Federal Plaza — Suite 3312 New York, NY 10278
Region III — Philadelphia (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)	Paul Cushing, Regional Manager	**T:** 215-861-4441 **Hotline:** 800-368-1019 **F:** 215-861-4431 **TDD:** 215-861-4440	OCR DHHS 150 S. Independence Mall West Suite 372, Public Ledger Building Philadelphia, PA 19106-9111
Region IV — Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)	Roosevelt Freeman, Regional Manager	**T:** 404-562-7886 **F:** 404-562-7881 **TDD:** 404-331-2867	OCR DHHS Atlanta Federal Center, Suite 3B70 61 Forsyth Street, S.W. Atlanta, GA 30303-8909
Region V — Chicago (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)	Valerie Morgan-Alston, Regional Manager	**T:** 312-886-2359 **F:** 312-886-1807 **TDD:** 312-353-5693	OCR DHHS 233 N. Michigan Ave., Suite 240 Chicago, IL 60601
Region VI — Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)	Ralph Rouse, Regional Manager	**T:** 214-767-4056 **F:** 214-767-0432 **TDD:** 214-767-8940	OCR DHHS 1301 Young Street, Suite 1169 Dallas, TX 75202
Region VII — Kansas City (Iowa, Kansas, Missouri, Nebraska)	Frank Campbell, Regional Manager	**T:** 816-426-7277 **F:** 816-426-3686 **TDD:** 816-426-7065	OCR DHHS 601 East 12th Street — Room 248 Kansas City, MO 64106
Region VIII — Denver (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)	Velveta Howell, Regional Manager	**T:** 303-844-2024 **F:** 303-844-2025 **TDD:** 303-844-3439	OCR DHHS 1961 Stout Street — Room 1426 FOB Denver, CO 80294-3538
Region IX — San Francisco (American Samoa, Arizona, California, Guam, Hawaii, Nevada)	Michael Kruley, Regional Manager	**T:** 415-437-8310 **F:** 415-437-8329 **TDD:** 415-437-8311	OCR DHHS 90 7th Street — Room 4-100 San Francisco, CA 94103
Region X — Seattle (Alaska, Idaho, Oregon, Washington)	Linda Yuu Connor, Deputy Regional Manager	**T:** 206-615-2290 **F:** 206-615-2297 **TDD:** 206-615-2296	OCR DHHS 2201 Sixth Avenue — M/S: RX-11 Seattle, WA 98121-1831

8 Glossary of Interpreting and Translation Terms

Glossary[84]

"A" language
A language in which the interpreter has native proficiency in speaking and listening.

accreditation
A term usually referring to the recognition of educational institutions or training programs as meeting and maintaining standards that qualify its graduates for professional practice. See also **certified interpreter**.

ad hoc interpreter
An untrained person who is called upon to interpret, such as a family member interpreting for her parents, a friend, a bilingual staff member who is pulled away from other duties to interpret, or a self-declared bilingual individual who volunteers to interpret. These individuals may not have sufficient language capability or knowledge of medical terminology and confidentiality issues to function adequately as interpreters. Also called a *chance interpreter* or *lay interpreter*.

advocacy
Any intervention (by an interpreter) that does not specifically relate to the interpretation process. Advocacy is intended to further the interests of one of the parties for whom the interpreting is done. For example, if an interpreter intervenes when she believes the physician is not giving the patient a chance to describe the problem she made the appointment to address, that intervention would be considered advocacy. Experts in the field of health care interpreting disagree on the degree of advocacy that interpreters should provide. This is the subject of an ongoing national dialogue. See also **transparency**.

advocate
A role that an interpreter takes that moves from interpreting the communication between speakers to acting on behalf of one of the speakers based on the interpreter's understanding of what the speaker's intended outcome is.

autonomy	The principle by which patients who are competent to make decisions should have the right to do so while health care providers should respect patients' preferences regarding their own health care.
"B" language	A language in which the interpreter has full functional proficiency in speaking and listening.
back translation	Translation of a translated document back into the original language. Often used to check the accuracy of the original translation, although professional translators do not use this process to check the accuracy of a translation.
bilingual	A term describing a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter or translator but by itself does not insure the ability to interpret or translate.
bilingual provider	A person with proficiency in more than one language, enabling the person to provide services directly to limited English proficient patients in his/her non-English language.
bilingual worker/employee	An employee who is a proficient speaker of two languages, usually English and a language other than English, who is often called upon to interpret for limited English proficient patients, but who is usually not trained as a professional interpreter. Using a bilingual employee who is neither proficiently bilingual nor trained to interpret is not recommended. See also **professional interpreter**.
Centers for Medicare & Medicaid Services (CMS)	As a part of the U.S. Department of Health and Human Services (HHS), CMS oversees Medicare, Medicaid and State Children's Health Insurance Program (SCHIP).
certificate	A document, such as a certificate of attendance or completion, that attests to participation in a course of study and attainment of some learning objective. A person who holds a certificate related to interpreter training is not thereby **certified**. See also **certification**, **certified interpreter**.

certification

A process by which a governmental or professional organization attests to or certifies that an individual is qualified to provide a particular service. Certification calls for formal assessment, using an instrument that has been tested for validity and reliability, so that the certifying body can be confident that the individuals it certifies have the qualifications needed to do the job. Currently, no national certification standards exist for medical/health care interpretation or translation. Washington State has state-based medical interpreting certification, and Indiana, Massachusetts and Oregon are developing state interpreter certification standards. Rhode Island has a state law mandating that hospitals provide a "qualified interpreter."[85] Some colleges and universities have medical interpreting "certificate" programs, and a variety of health care interpreting training programs exist. Many training programs are 40- to 50-hours in length and issue certificates of completion. These programs do not constitute certification. Sometimes called *qualification*. See also **certified interpreter**.

certified interpreter

A **professional interpreter** who has certification. Interpreters who have had limited training or have taken a screening test administered by an employing health, interpreter or referral agency are not considered certified. See also **certification**.

clarifier

An interpreter who helps a speaker explain a message or concept in a more easily understood way to facilitate communication between parties during an interpreting session.

community interpreting

Interpreting that takes place in the course of communication in the local community among speakers of different languages. The community interpreter may or may not be a trained interpreter. See **professional interpreter**.

conduit	The basic role of an interpreter, to reproduce everything that one party says in one language into the target language, exactly as it is said, adding nothing, omitting nothing, and changing nothing. See also **clarifier**.
consecutive interpreting	The conversion of a speaker's message into another language in a sequential manner after the speaker or signer pauses, in a specific social context. In other words, the interpreter waits until the speaker has finished the utterance before rendering it in the other language. See also **simultaneous interpreting**.
converter	See **conduit**.
cultural and linguistic competence	The ability of health care providers to understand and respond effectively to the cultural and linguistic needs of the patient and his/her family. See also **cultural sensitivity**.
cultural bridging/broker(ing)/ liasing/mediating	Any action taken by the interpreter that provides cultural information in addition to linguistic interpretation of the message given. See also **transparency**.
cultural sensitivity	Awareness of one's own cultural assumptions, biases, behaviors and beliefs, and the knowledge and skills to interact with and understand people from other cultures without imposing one's own cultural values on them.
Department of Health and Human Services (United States) (DHHS or HHS)	DHHS administers many of the programs at the Federal level dealing with the health and welfare of the residents of the United States.[86] In August 2003, HHS issued an LEP guidance to inform recipients of HHS funds of the expectations to provide meaningful access to LEP individuals. In the health care context, the guidance applies to most hospitals, doctors (except those only receiving funds through Medicare Part B), nursing homes, managed care organizations, state Medicaid agencies, and social service organizations.

Department of Justice (DOJ) Coordinating Authority

DOJ coordinates the federal government's implementation of Title VI. In June 2002, DOJ issued LEP policy guidance, which provides four factors that federal agencies should use in developing their recipient specific guidance for language access to LEP individuals.[87] These four factors include: (1) the number or proportion of LEP persons served or encountered; (2) the frequency of contact with the program; (3) the nature and importance of the program to LEP beneficiaries; (4) and the resources available and cost considerations.

face-to-face interpreting

Interpreting done by an interpreter who is directly in the presence of the speakers. Also called *on-site interpreting*. See also **remote interpreting**, **telephone interpreting**.

first-person interpreting

The promotion by the interpreter of direct communication between the principal parties in the interaction through the use of direct utterances of each of the speakers, as though the interpreter were the voice of the person speaking, albeit in the language of the listener. For example, if the patient says, "My stomach hurts," the interpreter says (in the second language), "my stomach hurts," and not "she says her stomach hurts."

Executive Order (EO) 13166

President Clinton signed and President Bush reaffirmed EO EO 13166 to improve access to federally funded programs and activities for persons with LEP, based on Title VI of the 1964 Civil Rights Act. EO 13166 requires each federal agency to develop guidance on language access to its federal fund recipients. It also applies Title VI requirements to federal departments and agencies themselves.[88]

Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (2003)

This guidance was finalized by HHS in 2003 after being reissued to follow the LEP guidance template from the Department of Justice.

HHS	See **Department of Health and Human Services**.
health care interpreting	Interpreting that takes place in health care settings of any sort, including physicians' offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations. Typically the setting is an encounter between a health care provider (physician, nurse, lab technician) and a patient (or the patient and one or more family members). See also **medical interpreting**.
HIPAA (Health Insurance Portability and Accountability Act of 1996)	The Health Insurance Portability and Accountability Act was enacted to simplify health care claims by establishing national standards for electronic claims. In addition, the HIPAA privacy regulations establish a set of minimum national standards that limit the ways that health plans, pharmacies, hospitals, clinicians, and others (called "covered entities") can use patients' personal medical information. For a discussion of how HIPAA affects language services, refer to NHeLP's document *HIPAA and Language Services in Health Care*.[89]
informed consent	The process in which a health care provider informs his/her patient about treatment options and the risks involved and the patient makes a decision regarding what he/she wants to do.
interpretation	See **interpreting**. While the two words have the same meaning in the context of oral/signed communication, the term *interpreting* is preferred, because it emphasizes process while *interpretation* refers to the product and because interpretation has so many other uses outside the field of translation and interpreting.
interpreter	A person who renders a message spoken in one language into a second language. Within the language professions, *interpreting* is distinguished from *translating* according to whether the message is produced *orally* (or manually) or *in writing*. In popular usage, however, the terms "translator" and "translation" are frequently used for conversion of either oral or written communications. See also **professional interpreter**.

interpreting

(noun) The process of understanding and analyzing a spoken or signed message and reexpressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account. The purpose of interpreting is to enable communication between two or more individuals who do not speak each other's languages.

(adjective) Concerning or involved with interpreting. Examples: *interpreting services*, *interpreting issues*.

interpretive

See **interpreting**. Like the word *interpretation*, *interpretive* has many meanings and is often unclear when used in the context of oral/signed communication. It is preferable to use *interpreting* as an adjective, e.g. *interpreting services*, *interpreting issues*.

language agency

Organization that provides language services, including interpreting and/or translation. Language agencies can provide services on-site at a health care provider and/or via telephone or video conferencing. There are a variety of for- and non-profit organizations around the country offering these services.

language combination

The two languages that serve as **source** and **target languages** for an individual interpreter in a particular encounter. See also **source language**, **target language**.

language identification cards/ posters

This card identifies the language spoken by an individual ("I speak _____ language") and is often in both English and a target language – the English informs the health care provider of the language needs of the patient. These are commonly referred to as "I Speak" cards or posters.

language pair

See **Language Combination**.

LEP

See **Limited English Proficiency**.

licensed

Having formal permission or authority to perform some professional role, such as interpreting. There is no national licensure for medical interpreters in the United States.

licensure

The process of obtaining an official license or authorization to perform a particular job. For example, in every state, a state board grants licensure to physicians, who must meet certain requirements in order to periodically renew their licenses. There is no national licensure for interpreters or translators in the United States.

Limited English proficiency (LEP)

The inability to speak, read, write, or understand English at a level that permits an individual to interact effectively with health care providers or social service agencies.[90] According to the 2000 Census, over 21 million individuals speak English less than "very well." Many states have experienced significant increases in their LEP populations because of the changing demographics of the U.S. population.

See also Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (2003), **http://www.justice.gov/crt/cor/lep/hhsrevisedlepguidance.php**.

literal interpretation or translation

A form of rough interpreting or translation in which every word or word element is translated in sequence without regard to how the message would normally be expressed in the other language, giving insight into the workings of the source language. Example: (*French*) "*Il y avait beaucoup de gens*," literally "It there had many of people," which means, "There were lots of people (there)." Literal interpreting is not considered useful or part of professional interpreting; literal translations (written) are sometimes useful for analysis of the source text, but are not suitable when the aim is to assist communication.

machine translation

Translation that is accomplished by entering text in one language into a computer software program and obtaining a computed translation in a second language. Machine or computer translation programs often have difficulties recognizing idioms, context, regional differences and symbolic speech.

Medicaid and State Children's Health Insurance Program (SCHIP)

Health insurance programs for certain low-income individuals, operated jointly by the federal and state governments. Medicaid provides health insurance to over 44 million individuals, SCHIP to over 3 million children and sometimes others such as parents and pregnant women. Both programs allow states to draw down federal matching dollars to help pay for language services. At the time of this writing, eleven states (Hawaii, Idaho, Kansas, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, Vermont and Washington) utilize the federal matching funds for language services. Two additional states, Texas and Virginia, are initiating pilot projects for reimbursement. Health care providers who participate in these programs must abide by Title VI.

medical interpreting

Interpreting that takes place in health care settings, such as between health care providers (physicians, nurses, lab technicians, staff) and patients. The skills needed for medical/health care interpreting vary from other settings, such as court interpreting. Medical/health care interpreters must be aware of confidentiality and HIPAA issues, medical terminology, and how to work in the health care setting.

methods of providing interpreting

Interpreting may be provided through various methods, including hiring bilingual staff and staff interpreters, contracting for interpreters, using telephonic/ video conferencing interpreting services, and using community volunteers.

multilingual

A term describing a person who has some degree of proficiency in two or more languages. A high level of bilingualism or multilingualism is the most basic of the qualifications of a competent interpreter, but by itself does not insure the ability to interpret.

national origin discrimination — Violation of the 'national origin' clause of Title VI of the Civil Rights Act of 1964, which states that "no person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, or be denied benefits of, or be subjected to discrimination under any program or activity receiving federal assistance." *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (2003), **http://www.justice.gov/crt/cor/lep/hhsrevisedlepguidance.php**, details how national origin discrimination may be avoided through the use of qualified interpreters and translators.

Office for Civil Rights (OCR) — OCR has responsibility to oversee Title VI implementation for HHS. It provides technical assistance to recipients of federal funds and can also initiate investigations or respond to complaints of discrimination pursuant to Title VI. See also **Title VI**.

on-site interpreting — Interpreting done by an interpreter who is directly in the presence of the speakers. Also called *face-to-face interpreting*. See also **remote interpreting**, **telephone interpreting**.

pre-session — A brief meeting held before an appointment, between the provider and the interpreter or sometimes between the interpreter and the patient, in which the participants establish an understanding of how communication should be conducted, discuss the health issues at hand, relevant cultural issues, or other topics concerning the appointment.

proficiency — Thorough language competence in a given setting derived from training and practice. In health care settings, proficiency requires knowledge of medical terminology in both languages.

professional interpreter — An individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to a code of professional ethics. See also **interpreter**, **ad hoc interpreter**.

register	The level of formality or complexity of language a person uses, or a speaker's linguistic features of pronunciation, vocabulary and grammar that contribute to the speaker's perceived level of education or social class.[91] A speaker's choice of register may be adapted to a particular topic, the parties spoken to, and the perceived formality of the situation.[92] For example, in interpreting and translation, in some languages, the vocabulary used for Western medical concepts may only be familiar to people with a university education, but not to others, even though the vocabulary exists in that language.
relay interpreting	An interpreting process in which two individuals attempting a conversation communicate through two interpreters, each of whom speaks only one of the two languages required as well as a common third language. An example of this would be interpreting Quechua into Spanish, which in turn is interpreted into English.
remote interpreting	Interpreting provided by an interpreter who is not in the presence of the speakers, e.g., interpreting via telephone or videoconferencing. See also **telephone interpreting**, **video interpreting**, **on-site interpreting**.
sight translation	Translation of a written document into spoken language, on the spot. An interpreter reads a document written in one language and simultaneously interprets it into a second language.
simultaneous interpreting	Converting a speaker message into another language while the speaker continues to speak or sign. For example, the United Nations utilizes simultaneous interpreting via headphones. See also, contra, **consecutive interpreting**.
sign(ed) language	Language of hand gestures and symbols used for communication with deaf and hearing-impaired people.
source language	The language of a speaker who is being interpreted. See also, contra, **target language**.

summarizing	A limited interpretation that excludes all or most details focusing only on the principal points of the interpreted speech — not a full interpretation. Summarizing does not comply with codes of ethics that require full interpretation.
summary interpretation	See **summarizing**.
target language	The language into which an interpreter is interpreting at any given moment. See also **source language**.
telephone/telephonic interpreting	Interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through a speaker-phone or headsets. In health care settings, the principal parties, e.g., health care provider/clinician and patient, are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone. See also **remote interpreting**.
Title VI of the Civil Rights Act of 1964	This federal law states "no person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, or be denied benefits of, or be subjected to discrimination under any program or activity receiving federal assistance."[93] The Supreme Court and federal agencies have determined that recipients of federal funds must ensure that LEP individuals have meaningful access to their programs and services. In most health care settings, HHS' Office for Civil Rights oversees implementation of Title VI.
trained interpreter	A professional with formal training, accreditation or certification who has developed the knowledge and skills for competent interpreting. In addition to demonstrating fluency in English and a second language, a trained interpreter is bound by a professional code of ethics, culturally competent, capable of delivering accurate and timely messages in two languages and knowledgeable of specialized terminology.

translation — The conversion of a written text into a corresponding written text in a different language. Within the language professions, **translation** is distinguished from **interpreting** according to whether the message is produced *in writing* or *orally* (or manually). In popular usage, the terms "translator" and "translation" are frequently used for conversion of either oral or written communications.

translator — A person who translates written texts. See also **translation**, **interpreter**.

transparency — The principle that during the encounter the interpreter informs all parties of any action he or she takes, including speaking for him- or herself, outside of direct interpreting.[94] Whenever the interpreter speaks directly to either party in either language, the interpreter must subsequently interpret both his/her own speech and that of the party spoken to, for the benefit of those present who do not understand the language used.

treating team — All health care providers involved in the care of a particular patient within a single facility.

TTY relay — A service enabling telephone communication between TTY/TDD customers (who are usually deaf or hard of hearing) and hearing people.

unidirectional interpreting — Interpretation from only one source language (usually found in conference interpreting where participants' responses are not interpreted).

video conferencing — Remote conference by televideo technology. See also **remote interpreting**, **video interpreting**.

video interpreting

Interpreting carried out remotely, using a video camera that enables an interpreter in a remote location to both see and hear the parties for whom he/she is interpreting via a TV monitor. The interpretation is relayed to the principal parties by speakerphone or through headsets. Two-way interactive television can also be used, so that the other parties can interact with the interpreter as if face to face. See also **remote interpreting**.

visual language

Forms of communication used by interpreters for the deaf, including American Sign Language (ASL), Quebecois French (LSQ) and other sign language variants in other parts of the world (e.g., British, Spanish, French, Mexican), transliterated English (word by word interpretation from English into visual language), lip reading, and tactile interpretation. Note that sign languages for the deaf are unique languages with their own syntax and are not signed versions of English or other spoken languages (CHIA).

working language

A language an interpreter uses professionally; a language into and/or out of which an interpreter interprets. See also **language combination**.

Chapter Endnotes

1 *See, e.g.,* J.A. Crane, *Patient Comprehension of Doctor-Patient Communication on Discharge from the Emergency Department*, 15 J. Emergency Med. 1 (1997) (finding Spanish-speaking patients discharged from ERs less likely than English speakers to understand their diagnoses, prescribed medications, and follow-up instructions).

2 *See, e.g.*, Judith Bernstein *et al., Trained Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-Up*, 4 J. Immig. Health 171 (Oct. 2002) (finding interpreters improved clinic follow-up and reduced post emergency room visits and charges); L.C. *Hampers, Language Barriers and Resources Utilization in a Pediatric Emergency Department*, 103 Pediatrics 1253 (1999) (finding patients with a language barrier had higher charges and longer stays).

3 *See, e.g.*, Michelle M. Doty, The Commonwealth Fund, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*, at vii–viii, 8, 11–14, & 21 (Feb. 2003); Dennis P. Andrulis *et al.*, The Access Project, *What a Difference an Interpreter Can Make* 1–2 (Apr. 2002).

4 *See, e.g.*, Barry Newman, *Doctors' Orders Can Get Lost in Translation for Immigrants*, Wall Street J., Jan. 9, 2003.

5 Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*, at 17 (2002).

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

7 Leighton Ku & Alyse Freilich, Urban Institute, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii–iii (Feb. 2001). *See also* Jennifer Cho & Beatriz M. Solis, L.A. Care Health Plan, *Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on their Diverse Member Population* (Jan. 2001) (51 percent of doctors said their patients do not adhere to treatments because of culture and language barriers).

8 *See* Robin M. Weinick & Nancy A. Krauss, *Racial and Ethnic Differences in Children's Access to Care*, 90 Am. J. Public Health 1771 (Nov. 2000).

9 Sora Tanjasiri, PALS For Health, *Client Evaluation of Interpretation Services* 6 (Apr. 30, 2001).

10 E.J. Perez-Stable *et al.*, *The Effects of Ethnicity and Language on Medical Outcomes of Patients with Hypertension or Diabetes*, 35 Med. Care 1212 (1997).

11 Elizabeth A. Jacobs *et al.*, *Impact of Interpreter Services on Delivery of Health Care to Limited-English Proficient Patients*, 16 J. Gen. Internal Med. 468 (2001).

12 *See* David W. Baker *et al.*, *Use and Effectiveness of Interpreters in an Emergency Department*, 275 JAMA 783–788 (Mar. 13, 1996); Bruce T. Downing, *Quality in Interlingual Provider-Patient Communication and Quality of Care* 7–9 (Sept. 1995) (available from Kaiser Family Foundation Forum, *Responding to Language Barriers to Health Care*) (finding 28% of words incorrectly translated by a son for his Russian-speaking father); Steven Woloshin *et al.*, *Language Barriers in Medicine in the United States*, 273 JAMA 724 (Mar. 1, 1995. The literature thus belies the layman's belief of Dr. Colwell that family members provide the "best translation service." Appellants' Opening Brief at 43, fn. 13. Rather, the research demonstrates that family members not only raise all the problems associated with any untrained "interpreter", but also interject complicated issues of privacy and family dynamics into the equation.

13 *See generally*, J. McQuillan & L.Tse, *Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy*, Language and Education 9(3) at 195–215 (1995).

14 *See, e.g.*, David W. Baker *et al.*, *Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-speaking Patients*, 36 Med. Care 1461 (1998); Gold, *Small Voice for Her Immigrant Parents*, L.A. Times, May 24, 1999, at A1; Thomas Ginsberg, *Shouldering a Language Burden*, The Phil. Inquirer, Mar. 3, 2003; Queena Lu, *Children: Voices for Their Parents*, Asian Week, May 17–23, 2001, at 6 (describing a young woman's traumatic experience of telling her mother she had cancer and trying to explain treatment options with her limited vocabulary).

15 Glenn Flores *et al.*, *Errors in Medical Interpretation and Their Potential Consequences in Pediatric Encounters*, 111 Pediatrics 4 (Jan. 2003). Of 165 total errors committed by nonprofessional interpreters, 77 percent had potentially serious clinical consequences. *See also*, Garret Condon, *Translation Errors Take Toll on Medical Care*, Clev. Plain Dealer, Jan. 20, 2003, at C3.

16 Glenn Flores, Abstract, *Pediatric Research*, April 2003, Volume 53, Number 4. For hospital interpreters with at least 100 hours of training, the rate of errors of potential clinical consequence was only 2 percent.

17 Office of Minority Health, U.S. Dept. of Health and Human Services, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, Final Report at 73 (March 2001), *available at*: **http://www.omhrc.gov/clas**. The Flores and OMH reports, and the research upon which they are based, thus undermine the Appellant doctors' claim that their "professional judgment" is somehow implicated by a requirement to communicate with LEP patients in a manner that has been demonstrated effective. While such communication may not reflect their personal preferences, they have offered the Court no basis upon which to conclude that evaluating what does and does not constitute effective communication is a matter within the scope of their "professional judgment." They, like the vast majority of us, claim no training in linguistics or interpretation, much less a professional level of expertise in those fields.

18 Office of Management and Budget, *Report to Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons With Limited English Proficiency* 43–52, 55 (Mar. 14, 2002) (based on total and average cost of emergency room, inpatient hospital, outpatient physician and dental visits).

19 Elizabeth Jacobs *et al.*, *Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services*, 16 Supp. J. Gen. Internal Med. 201 (Abstract) (2001).

20 These include "I Speak" cards, examples of which are available at **http://www.lep.gov** and **http://www.palsforhealth.org**.

21 Kaiser Permanente maintains a library of translated clinical materials for its physicians and another of translated non-clinical materials, including consent forms and health education materials. For California's Medicaid and SCHIP programs, L.A. Care Health Plan has translated forms and member materials and is developing a web-based translation service that will identify and translate forms into appropriate threshold languages.

22 *See* Cindy E. Roat, The California Endowment, *How to Choose and Use a Language Agency: A Guide For Health and Social Service Providers Who Wish to Contract With Language Agencies* (2002).

23 *See* Centers for Medicare & Medicaid Services, U.S. Department of Health And Human Services, *Dear State Medicaid Director Letter* (Aug. 31, 2000), *available at* **http://www.cms.hhs.gov/states/letter/smd83100.asp**. To date, thirteen states have chosen cover these costs, either as a covered service or an administrative expense. They are HI, ID, KS, MA, ME, MN, MT, NH, UT, TX (pilot), VA (pilot), VT and WA. *See* Medicaid/SCHIP Reimbursement Models for Language Services (updated 2005), *available at* **http://www.healthlaw.org**.

24 Agency for Healthcare Research and Quality, *Language Barrier: The Case*, Pediatrics (2006), *at* **http://www.webmm.ahrq.gov/**.

25 With permission, excerpted and adapted from The Access Project & The National Health Law Program, *Language Services Action Kit*, (2002), available at **http://www.healthlaw.org.**

26 2008 American Community Survey, *Selected Characteristics of the Native and Foreign-Born Populations*, (Table S0501.), *available at* **http://factfinder.census.gov**

27 2008 American Community Survey, *Language Spoken at Home*, (Table S1601, B1601), *available at* **http://factfinder.census.gov**.

28 2008 American Community Survey, *Linguistic Isolation* (Table S1602), *available at* **http://factfinder.census.gov**.

29 Betsy Guzman, U.S. Department of Commerce Census Bureau, *The Hispanic Population Census 2000 Brief* at 2 (May 2001) (finding from 1990 to 2000, the Hispanic population increased by 57.9 percent, from 22.4 million to 35.3 million, compared with an increase of 13.2 percent for the total population in the United States).

30 U.S. Bureau of the Census, *Language Spoken at Home: 2000* (Table QT-P16), *available at* **http://factfinder.census.gov**.

31 U.S. Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table DP-2), *available at* **http://factfinder.census.gov**.

32 *See* Peter T. Kilborn and Lynette 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).

33 *See* National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, (2003).

34 For examples of these studies, *see Consequences of Poor Communication* in this Toolkit.

35 Sheila Leatherman and Douglas McCarthy, *Quality of Health Care in the United States: A Chartbook* at 122 (Apr. 2002) (available from The Commonwealth Fund) (citing Robert Weech-Maldonado et al., *Racial and Ethnic Difference in Parents' Assessments of Pediatric Care in Medicaid Managed Care*, 36 Health Services Research 575 (July 2001)).

36 *See* Dennis P. Andrulis, Ph.D., Nanette Goodman, M.A., and Carol Pryor, M.P.H., The Access Project, *What a Difference an Interpreter Can Make* at 1[????] (Apr. 2002).

37 Kaiser Family Foundation, *National Survey of Physicians Part I: Doctors on Disparities in Medical Care, Highlights and Charts* 3–4 (Mar. 2002), *available at* **http://www.kff.org/content/2002/20020321a/Physician_SurveyPartl_disparities.pdf**.

38 A number of federal laws have been cited to improve language access, including the civil rights laws, provisions of the Medicare and Medicaid Acts, the Hill-Burton Act, federal categorical grant requirements, the Emergency Medical Treatment and Active Labor Act (EMTALA), and the United States Constitution. *See, e.g.*, National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, (2003); National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities*, Kaiser Family Foundation (2003).

39 With permission, excerpted and adapted from The Access Project & The National Health Law Program, *Language Services Action Kit*, (2002), *available at* **http://www.healthlaw.org**.

40 Glenn Flores, *et al.*, *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, 111 Pediatrics 6 (No. 1) (January 2003).

41 *See* 65 Fed. Reg. at 52769-80 (August 30, 2000). While OCR is currently reviewing its guidance to comply with a Memorandum from the Department of Justice (July 8, 2002), we anticipate that the substance will remain similar. OCR's existing guidance remains in effect.

42 *See generally*, McQuillan & Tse, *Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy*, Language and Education, 9(3) at 195–215 (1995).

43 Adapted from: NHeLP, *Promising Practices to Provide Language Services in Small Provider Settings: Examples from The Field*, The Commonwealth Fund, 2005. Available at **http://www.cmwf.org**.

44 To download materials, see **http://www.familydocs.org/mlc**.

45 Materials available at **http://www.healthlaw.org/pubs/nlaap/ICECulturalCompetencies.pdf**.

46 States may pay for language services in Medicaid. For more information, see Appendices G and H. Medicare does not currently pay for language services; some private insurers do pay.

47 For examples of "I Speak . . ." posters, *see* **http://www.dol.gov/oasam/programs/crc/ISpeakCards.pdf** and **http://www.dhfs.state.wi.us/civilrights/LEPposter.pdf**.

48 For examples of "I Speak" cards, *see* **http://www.palsforhealth.org/**, **http://www.dss.cahwnet.gov/civilrights/ISpeakCard_1304.htm**, and **http://www.dhfs.state.wi.us/civilrights/ISPEAKCARDS.pdf**.

49 Glenn Flores, et al., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, 111 Pediatrics 6 (No. 1) (Jan. 2003).

50 For more information on the differences between interpreting and translation, see NHeLP, NCIHC & ATA, *What's in a Word: A Guide to Understanding Interpreting and Translation in Healthcare*, available at **http://www.healthlaw.org/**. An excerpt is included in this chapter.

51 Roat, Cynthia E. *How to choose and use a language agency: A guide for health and social service providers who wish to contract with language agencies*. Woodland Hills CA: The California Endowment, 2003. **http://www.calendow.org/uploadedFiles/how_to_choose_use_language_agency.pdf**.

52 For more information, see Certification Commission for Healthcare Interpreters, **http://healthcareinterpretercertification.org/**.

53 In a pre-session, an interpreter and clinician meet briefly before an appointment to establish an understanding of how the encounter should proceed, discuss relevant cultural issues, the health topic or

procedure at hand, and/or whatever they believe necessary to prepare for the appointment. There are continuing conversations and strong opinions about some of these issues, pro or con, because of the continuing evolution of this profession.

54 For more information on the differences between interpreting and translation, see NHeLP, NCIHC & ATA, *What's in a Word: A Guide to Understanding Interpreting and Translation in Health Care*, available at **http://www.healthlaw.org/**.

55 ASTM *Standard Guide for Language Interpretation Services* (F 2089-01 (reapproved 2007).

56 NCIHC *The Terminology of Healthcare Interpreting — A Glossary of Terms* (October 2001, revised August 2008)

57 NCIHC *The Terminology of Healthcare Interpreting — A Glossary of Terms* (October 2001, revised August 2008)

58 For more information on certification for health care interpreters, see Certification Commission for Healthcare Interpreters, **http://www.healthcareinterpretercertification.org**.

59 The Certification Commission for Healthcare Interpreters is currently developing a national, credible certification program for health care interpreters. It is expected to be available in Fall 2010. For more information, see **http://healthcareinterpretercertification.org/**. In addition, the National Council on Interpreting in Health Care is developing National Standards for Training of health care interpreters, also expected in late 2010. For more information, see **http://www.ncihc.org**.

60 Commonwealth of Massachusetts, Massachusetts Department of Public Health, Executive Office of Health and Human Services, Office of Minority Health. *Best practice recommendations for hospital-based interpreter services, available at* **http://mass.gov/dph/omh/interp/interpreter.htm**.

61 This information was gathered in 2008 via an online survey and telephone interviews with representatives from schools and colleges of pharmacy, pharmacy associations, and other professionals involved in the provision of pharmaceutical care to LEP patients

62 Barry D. Weiss, *Health Literacy and Patient Safety: Help Patients Understand*, **http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf**, citing Baker DW, Parker RM, Williams MV, et al. The health care experience of patients with low literacy. *Arch Family Med.* 1996; 5:329–334.

63 See **http://www.pharmacotherapy.org/**.

64 See **http://www.pharmacotherapy.org/**.

65 See **http://www.amcp.org/data/nav_content/AMCP%20Policy%20Digest%20July%202005.pdf**.

66 Am J Health-System Pharm. 2008; 65:728–33.

67 See **http://www.riteaid.com/company/news/news_details.jsf?itemNumber=728**.

68 See **http://www.riteaid.com/company/news/news_details.jsf?itemNumber=1158**.

69 See **http://www.rxtalks.com/index.php**.

70 See **http://www.pgsi.com/Products/Meducation.aspx**.

71 Available at **http://www.accp.com/bookstore/th_05pmet.aspx**.

72 Available from Hesperian Foundation, **http://www.hesperian.org/**. Hesperian also allows others to translate their materials and lists the availability of other language versions of this book at **http://www.hesperian.org/publications_translation.php**.

73 See **http://www.walgreens.com/pharmacy/services/language.jsp**.

74 See **http://www.riteaid.com/company/news/news_details.jsf?itemNumber=1158**.

75 Institute of Medicine, crossing the quality chasm: a new health system for the 21st century. Washington (DC): National Academy Press; 2001.

76 Stair, Ralph M., 1992. Principles of Information Systems, Boston, MA: Boyd & Fraser Publishing Co, pp. 6.

77 See **http://lexi.com**.

78 See **http://www.adam.com/**.

79 See **http://blausen.com**.

80 The information in this chapter is adapted with permission from USP, **http://www.usp.org/audiences/consumers/pictograms/form.html**, and Hablamos Juntos, **http://www.hablamosjuntos.org/**.

81 Reprinted with permission from Hablamos Juntos, **http://www.hablamosjuntos.org/**.

82 All information in this section is drawn from the United States Department of Health and Human Services Office for Civil Rights' web site at **http://www.hhs.**

gov/ocr/office/index.html, Washington, DC: U.S. Department of Health & Human Services, 2009.

83 This information is current as of January, 2009.

84 Definitions in this glossary were compiled from the National Council on Interpreting in Health Care, California Healthcare Interpreters Association, International Medical Interpreters Association, ASTM International, and the National Health Law Program.

85 Rhode Island Public Law, Chapter 88. Passed in 2001.

86 Center for Medicare and Medicaid Services. *Glossary*. 2005. U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services. **http://www.cms.hhs.gov/apps/glossary/**.

87 U.S. Department of Health and Human Services, Office for Civil Rights. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. August 16, 2000. 65 Fed. Reg. at 50123.

88 65 Fed. Reg. 50121 (Aug. 16, 2001), see also 67 Fed. Reg. 41455 (June 18, 2002).

89 National Health Law Program. *HIPAA and Language Services in Health Care*. Washington, DC: NHeLP, 2005, *available at* **http://www.healthlaw.org**.

90 U.S. Department of Health and Human Services, Office for Civil Rights. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. 68 Fed. Reg. at 47311-47323.

91 CHIA Standards & Certification Committee. *California Standards for healthcare interpreters: Ethical principles, protocols, and guidance on roles & intervention*. Woodland Hills, CA: California Interpreters Association, 2002.

92 National Council on Interpreting in Health Care. *NCIHC National Standards of Practice for Interpreters in Health Care*. [Santa Rosa, CA]: National Council on Interpreting in Health Care, 2005.

93 42 U.S.C. § 2000d

94 National Council on Interpreting in Health Care. *NCIHC National Standards of Practice for Interpreters in Health Care*, *available at* **http://www.ncihc.org**.

A

Appendix A. Statement of Principles

This Statement of Principles springs from the work of numerous national organizations over the past six months to develop an agenda to improve policies and funding for access to health care for individuals with limited English proficiency (LEP). Participants in this effort included health care provider organizations, advocates, language companies, interpreters and interpreter organizations, and accrediting organizations.

Language Access in Health Care Statement of Principles

To guide the way toward a world in which language barriers do not affect health outcomes, a diverse group of interested stakeholders developed these principles. The intent is to provide a broad framework to inform efforts to improve health care delivered to limited English proficient individuals.

Nearly 47 million people — 18% of the U.S. population — speak a language other than English at home.[1] The 2000 census documented that over 28% of all Spanish speakers, 22.5% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English "not well" or "not at all."[2] Estimates of the number of people with limited English proficiency (LEP) range from a low of about 11 million, or 4.2% of the U.S. population — who speak English "not well" or "not at all" — to over 21 million people, or 8.1% of the U.S. population — if one includes those who speak English less than "very well."[3]

As demographic trends continue to evolve,[4] the prevalence, composition and geographic distribution of languages spoken will continue to be fluid and 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% 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 non-English speaking residents continues to increase, so does the demand for English-as-a-Second-Language (ESL) classes. 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 while in Massachusetts, less than half of those who applied for English classes were able to enroll.[8]

Research documents how the lack of language services creates a barrier to and diminishes the quality of health care for limited English proficient individuals.[9] Over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only 2% 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] Language access is one aspect of cultural competence that is essential to quality care for LEP populations.

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] The increasing diversity of the country only amplifies the challenge for health care providers,[13] 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. But 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 appropriate access to quality health care.

Those endorsing this document view it as an inseparable whole that cannot legitimately be divided into individual parts. 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 entire framework.[14] The principles are as follows:

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

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

Endorsing Organizations

Aetna

Allergy and Asthma Network Mothers of Asthmatics

American Academy of Family Physicians

American Academy of Pediatrics

American Academy of Physician Assistants

American Association of Colleges of Pharmacy

American Association of Physicians of Indian Origin

American Civil Liberties Union

American College of Obstetricians and Gynecologists

American College of Physicians

American Counseling Association

American Hospital Association

American Medical Association

American Medical Student Association

American Nurses Association

American Psychiatric Association

American Psychological Association

American Public Health Association

Asian American Justice Center

Asian Pacific Islander American Health Forum

Association of Asian Pacific Community Health Organizations

Association of Clinicians for the Underserved

Association of Community Organizations for Reform Now

Association of Language Companies

Association of University Centers on Disabilities

Asthma and Allergy Foundation of America

Bazelon Center for Mental Health Law

California Association of Public Hospitals and Health Systems

California Health Care Safety Net Institute

California Healthcare Association

California Healthcare Interpreting Association

California Primary Care Association

Catholic Charities USA

Catholic Health Association of the US

Center for Medicare Advocacy

Center on Budget and Policy Priorities

Center on Disability and Health

Certification Commission for Healthcare Interpreters

Children's Defense Fund

Community Health Councils (CA)

Cross-Cultural Communications, LLC

Cuban American National Council

District of Columbia Language Access Coalition

District of Columbia Primary Care Association

Families USA

Family Voices

Greater N.Y. Hospital Association

HIV Medicine Association

Indiana Latino Institute, Inc.

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 U.S. Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table DP-2), *available at* **http://factfinder.census.gov**. *See also* Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* at 70–71 (2002) (reporting that more than one in four Hispanic individuals in the U.S. live in language-isolated households where no person over age 14 speaks English "very well," over half of Laotian, Cambodian, and Hmong families are in language isolated households, as well as 26–42% of Thai, Chinese, Korean, and Vietnamese).

2 *See* U.S. Bureau of Census, *Ability to Speak English: 2000* (Table QT-P17) *available at* **http://factfinder.census.gov**.

3 *Id.*

4 For example, from 1990–2000, the "top ten" countries of origin of immigrants residing in the U.S. 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* Peter T. Kilborn and Lynette 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%, 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, e.g.,* 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 Suzanne Sataline, *Immigrants' First Stop: The Line for English Classes*, The Christian Science Monitor (Aug. 27, 2002).

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

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

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

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 (Feb. 2001) (prepared by Leighton Ku and Alyse Freilich, The Urban Institute, Washington, DC). *See also* Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 71–72 (2002) (describing recent survey finding 51% of providers believed patients did not adhere to treatment because of culture or language but 56% reported no cultural competency training).

13 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.

14 It is anticipated that this document will be disseminated to other interested stakeholders, Congressional and Administration staff, and the media solely to raise awareness of this issue and to support policies consonant with these principles. However, endorsement of these principles by an organization should not be interpreted as indicating its support for, or opposition to, any particular legislation or administrative proposal that may emerge.

B

Appendix B. Federal Laws and Policies to Ensure Access to Health Care Services for People with Limited English Proficiency

Federal Laws and Policies to Ensure Access to Health Care Services for People with Limited English Proficiency

1. Is there a federal requirement that health care providers offer interpreters to individuals who do not speak English well?

Yes. In 1964, Congress passed Title VI of the Civil Rights Act. This is a civil rights law that prohibits discrimination. Its purpose is to ensure that federal money is not used to support health care providers who discriminate on the basis of race, color, or national origin.[1] Title VI says:

> *No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.*[2]

The federal Department of Health and Human Services (HHS) and the courts have applied this statute to protect national origin minorities who do not speak English well. Thus, recipients of federal funding must take reasonable steps to ensure that people with limited English proficiency (LEP) have meaningful access to their programs and services.

2. What if a provider unintentionally discriminates against individuals?

HHS issued regulations to implement Title VI that reiterate the statute and extend Title VI beyond the prohibition of intentional discrimination. They prohibit federal fund recipients from:

- using criteria or methods of administration which have the *effect* of discriminating because of race, color or national origin;
- restricting the enjoyment of any advantage or privilege enjoyed by others receiving services through the same program;
- providing services or benefits to an individual that are different, or provided in a different way, from those provided to others;
- treating an individual differently from others in determining admission, enrollment, eligibility, or other requirement to receive services.[3]

Through these regulations, the HHS Office for Civil Rights (OCR) can initiate investigations or respond to complaints of discrimination.

3. Who is covered by Title VI?

The obligations under Title VI and HHS' regulations apply broadly to any "program or activity" that receives federal funding, either directly or indirectly (through a contract or subcontract, for example), and without regard to the amount of funds received.[4] This includes payment for services provided to Medicare, Medicaid and State

Children's Health Insurance Program (SCHIP) enrollees. Thus, in the health care context, this includes virtually all:

- Hospitals;
- Doctor's offices;[5]
- Nursing homes;
- Managed care organizations;
- State Medicaid agencies;
- Home health agencies;

Health service providers; and

Social service organizations.

Further, the Title VI protections extend to all of the operations of the organization or individual, not just that part that received the federal funds.[6]

4. Why has so much discussion recently focused on language access?

The number of languages spoken in the United States is increasing significantly. According to the 2000 Census, over 21 million individuals speak English less than "very well." Many states saw significant increases in their LEP populations. Recent federal activities focusing on improving language access have also increased discussion on the issue. These activities include a presidential "Executive Order" (EO) entitled *Improving Access to Services for Persons with Limited English Proficiency*,[7]publication of guidance on language access by many federal departments, and release of the "CLAS Standards" (Standards for Culturally and Linguistically Appropriate Services in health care) by the Office of Minority Health.[8]

The Executive Order affects all "federally conducted and federally assisted programs and activities." This includes health care providers that receive federal funds such as Medicare, Medicaid and SCHIP. The EO asks each federal agency to draft a guidance specially tailored to its federal fund recipients and applies Title VI to the federal departments and agencies themselves so that they have to administer their programs in a non-discriminatory way.

The current Administration has re-affirmed its commitment to the Executive Order and has continued activities to ensure its implementation.

5. How does a health care provider know what it should do to provide language services?

The Department of Justice, which coordinates the federal government's Title VI oversight, announced four factors for federal fund recipients to use to determine what steps they should take to assist LEP persons:[9]

- *The number or proportion of LEP individuals served or encountered*.[10]
- *The frequency of contact with the program*. If LEP individuals access the program on a daily basis, a recipient has greater duties than if contact is infrequent.
- *The nature and importance of the program to beneficiaries*. More steps must be taken if a denial or delay of services may have critical implications for daily life (e.g. hospitals,

schools) than in programs that are not as crucial (e.g. theaters, zoos).

- *The resources available and cost considerations*. A small recipient with limited resources may not have to take the same steps as a larger recipient in programs where the numbers of LEP persons are limited. Costs are a legitimate consideration in identifying the reasonableness of particular language assistance measures.[11]

In balancing these factors, providers should address the appropriate mix of written and oral language assistance, including which documents must be translated, when oral interpretation is needed, and whether such services must be immediately available.[12]

6. Are there specific guidelines for health care providers?

Yes. On August 8, 2003, the HHS Office for Civil Rights (OCR) issued guidance for its recipients of federal funds, which include health care providers.[13] This guidance does not impose any new requirements but merely brings together all of OCR's policies for overseeing Title VI since 1965.

7. How does OCR determine if a health care provider is discriminating?

OCR looks at the totality of the circumstances in each case. Four factors will be assessed: (1) the number or proportion of LEP individuals eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. According to DHHS, after the four factors have been applied, fund recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Fund recipients may choose to develop a written implementation plan as a means of documenting compliance with Title VI.

8. How should a provider offer oral interpretation services?

The HHS Guidance describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines,[14] and using community volunteers. It stresses that interpreters need to be competent, though not necessarily formally certified. The Guidance allows the use of family members and friends as interpreters but clearly states that an LEP person may not be required to use a family member or friend to interpret. Moreover, DHHS says recipients should make the LEP person aware that he or she has the "option" of having the recipient provide an interpreter for him/her without charge.

"Extra caution" should be taken when the LEP person chooses to use a minor to interpret. Recipients are asked to verify and monitor the competence

and appropriateness of using the family member of friend to interpret, particularly in situations involving administrative hearings; child or adult protective investigations; life, health, safety or access to important benefits; or when credibility and accuracy are important to protect the individual.

9. When should a provider translate written materials?

It depends on the relevant circumstances of each provider based on the factors listed above. After the four factors have been applied, recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Recipients could develop a written implementation plan as a means of documenting compliance with Title VI. If so, the following five elements are suggested when designing such a plan:

- Identifying LEP individuals who need language assistance, using for example, language identification cards.
- Describing language assistance measures, such as the types of language services available, how staff can obtain these services and respond to LEP persons; how competency of language services can be ensured.
- Training staff to know about LEP policies and procedures and how to work effectively with in-person and telephone interpreters.
- Providing notice to LEP person through, for example, posting signs in intake areas and other entry points, providing information in outreach brochures, working with community groups, using a telephone voice mail menu, providing notices in local non-English media sources, and making presentations in community settings.
- Monitoring and updating the LEP plan, considering changes in demographics, types of services, and other factors.[15]

OCR will evaluate a provider's efforts on a case-by-case basis. For the translation of written materials, the Guidance designates "safe harbors" that, if met, will provide strong evidence of compliance.[16]

10. What are the costs and benefits of providing language services?

The federal Office of Management and Budget (OMB) reported to Congress:

> *Almost all individuals, LEP and non-LEP, need to access the health care system at multiple points in their lives. Making these interactions more effective and more accessible for LEP persons may result in a multitude of benefits, including: increased patient satisfaction, decreased medical costs, improved heath, sufficient patient confidentiality in medical procedures, and true informed consent.17*

The OMB was unable to evaluate the actual costs due to insufficient information. However, using data from emergency room and inpatient hospital visits and outpatient physician and dental visits, it estimated that language

services would cost an extra 0.5 percent of the average cost per visit.18

11. How can health care providers pay for language services?

On August 31, 2000, the Health Care Financing Administration (now Centers for Medicare & Medicaid Services (CMS)) stated that federal Medicaid and SCHIP funds can be used for language activities and services.[19] States can thus submit the costs incurred by themselves or health care providers serving Medicaid and SCHIP enrollees to the federal government for partial reimbursement. For more information, see *How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and CHIP Enrollees?* Available at **http://www.healthlaw.org**.

12. If my state draws down Medicaid/ SCHIP funds, to whom can language services be provided?

States can only receive federal reimbursement for language services provided to Medicaid and SCHIP enrollees (or applicants who need assistance in applying). Depending on how your state structures the reimbursement, it can be available to all providers, including community health centers, managed care organizations and hospitals. Some states have limited the reimbursement to "fee-for-service" providers. Many states currently set their reimbursement rates for hospitals, clinics and managed care organizations to include the costs of language services as part of the entity's overhead or administrative costs. But a state could allow all providers to submit for reimbursement.

13. What if my state has an English-only law — does Title VI still apply?

Yes. As noted by OCR's guidance, the federal law applies regardless of whether your state law makes English its only recognized language (because federal law "preempts" any conflicting state law).[20] Since Title VI applies to the receipt of federal funds, a health care provider cannot forego his/ her obligations under federal law. In addition, your state's English-only laws may have a specific exemption for health care/social services and/or may only apply to government activities.

14. Where can I get more information?

The federal government has launched a website called "Let Everyone Participate," http://www.lep.gov. In addition to tracking federal activities, the website offers direct assistance to federal fund recipients and advocates. For example, fund recipients can download "I Speak" cards that allow LEP persons to identify their primary language.

Endnotes

1 100 Cong. Rec. 1658 (1964). The United States Supreme Court has treated discrimination based on language as national origin discrimination. *See* Lau v. Nichols, 414 U.S. 563 (1974).

2 42 U.S.C. § 2000d. *See also* 45 C.F.R. § 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

3 45 C.F.R. § 80.3(b).

4 *See* 42 U.S.C. § 2000d-4a (defining "program or activity").

5 Title VI has traditionally not applied, however, to doctors who only receive federal payments through Medicare Part B.

6 *See* 42 U.S.C. § 2000d-4a.

7 *See* 65 Fed. Reg. 50121 (Aug. 16, 2000), *see also* 67 Fed. Reg. 41455 (June 18, 2002).

8 *See* 65 Fed. Reg. 80865 (Dec. 22, 2000), *available at* **http://www.omhrc.gov/chas**.

9 *See* 65 Fed. Reg. 50123 (Aug. 16, 2000). In addition to EO 13166, this Guidance is authorized by 28 C.F.R. § 42.404(a), directing agencies to "publish title VI guidelines for each type of program to which they extend financial assistance, where such guidelines would be appropriate to provide detailed information on the requirements of Title VI." According to DOJ, the Guidance does not create new obligations beyond those already mandated by law. *Id.* at 50121–22.

10 *See* 67 Fed. Reg. 41459. "But even recipients that serve LEP person on an unpredictable or infrequent basis should use this balancing analysis to determine what to do if an LEP individual seeks services under the program in question."

11 *Id.* at 50124–25. *See also*, e.g., 67 Fed. Reg. 41455, 41457 (June 18, 2002).

12 *See* 67 Fed. Reg. 41460 (June 18, 2002).

13 68 Fed. Reg 47311 (August 8, 2003). To review previous versions of this guidance, *see* 65 Fed. Reg. 52762 (Aug. 30, 2000).

14 Previous guidance cautioned the fund recipient that telephone interpreter lines should not be the sole language assistance option, unless other options were unavailable. *See* 67 Fed. Reg. at 4975.

15 68 Fed. Reg. at 47319–21. Previous guidance called on recipients to develop and implement a language assistance program that addressed: (1) assessment of language needs; (2) development of a comprehensive policy on language access; (3) training of staff; and (4) vigilant monitoring. See 67 Fed. Reg. at 4971.

16 The safe harbors designate that the recipient provides written translations of "vital" documents (e.g. intake forms with the potential for important consequences, consent and complaint forms, eligibility and service notices) for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally. Or, if there are fewer than 50 persons in a language group that reaches the five percent trigger, above, the recipient provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of vital written materials, free of cost. 68 Fed. Reg. at 47319.

17 Office of Management and Budget, *Report To Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No.13166: Improving Access to Services for Persons with Limited English Proficiency* (Mar. 14, 2002), available at **http://www.justice.gov/crt/cor/lep/omb-lepreport.pdf.**

18 *Id.*

19 *See* CMS, *Dear State Medicaid Director* (Aug. 31, 2000).

20 *See* 68 Fed. Reg. at 47313.

C

Appendix C. Language Services in Pharmacies: What is Required?

Language Services in Pharmacies: What is Required?[1]

A 10-month old girl was taken to a pediatrician's office by her parents, who spoke no English. The infant was diagnosed with iron-deficiency anemia and prescribed an iron supplement. The parents took the prescription to a local pharmacy that did not provide language services, and the prescription label on the bottle was provided in English. The pharmacist attempted to demonstrate the proper dosing and administration. The prescribed dose was 15 mg per 0.6 ml (1.2 ml) daily. Fifteen minutes after the parents administered the medication to the infant, she appeared ill and vomited twice. She was taken to the emergency room where it was discovered that the parents had administered 15 ml (a 12.5-fold overdose).[2]

As this example illustrates, it is critical that pharmacists and limited English proficient (LEP) patients be able to communicate effectively. As complicated as it may be for English-speakers to understand medication instructions, the difficulties are exacerbated for LEP individuals. In a recent study, over one-quarter of LEP patients who needed, but did not get, an interpreter reported that they did not understand their medication instructions, compared with only two percent of those who either needed and received an interpreter or did not need an interpreter.[3]

Given that more than 4 billion prescriptions are written yearly and that 8.7% of Americans are LEP,[4] millions of prescriptions are likely for LEP patients. This issue brief provides an overview of existing federal laws addressing the provision of language services in the pharmacy setting.

FEDERAL REQUIREMENTS

1. **Is there a federal requirement for communication assistance (also called language services) to individuals who do not speak English well?**

   Yes. In 1964, Congress passed Title VI of the Civil Rights Act. This law prohibits discrimination and ensures that federal money is not used to support health care providers – including pharmacies and pharmacists – who discriminate on the basis of national origin.[5] Title VI says:

   > *No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.*[6]

The U.S. Department of Health and Human Services (HHS) and the courts have applied Title VI to protect national origin minorities who do not speak English well. Thus, recipients of federal financial assistance (hereafter "federal funding") must take reasonable steps to ensure that LEP individuals have meaningful access to their programs and services.[7]

2. Does Title VI cover pharmacies and pharmacists?

Yes. The obligations under Title VI (and HHS' regulations and guidance implementing Title VI, see Q. 4-5, and 12 below) apply broadly to any "program or activity" that receives federal funding, either directly or indirectly (through a contract or subcontract, for example), and without regard to the amount of funds received.[8] For independent and chain pharmacies and pharmacists, federal funding includes federal payments for prescription drugs (including dispensing fees or any other related payments) provided to Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) enrollees. It also applies to pharmacies providing prescription drugs to enrollees of federally-funded managed care plans (such as Medicaid managed care and Medicare Advantage plans) or Medicare Part D prescription drug plans.

Further, the Title VI protections extend to all of the operations of the organization or individual, not just that part that receives the federal funds.[9] So once federal funds are accepted, language services must be provided to all pharmacy patients, not just those patients participating in federally funded programs. And if a pharmacy does not take federal funds but is located in a facility that does (such as a hospital or long term care facility), Title VI still applies.

3. Who is "limited English proficient?"

HHS defines individuals as "limited English proficient" if they do not speak English as their primary language and have a limited or no ability to read, write, speak, or understand English.

In determining language ability, the Census Bureau asks how well a person speaks English — the options are "very well," "well," "not well" or "not at all." Due to the complex nature of health care interactions, it is generally accepted that a person who speaks English less than "very well" is likely LEP and will need language services. Nationally, over 24 million individuals speak English less than "very well."[10]

4. How does a pharmacist know how to provide language services?

The federal Departments of Justice and Health and Human Services (HHS) have adopted four factors for assessing how to assist LEP persons. These factors call upon the federally funded pharmacy to determine:[11]

- *The number or proportion of LEP individuals served or encountered*.[12]
- *The frequency of contact with the program*. If LEP individuals access

the pharmacy on a daily or weekly basis, a recipient has greater duties than if contact is infrequent.

- *The nature and importance of the program to beneficiaries*. More steps must be taken if a denial or delay of services may have critical implications for daily life (e.g. medication errors that can result from a misunderstanding of prescription drug instructions).
- *The resources available and cost considerations*. If the number of LEP persons is limited, a small recipient with few resources may not have to take the same steps as a larger recipient. Costs are a legitimate consideration in identifying the reasonableness of particular language assistance measures.[13]

In balancing these factors, pharmacies and pharmacists should consider the appropriate mix of written and oral language assistance, considering which documents must be translated, when oral interpretation is needed, and whether such services should be immediately available.[14]

The HHS Office for Civil Rights (OCR) will apply these factors when determining whether an entity is compliance with Title VI. OCR recognizes that one size does not fit all and will determine compliance on a case-by-case basis.

5. Are there specific guidelines that explain how to provide language services?

Yes. On August 8, 2003, HHS' OCR issued guidance for federal fund recipients, including pharmacies and pharmacists participating in HHS-funded programs.[15] The guidance is available at **http://www.hhs.gov/ocr/lep/**. This guidance does not impose any new requirements but merely brings together all of OCR's policies for overseeing Title VI since 1965.

6. How should a pharmacy offer oral language services?

The HHS Guidance describes various options to provide oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines,[16] and using community volunteers. It stresses that interpreters need to be competent, though not necessarily formally certified. A combination of oral language assistance may work best. For example, bilingual pharmacists could provide services directly in some non-English languages while other bilingual staff (including pharmacy or non-pharmacy in-store staff) may be competent to interpret between pharmacists and patients. A telephone language line can offer coverage when existing staff are unavailable. In general, all interpreters — whether staff or contract — must abide by the HIPAA (Health Insurance Portability and Accountability Act) privacy rules (see Q. 7 below).[17]

The HHS Guidance allows the use of a person's family members and friends to interpret but clearly states that an LEP person may not be *required* to use a

family member or friend and that "extra caution" should be taken if an LEP person chooses to use a minor to interpret. Similarly, an LEP person may not be required to use unrelated individuals, such as other customers, to interpret. These untrained interpreters are often called "ad hoc" interpreters. Pharmacists should verify and monitor their competence and appropriateness of ad hoc interpreters, including the person's language and comprehension skills and awareness of confidentiality and HIPAA issues.

The HHS Guidance notes that particular care must be paid in situations involving health, safety or access to important benefits, or when credibility and accuracy are important to protect the individual – all directly relevant to pharmacy interactions. Moreover, OCR says recipients should make the LEP person aware that he or she has the "option" of having the pharmacy provide an interpreter without charge.

Patient counseling, which may be required under state pharmacy laws, is an area where the Guidance's emphasis on health and safety is highly relevant. Without being able to communicate with LEP patients, a pharmacist may be unable to provide information about correct dosing, drug interactions, and potential side effects. In addition to potential liability under state law, a pharmacy or pharmacist may be liable for malpractice or negligence if a patient suffers adverse harm because required information is not provided in a manner the patient understands.

The HHS Guidance's concern with access to important benefits is also implicated. For example, if a prescription coverage request is denied because the insurer refuses to cover it, the pharmacist should be able to explain the rejection codes or translate information provided about the denial. If the patient does not understand the basis for the denial, he may not understand his ability to appeal and thus is denied access to important benefits.

7. How does HIPAA impact pharmacies use of interpreters?

HIPAA protects individuals from the release of their private (or protected) health information. Generally, those working in a pharmacy setting may not disclose a patient's protected health information except in limited circumstances and to certain entities, as defined by law. If the pharmacy discloses the information to outside sources (for example, if it uses a language agency to provide interpreters), it should have a "business associate" agreement to ensure that the outside organization also protects the patient's health information.

The HIPAA privacy rule allows others to have access to a patient's health information *with the patient's consent*. To these persons approved by the patient, the pharmacy may disclose protected health information directly relevant to the patient's care or payment if the pharmacy:

- obtains the individual's agreement; ***or***

- provides the individual with the opportunity to object to the disclosure and the individual does not express an objection; ***or***
- reasonably infers from the circumstances, based on the exercise of professional judgment that the individual does not object to the disclosure. (For example, when a person comes to a pharmacy to pick up a prescription on behalf of an individual he identifies by name, a pharmacist, based on professional judgment and experience with common practice, the pharmacist may allow the person to do so.[18])

Under any of these circumstances, if a patient consents, a family member or friend brought by the patient to the pharmacy would be allowed to interpret and have access to a patient's protected health information. This could also include, *but only if the patient consents*, an *ad hoc* interpreter such as another patient or pharmacy customer. Because in this situation the patient has consented *and* the interpreter is neither a member of the covered entity's workforce nor a business associate, the interpreter is not bound by the privacy rule.

Before a pharmacy relies on an *ad hoc* interpreter, the pharmacy should ensure that the patient is informed of the need to provide consent; without informed consent, the pharmacy may be liable for a HIPAA violation.[19] The patient may ask the covered entity to provide an interpreter who would be subject to the protections of the HIPAA privacy rule.

WRITTEN TRANSLATED MATERIALS

8. When should a pharmacist translate written materials?

It depends on the relevant circumstances of each pharmacy based on the four factors listed above (see Q. 4). After these have been assessed, pharmacies and pharmacists should decide what reasonable steps to take to ensure meaningful access. At a minimum, the pharmacist should translate dosage instructions and warning labels to ensure that a patient fully understands the instructions for usage. Many pharmacy software programs have translation capacity built in; pharmacies and pharmacists should check with their vendors about availability.

Nothing in federal or state law prohibits the translation of prescription drug labels, instructions or inserts. While federal law requires certain information to be on the label in English,[20] it takes a permissive approach and allows, but does not require, the inclusion of other languages on the prescription drug label.[21] Posted information or handouts about patients' rights, such as the right to seek a written explanation or to appeal a denial in Medicaid or the Medicare Part D program, are also items where the importance of translated materials should be considered.

As noted, OCR will evaluate a provider's efforts on a case-by-case basis. For the translation of written materials, the HHS Guidance designates "safe harbors" that, if met, will provide strong evidence of compliance.[22]

STATE REQUIREMENTS

9. In addition to federal law, do state laws require pharmacies to provide oral language services?

It depends on the state. All states have enacted laws that address the provision of language services in healthcare settings and some of these apply to pharmacies.[23] In the coming months, the National Health Law Program will be conducting a 50-state survey of pharmacy laws related to language access and will provide results when available. As one example, New York pharmacy regulations include a counseling requirement when pharmacists dispense prescriptions to new pharmacy patients or dispense new medications to current patients.[24] The regulations do not include an exemption for LEP patients. Thus, a pharmacist will be unable to comply with the counseling requirement if language services are not provided. The pharmacist should ensure that effective communication occurs, either by using an interpreter or translating drug information handouts (however, it is unlikely that providing translated documents alone would satisfy the counseling requirement because it implies oral communication).

10. What about pharmacies located in hospitals, nursing homes, or other health care settings?

For co-located pharmacies, Title VI may independently apply to both the pharmacy and host facility since both are likely recipients of federal funds. Even if the host facility does not receive federal funds, the pharmacy would still be subject to Title VI if it does. Further, additional state laws may require language access in the host facility.[25] For example, Massachusetts, Rhode Island and New York require hospitals to provide language services. A pharmacy located in a hospital would be subject to these laws.

The pharmacy should obtain information about the facility's policies and whether pharmacy staff can access the facility's interpreters and translated materials.[26]

ADDITIONAL INFORMATION

11. Is a pharmacy liable if it does not provide language services to LEP patients?

Yes, it is potentially liable under both federal and state law. Under federal law, OCR investigates complaints against pharmacies and first has an obligation to seek compliance from those who fail to abide by Title VI. OCR is also available to provide ongoing technical assistance. If compliance is not obtained voluntarily, OCR may refer the issue to the Department of Justice for formal compliance proceedings that could result in suspension or termination of federal assistance.[27]

If a patient suffers medical harm caused by the pharmacist, the patient could initiate a malpractice or negligence claim against the pharmacy or pharmacist. And if the HIPAA privacy rules are violated, a pharmacy may be liable for fines of $100 per violation, up to $25,000 per year.

Depending on state law, additional liability may apply. For example, under New York law, the failure to abide by the requirements for labeling and counseling could result in a pharmacist facing misdemeanor charges with fines and possible jail time for multiple violations.[28]

12. What if a pharmacist unintentionally discriminates against individuals?

HHS' regulations prohibit federal fund recipients from:

- Using criteria or methods of administration that have the *effect* of discriminating against LEP patients;
- Restricting access to advantages or privileges for LEP patients that non-LEP patients receive from the same program;
- Providing services or benefits to LEP patients that are different, or provided in a different way, from those provided to non-LEP patients (NOTE: a translated document should not be considered "different" since the content is the same as the English document while being presented in a non-English language);
- Treating LEP patients differently from non-LEP patients in determining admission, enrollment, eligibility, or other requirements to receive services.[29]

13. How can pharmacies document their language services?

Pharmacies and pharmacists can develop a written implementation plan as a means of documenting compliance with Title VI. The Office for Civil Rights suggests five elements when designing a plan:

- *Identify LEP individuals who need language assistance*, using for example, language identification cards or recording patient language needs in the pharmacy's computer system.
- *Describe language assistance measures*, such as the types of language services available, how staff can obtain these services and respond to LEP persons, and how competency of language services can be ensured.
- *Train staff*, including pharmacists, pharmacy interns, and cashiers, to understand LEP policies and procedures and how to work effectively with LEP patients and interpreters (both in-person and telephonic).
- *Provide notice of language services* by, for example, posting signs in intake areas and other entry points, providing information in outreach brochures, working with community groups, using a telephone voice mail menu, providing notices in local non-English media sources, and making presentations in community settings.
- *Monitor and update the LEP plan*, considering changes in demographics, types of services, and other factors.[30]

14. How can pharmacies pay for language services?

HHS' Centers for Medicare & Medicaid Services (CMS) recognizes that federal Medicaid and SCHIP funds can be used for language activities and services.[31] States can thus submit the costs of language services needed by Medicaid

and SCHIP enrollees to the federal government for partial reimbursement.

Currently, twelve states plus the District of Columbia directly pay for language services in Medicaid and SCHIP. Some states have limited the reimbursement to "fee-for-service" providers so providers participating in managed care plans might not be eligible. Other states report that they currently set their reimbursement rates for all providers to include the costs of language services as part of the entity's overhead or administrative costs.[32]

15. Where can pharmacies and pharmacists get more information?

The federal government has launched a website called "Let Everyone Participate," **http://www.lep.gov**. In addition to tracking federal activities, the website offers direct assistance to federal fund recipients and advocates. For example, fund recipients can download "I Speak" cards that allow LEP persons to identify their primary language. The presidential "Executive Order" (EO) entitled *Improving Access to Services for Persons with Limited English Proficiency*,[33] and OCR Guidance are also available on this website.

The "CLAS Standards" (Standards for Culturally and Linguistically Appropriate Services in health care) from the HHS Office of Minority Health, offer additional information and resources.[34]

Endnotes

1 This issue brief was made possible with the generous support of the California Endowment, the New York Academy of Medicine and the Altman Foundation.

2 Agency for Healthcare Research and Quality, *Language Barrier: The Case*, Pediatrics (2006), *at* **http://www.webmm.ahrq.gov/**.

3 D. Andrulis, N. Goodman, C. Pryor, *What a difference an Interpreter Can Make* (April 2002), *at* **http://www.accessproject.org**.

4 LEP is defined as individuals who are unable to speak English "very well". *See* U.S. Census Bureau, "*Language Spoken at Home*" (Table S1601), 2006 American Community Survey, *at* **www.factfinder.census.gov**.

5 100 Cong. Rec. 1658 (1964). The United States Supreme Court has treated discrimination based on language as national origin discrimination. *See* Lau v. Nichols, 414 U.S. 563 (1974). "National origin" is not defined in federal law but generally refers to the country where one is born. The U.S. Supreme Court and federal agencies have determined that language can be a proxy for national origin.

6 42 U.S.C. § 2000d. *See also* 45 C.F.R. § 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

7 While some states or localities have declared English as their official language, federal fund recipients must continue to follow federal laws regarding non-discrimination. *See, e.g.,* 42 C.F.R. §§ 438.6(f), 438.100(d).

8 *See* 42 U.S.C. § 2000d-4a (defining "program or activity").

9 *Id.*

10 2006 American Community Survey, (Tables S1601, B16001), *at* **http://www.factfinder.census.gov**.

11 *See* 65 Fed. Reg. 50123 (Aug. 16, 2000). In addition to Executive Order 13166, this Guidance is authorized by 28 C.F.R. § 42.404(a), directing agencies to "publish title VI guidelines for each type of program to which they extend financial assistance, where such guidelines would be appropriate to provide detailed information on the requirements of Title VI." According to the Department of Justice, the Guidance does not create new obligations beyond those already mandated by law.

12 *See* 67 Fed. Reg. 41459 (June 18, 2002). "But even recipients that serve LEP persons on an unpredictable or infrequent basis should use this balancing analysis to determine what to do if an LEP individual seeks services under the program in question." *Id.* at 41460.

13 *Id.* at 50124–25. *See also, e.g.,* 67 Fed. Reg. 41455, 41457 (June 18, 2002).

14 *See* 67 Fed. Reg. 41460 (June 18, 2002).

15 68 Fed. Reg. 47311 (Aug. 8, 2003). For previous versions of this guidance, *see* 65 Fed. Reg. 52762 (Aug. 30, 2000).

16 Previous guidance cautioned the fund recipient that telephone interpreter lines should not be the sole language assistance option, unless other options were unavailable. *See* 67 Fed. Reg. at 4975.

17 For more information on the use of interpreters and HIPAA, *see HIPAA and Language Services in Health Care*, National Health Law Program, at **http://www.healthlaw.org**.

18 HIPAA Frequently Asked Questions, Notice and Other Individual Rights, *Does the HIPAA Privacy Rule permit a doctor to discuss a patient's health status, treatment, or payment arrangements with the patient's family and friends? at* **http://www.hhs.gov/hipaaf-aq/notice/488.html**.

19 *See footnote 17.*

20 This information includes the date of filling; pharmacy name and address; serial number of the prescription; name of the patient; name of the prescribing practitioner; and directions for use and cautionary statements, if any contained in such prescription or required by law. 21 C.F.R. § 1306.14(a) and § 1306.24.

21 21 C.F.R. § 201.15.

22 The safe harbors designate that the recipient provides written translations of "vital" documents (e.g. intake forms with the potential for important consequences, consent and complaint forms, eligibility and service notices) for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally. Or, if there

are fewer than 50 persons in a language group that reaches the five percent trigger, above, the recipient provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of vital written materials, free of cost. 68 Fed. Reg. at 47319.

23 *See* J. Perkins and M. Youdelman, "Summary of State Law Requirements Addressing Language Needs in Health Care," National Health Law Program (March 2007), *at* **http://www.healthlaw.org/library/item.174993-Summary_of_State_Law_Requirements_Addressing_Language_Needs_in_Health_Care_**.

24 N.Y. Comp. Codes R. & Regs tit. 8, § 63.6(b)(8). Counseling can include, but is not limited to: (1) the name and description of the medication and known indications; (2) dosage form, dosage, route of administration and duration of drug therapy; (3) special directions and precautions for preparation, administration and use by the patient; (4) common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur; (5) techniques for self-monitoring drug therapy; (6) proper storage; (7) prescription refill information; and (8) action to be taken in the event of a missed dose. Counseling requirements are also required, but adapted to the specific situations of in-pharmacy delivery to the patient, dispensing to a person authorized to act on behalf of a patient, and mail delivery of prescription drugs.

25 For more information on state laws related to language access and health care, *see* J. Perkins and M. Youdelman, "Summary of State Law Requirements Addressing Language Needs in Health Care," National Health Law Program (March 2007), *at* **http://www.healthlaw.org/library/item.174993-Summary_of_State_Law_Requirements_Addressing_Language_Needs_in_Health_Care_**.

26 N.Y. Comp. Codes R. & Regs. tit. 10, § 405.7(a)(7).

27 45 C.F.R. § 80.8.

28 NY CLS Educ § 6816 (1)(a). A second conviction for violation of § 6816 ("untrue labels" violation) can result in the pharmacist being fined a maximum of $1,000 fine and/or a maximum of one year in prison. A third conviction can result in the above fines and/or jail time in addition to the individual pharmacist's license revocation.

29 45 C.F.R. § 80.3(b).

30 68 Fed. Reg. *at* 47319–21. Previous guidance called on recipients to develop and implement a language assistance program that addressed: (1) assessment of language needs; (2) development of a comprehensive policy on language access; (3) training of staff; and (4) vigilant monitoring. *See* 67 Fed. Reg. *at* 4971.

31 *See* CMS, *Dear State Medicaid Director* (Aug. 31, 2000), *available at* **http://www.cms.hhs.gov/states/letters/smd83100.asp**.

32 Of the 13 states currently using Medicaid/SCHIP funds to pay for language services, none are doing so in the pharmacy setting. However, there is no prohibition on this. For more information on this issue, see M. Youdelman, *Medicaid and SCHIP Reimbursement Models for Language Services, 2007 Update, at* **http://www.healthlaw.org**.

33 *See* 65 Fed. Reg. 50121 (Aug. 16, 2000); *see* also 67 Fed. Reg. 41455 (June 18, 2002).

34 *See* 65 Fed. Reg. 80865 (Dec. 22, 2000), *at* **http://www.omhrc.gov/clas**.

D

Appendix D. Analysis of State Pharmacy Laws: Impact of Pharmacy Laws on the Provision of Language Services

Introduction

Almost 4 billion prescriptions are written yearly.[1] Since over 24 million, or 8.6 percent of the population, speak English less than "very well,"[2] millions of prescriptions are likely to be written for persons who are limited English Proficient (LEP) each year.[3] As complicated as it may be for English-speakers to understand medication instructions, the difficulties are exacerbated for LEP individuals. In a 2002 study, over one-quarter of LEP patients who needed, but did not get, an interpreter reported that they did not understand their medication instructions, compared with only two percent of those who either needed and received an interpreter or did not need an interpreter.[4] Therefore, it is critical that pharmacists and LEP patients communicate effectively with each other.

Pharmacists play a pivotal role in communicating health information to patients, particularly with regard to instructing patients on how to properly use medications, as well as alerting them to potentially adverse health situations that could develop. The contemporary emphasis in pharmacy practice stresses patient communication as part of the overall professional responsibility of the pharmacist. The goal is to assist the patient with achieving optimal outcomes from the use of medications and medical devices.[5]

This analysis first outlines federal requirements for providing language services (oral interpretation and written translated materials) to LEP patients. Then, it summarizes results from a 50-state (plus the District of Columbia)[6] survey of pharmacy laws that are related to the provision of language services.[7] The accompanying chart provides a summary of each provision.

No federal or state law prohibits the provision of language services in pharmacies or by pharmacists.[8] Indeed, federal and state laws strongly support the provision of language services. While few pharmacy law provisions directly address language services, each state has provisions that support providing language services. Most provisions can be categorized in three areas: provision of oral counseling; distribution of written information (either through the label or additional written information); and collection and maintenance of data in a patient medication profile.

Virtually all states have requirements regarding oral counseling and distribution of written materials. To comply with these requirements, pharmacists[9] must effectively communicate with all of their patients, not only those who speak English.

Highlights of the findings that support language services

- 48 states have requirements regarding oral counseling;
- 33 states require a process for counseling when the patient is not in the pharmacy;
- 28 states require a pharmacist to inform patients of substitution of a generic drug for a brand name drug, either orally or in writing; and
- 24 states require a pharmacist to distribute written information to patients.

Federal Legal Framework

Title VI of the Civil Rights Act of 1964

Any individual or entity that receives federal funds, including pharmacies and pharmacists, must comply with Title VI of the Civil Rights Act of 1964. Title VI prohibits discrimination and ensures that federal money is not used to support health care providers who discriminate on the basis of race, color or national origin.[10] The federal Department of Health and Human Services (HHS) and the courts have applied this statute to protect national origin minorities who do not speak English well.[11] Thus, pharmacies that receive federal funds must take "reasonable steps to ensure that limited English proficiency (LEP) individuals have meaningful access to their programs and services."[12]

OBRA 1990 — Amending the Federal Medicaid Act

In addition to Title VI, pharmacies and pharmacists must comply with federal and state laws specific to pharmacy practice. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990),[13] which modifies a section of the federal Medicaid Act, had a significant impact on standardizing state pharmacy laws. OBRA 1990 requires, as a condition of receiving federal Medicaid matching funds, standards for dispensing prescriptions to assure the quality of use and distribution of prescription drugs.

Each state must have a Prospective Drug Use Review (DUR) program.[14] This is a standard process undertaken by a pharmacist prior to dispensing a medication. The DUR sets forth minimum standards in patient counseling and requirements for recording and maintaining a patient medication profile, among other requirements.[15] The DUR also prescribes other methods to assess the distribution of prescription medications and education of pharmacists.[16]

With respect to counseling of Medicaid recipients, the DUR requires that a pharmacist "offer to counsel" each individual (or a caregiver) who presents a prescription. The counseling should be done in person wherever practicable, or through a telephone service, which must be toll-free for long-distance calls.[17] These federal standards make clear the preference for in-person counseling. Importantly, the statute is clear that individuals may not be charged for telephonic counseling when it is long-distance. When applying these standards to LEP patients, pharmacists should conduct in-person counseling when possible and not charge LEP patients any long-distance charges.

Under OBRA 1990, a pharmacist must also make a reasonable effort to obtain, record and maintain certain information, including "comments relevant to the individual's drug therapy."[18] Pharmacists should consider recording a patient's language in the patient medication profile under a "comment relevant to the drug therapy" or other appropriate field capturing individual history. The pharmacist's

knowledge of the patient's language is not only relevant, but critical to being able to communicate with the patient regarding his/her drug therapy to achieve optimum results.

Drug Labeling Law

Federal law requires certain information to be on the label (of the container dispensed to the patient) in English, such as the patient name and expiration date.[19] Federal law does not prohibit translating labels into non-English languages. Indeed, federal law expressly permits the translation of the label into other languages, as long as the required information is printed on the label.[20]

SUMMARY OF FINDINGS:

Oral Counseling and Education of Patients

Forty-eight states[21] require pharmacists to counsel or offer to counsel patients.[22] Situations in which counseling provisions arise include: new and refill prescriptions, generic medication substitution for a brand name drug, and mail order or delivery. Some states exempt pharmacists from counseling in certain limited situations. The sections below describe each of these types of provisions.

Counseling Requirements

In 19 states, the pharmacist is required to provide oral counseling to patients in certain situations.[23] For example, the most common provision requires a pharmacist to counsel patients orally prior to dispensing a new prescription. In 29 states, the pharmacist is only required to "offer to counsel" patients.[24] To meet either requirement — to counsel or to offer to counsel — a pharmacist would likely need to provide language services to provide meaningful communication with their LEP patients. Otherwise, if a pharmacist has limited or no ability to communicate with an LEP patient because language services are not provided, a pharmacist may be exposed to a claim of negligence or malpractice by the patient.[25]

Fourteen states require the same level of counseling regardless of whether a prescription is new or a refill,[26] but most states have different counseling requirements depending on the type of prescription.[27] A state may require counseling or an offer to counsel for a new prescription, but allow other options for a refill, such as an offer to counsel, provision of written information instead of oral counseling, or discretion about whether to counsel the patient at all.

A number of states specify particular situations in which counseling must be provided or available to patients. Examples include:

- New Hampshire — requires counseling to convey the proper use of certain injection supplies;[28]
- New Jersey — requires counseling when patient records reveal sporadic, erratic or irrational use of medication;[29]
- New York — requires counseling to be offered to each patient for a pharmacy to participate in "Program for Elderly Pharmaceutical Insurance Coverage;"[30]
- North Carolina — requires counseling to be available when administering vaccinations;[31]
- South Carolina and South Dakota — require counseling, on-going training, and regular assessment of the patient's competence of managing the drug therapy and storage of sterile and compound drugs;[32] and

- Texas — requires counseling for persons receiving mental health services and "psychoactive" medications. This provision specifies that the counseling must be conducted "*in the person's primary language, if possible*" (emphasis added).[33]

Most states have standard definitions of counseling that explain the kind of information that should be conveyed, and the general purpose of informing patients about their medications to prevent medical errors and harm. This analysis does not capture routine definitions, but highlights those definitions that provide further guidance about providing effective or appropriate communication to patients. These provisions suggest further responsibilities for pharmacists to provide language services to ensure the communication between pharmacist and patient is indeed effective or appropriate. Examples of states with these provisions include: Arkansas (effective communication); Indiana (effective and appropriate communication); Louisiana (effective communication); Nebraska (appropriate to the individual patient); and Rhode Island (appropriate communication).

Generic Substitution and the Counseling Requirement

Twenty-eight states supplement their general counseling provisions with requirements that a pharmacist inform a patient of certain information, such as the efficacy of the drug or price difference prior to the substitution of a generic medication for a brand name drug.[34] A few states, including Alaska, Maine, South Carolina, Texas and Utah, go further, requiring consent from the patient prior to substitution. In these situations, the pharmacist would need to provide language services to meet the requirement to inform so that LEP patients can effectively understand the issues related to efficacy, substitution and/or consent.[35]

Texas also requires the posting of signs in English and Spanish that explain the generic substitution process and that the pharmacist must obtain consent from the patient prior to substitution. The English and Spanish signs must state, "Texas law requires a pharmacist to inform you if a less expensive generically equivalent drug is available for certain brand name drugs and to ask you to choose between the generic and the brand name drug. You have a right to accept or refuse the generically equivalent drug." This is one of the few examples in which written translation of specific information into a non-English language is explicitly required in a pharmacy setting.

Oral Counseling Exclusions

Many states exempt pharmacists from counseling requirements in certain settings, but these exemptions are not based on an individual's language. For example, pharmacists may not have to provide counseling to patients in inpatient hospital settings, institutions where a medical professional is administering the medication such as a nursing home, or in prisons.

Further, OBRA 1990 specifies that pharmacists are not required to counsel Medicaid patients who refuse counseling.[36] Thirty-seven states have a similar provision that has been broadened to the entire patient population,[37] and 25 states require pharmacists to document patient refusals in the patient records.[38] In determining whether an LEP patient has accepted or refused counseling, it is likely that a pharmacist would have to provide language services.[39]

In some situations, 16 states specifically allow the replacement of oral counseling with other means of communication.[40] Some provisions specify written information may be provided instead of oral counseling when there is a communication barrier, and others leave the method of communication to the pharmacist's discretion. In these states, oral interpretation might not be required to be provided to LEP persons. But even in these situations, translations of the written information that is substituted for oral counseling might be required.

Only three states — Iowa, North Carolina and Pennsylvania — provide an exemption for pharmacists in providing oral counseling specifically when individuals speak languages other than English. In these situations, oral counseling can be replaced with another form of communication. For example, North Carolina specifies that written information be provided in a language other than English, if a patient requests it. *See* section below on *Written Information* at III.B.

Pharmacy Professional Responsibility and Patient's Bill of Rights Require Counseling

Nine states — Arkansas, Alabama, Colorado, California, Michigan, Mississippi, North Dakota, Utah and West Virginia — include the obligation to counsel (or offer to counsel) in the professional responsibility section of the Pharmacy Act, or articulated as part of the pharmacist's "duty." For example, in Michigan, the pharmacy oral counseling and written information requirements are contained in a section called "professional responsibility" and specified as a duty of the pharmacist. This further emphasizes the duty of the pharmacist to provide counseling to all patients, not just those who speak English.

Utah and West Virginia have specified that a failure to provide an offer to counsel is a violation of professional responsibility and can result in disciplinary action. Utah has established monetary penalties for the pharmacist for first and subsequent failures to offer to counsel a patient, as well as a separate penalty for the pharmacy.

Minnesota, in its definition of unprofessional conduct, includes a prohibition of discrimination on the basis of race, gender and national origin. "National origin," as analyzed by the Courts and federal guidance, includes speaking a language other than English.[41] Similar to Title VI, this state law requires a pharmacist to provide oral counseling for LEP patients just as a pharmacist would for English speaking patients to prevent any discrimination.

North Dakota has gone one step further. It has enacted a Pharmacy "Bill of Rights." It establishes the pharmacists' responsibility to counsel patients using "methods appropriate to the patient's physical, psychosocial, and intellectual status." It also prohibits discrimination of patients based on a number of factors including "nationality." Similar to Minnesota, North Dakota would preclude a pharmacist from discriminating against LEP patients by not providing language services during the regular course of counseling or distribution of written information.

Counseling Requirements Outside the Pharmacy — Mail Order and Delivery

Thirty-three states have patient counseling requirements when a patient is not physically in the pharmacy, generally for mail order or home delivery.[42] Many states require communication with patients by telephone and/or through the distribution of written information. For example, both Florida and Washington require written information be distributed with the prescription that includes notification that a pharmacist is available to answer questions, and the contact information of the pharmacist in order to do so.

Twenty-four states require non-resident pharmacies, which presumably have mail order business in the state, to establish toll-free numbers and to inform patients of the telephone number.[43] These provisions all require a toll-free telephone number, available at least five days and 40 hours per week. Most provisions also require that the toll-free number be printed on the label and on any accompanying information. The provisions often clarify the purpose of the toll-free number is to "facilitate communication" between the pharmacist and the patient. Since the goal is to facilitate communication, these out-of-state pharmacies should provide language services to LEP patients who use the toll-free numbers. This can be accomplished by having bilingual staff answering the telephone or using three-way calling to include an over-the-phone interpreter.

Use of Technology — Telepharmacy and Remote Sites

Five states — Hawaii, Iowa, Kentucky, Missouri and North Dakota — are using innovative technology to reach patients, particularly in rural areas that are not well served by pharmacies. Each has addressed how counseling must take place when a patient is not in the same pharmacy with the pharmacist.

Iowa, Kentucky and North Dakota have telepharmacy programs. For example, in Iowa, the managing pharmacy and the

remote pharmacy must be connected by video and audio links. A remote pharmacy is staffed by at least one pharmacy technician, when there is no on-site pharmacist and no full service pharmacy in the community or for at least 15 miles. A pharmacist at the managing pharmacy is required to counsel each patient on all new prescriptions and supervise the pharmacy technician, among other responsibilities. A sign must inform people that a pharmacist will counsel patients regarding any prescription dispensed from the remote site. This counseling is conducted through video and audio technology with a pharmacist from the managing pharmacy. In Kentucky, pharmacists also must obtain a patient's informed consent before telepharmacy services are provided.

Missouri has an automated prescription pick-up system at a video kiosk. The kiosk system must maintain a video and audio system to provide effective oral communication between pharmacist and patient, as well as the ability to print written information. Patients using the kiosk can be connected to a pharmacist to ask questions about their prescriptions. Hawaii also requires remote pharmacies to use video systems to ensure face-to-face communication.

To meet the requirements for counseling, informed consent and effective communication, each of these systems should incorporate language services for LEP persons. Using technology to deliver pharmacy counseling services creates opportunities to use video interpreter services and interpreters who are in other locations to effectively serve LEP patients.

Other Pharmacy Situations in Which Counseling May be Necessary

Many pharmacists are now authorized to deliver immunizations or vaccinations. In some states, pharmacists must obtain either written or oral consent or provide written information to the patient prior to immunization. An example of such a provision can be found in North Carolina.[44] Additionally, pharmacists in some states are gaining prescribing authority. In these situations, language services would likely need to be provided to meet the requirements of these provisions and communicate effectively with patients. This analysis has not tracked each immunization or prescribing authority provision.

Written Information for Patients

Patients receive written information through two important means — information distributed with a prescription and information printed on the label of the prescription. States treat this information differently. Some states require certain written information to be distributed; some states allow written information to *replace* oral counseling; while other states require any written information distributed to a patient be *supplementary* to oral counseling. *See* section above *Oral Counseling* Exclusions at III.A.3, and *Information that Supplements Oral Counseling* at 3.B.2 below, for more details. This section summarizes and analyzes these provisions with respect to language services.

Distribution of Written Information

Three states — California, Texas and North Carolina — require pharmacists to translate certain written information into languages other than English for LEP patients. In California, the pharmacist must distribute specific written materials when dispensing Emergency Contraception. The state provides these materials in a number of languages. California also requires written information be made available in English, Spanish, Mandarin/Cantonese and Tagalog as a part of its AIDS drug program in which pharmacies may participate. Similarly, Texas requires that pharmacists provide written information in Spanish and English to patients at the time of generic substitution. Texas also requires posting of a specific notice that encourages patients to ask questions of the pharmacist in both languages. In North Carolina, pharmacists must provide written information in languages other than English when the patient requests it.

Twenty-four states require dissemination of written information to patients with a prescription in certain situations.[45] Fifteen of these states require distribution specifically when the patient is not in the pharmacy.[46] If the intent of the provision is to ensure effective communication with patients or for the patients to understand particular information, and the state has determined these written materials are thus important, it is likely that this information should be translated for LEP patients either to comply with the state provision or Title VI.[47]

Other states require distribution or availability of written information in certain circumstances. This information, which should likely be

translated into non-English languages, includes:

- Hawaii and New Hampshire — require written information when providing Emergency Contraception;[48]
- Kentucky — requires pharmacists to provide and prominently display pamphlets that explain certain provisions of the Pharmacy Act;[49]
- Maine — requires pharmacists to provide information on Maine Rx Program, and how to get help with high drug costs for persons who have no prescription drug coverage and are purchasing brand name drugs;[50]
- Maryland — requires distribution of information that helps people avoid medication errors;[51]
- New York — requires distribution of written information when dispensing hypodermic needles and syringes;[52] and
- Texas — requires distribution of written information when dispensing compounded drugs.[53]

Information that Supplements Oral Counseling

Twenty-nine states allow alternative types of communication in addition to oral counseling between pharmacists and patients, such as written information, leaflets, pictogram labels and video programs.[54] Most of the states further clarify that this additional information is not meant to replace oral counseling, only to supplement it.

For example, Arkansas states that "alternative forms of patient information may be used to supplement, but not replace face-to-face patient counseling."[55] Arkansas is one of the states that requires oral counseling for all patients obtaining a new prescription who are present in the pharmacy.[56]

The Prescription Label

Every state has labeling laws. Generally, the provisions track the federal requirements that specify what information must be found on each prescription label, as detailed in the *Federal Legal Framework* at Section II. above. There is no prohibition of translating a prescription label into another language in any state law.

In 2007, California enacted the first labeling statute that requires the standardizing of prescription labels. The Board of Pharmacy, which is developing the new label, must consider the needs of LEP patients, among other requirements. California is currently holding hearings and public meetings to develop this new standard prescription label. The final regulations designing and implementing the new label are expected in 2011.

Misbranding the Label

Two states, Arizona and New York, provide a label as "misbranded" if words and information are not readable and understandable to an *ordinary individual under customary conditions of purchase and use*. The origin of the language used in this provision is likely the federal Food, Drug, and Cosmetic Act, which applies to manufacturers of pharmaceuticals for labeling on the packages of medications or supplies. These states have incorporated this provision into their pharmacy act and apply it to the pharmacist.

With respect to providing language services, the analysis should focus on who is an "ordinary individual" and what are the "customary conditions." There is no formal definition in the relevant state statutes and regulations, and it appears that the courts have not addressed this issue. But for pharmacies serving a significant number of LEP patients, one can make the case that an "ordinary individual" includes an LEP patient. Thus, a label could be misbranded if it is not translated because an ordinary LEP patient would be unable to understand an English label. It may also be that "customary conditions of purchase and use" could likely include dispensing and selling medications to LEP individuals who cannot understand instructions in English. By failing to translate the directions for use on the prescription drug label into a language that is "likely to be read and understood" by an LEP individual, the pharmacist could be found to be dispensing a misbranded drug.

Patient Medication Records

As previously noted, OBRA 1990 requires a pharmacist to record and maintain a significant amount of demographic data and medical information, including "individual history where significant" and "comments" related to the patient's drug therapy for each Medicaid patient. Forty-one states have applied the OBRA 1990 requirement to record and maintain patient profiles for all patients.[57] When a state requires or allows a pharmacist to include additional relevant patient information in the profile, it can be suggested that a pharmacist should record the patient's language as "significant" data covered by OBRA. Knowing the patient's language is critical to effective communication for both oral counseling and distribution of written information.

Some states have given the pharmacist additional discretion to record information deemed important and relevant by the pharmacist. For example, Mississippi's patient profile provision states that a pharmacist should record, among other pieces of information, "pharmacist's comments relevant to the individual's drug therapy, *including any other information peculiar to the specific patient or drug* (emphasis added)."[58] States that require the collection of additional information have already determined that this information would be helpful to the pharmacist in fulfilling his/her duties. Recording the language that a patient speaks, thus enabling the pharmacist to provide language services to LEP patients, will allow patients and pharmacists to effectively communicate more efficiently.

Pharmacy Quality Improvement Program

Quality improvement programs are used by pharmacists to assess the quality of the services provided and to resolve problems when they arise. Often problems with medications occur when there was not clear or effective communication between the pharmacist and the patient. Including an analysis of language services in a pharmacist's quality improvement program provides an opportunity to assess the services provided to LEP patients as a part of effective communication, and to improve those services, where appropriate.

Iowa has a continuous quality improvement program, which requires pharmacists and trained pharmacy staff to record "reportable events" that include any issue "related to a prescription dispensed to a patient that results in or has the potential to result in serious harm to the patient."[59] There are specific policies and procedures that pharmacy staff must undertake upon being informed of such an event, including addressing the problem with the patient or caregiver to minimize any potential problem. Further, analysis and recommendations for resolving problems are required according to certain standards after a report of each event is received. This quality improvement program is one example of how communication and thus language issues could be addressed and improved when addressing quality and patient safety.

The New York Experience

In 2007, New York Lawyers for the Public Interest, Make the Road New York, and the New York Immigration Coalition filed a complaint with the New York Office of the Attorney General alleging failure of seven chain pharmacies to provide language services. The complaint was based on Title VI of the Civil Rights Act of 1964, two state pharmacy provisions (oral counseling and label misbranding), and a New York City human rights law, among other provisions. Between November 2008 and April 2009, New York State settled with all seven chains: CVS, Rite Aid, A&P, Costco, Duane Reade, Target and Wal-Mart.

The settlements require each pharmacy chain to provide free language assistance services — reaching almost 2,500 stores statewide. The settlements include requiring the pharmacies to: 1) provide oral counseling in a patient's primary language regarding prescriptions; 2) translate prescription labels, warning information, and other written important information in Spanish, Chinese, Italian, Russian and French; 3) train staff in language assistance policies; and 4) inform customers of their right to free language assistance in multi-lingual signs. Implementation of the requirements has been phased in. The provisions described above are currently effective, except translations of written information and labels, which must be implemented no later than May 15, 2010.

In September 2009, New York City enacted the first known comprehensive statute[60] requiring the provision of language services in a pharmacy.[61] It largely mirrors the settlements with the Attorney General. One difference is that the definition in the statute of a covered chain is broader than in the settlements — a chain is required to provide language services by the Act if it has four or more stores. The statute requires chain pharmacies to: 1) provide free, competent oral interpretation for all languages; 2) translate labels and written information in the top seven languages spoken by LEP persons in New York City (as determined by U.S. Census data); and 3) notify customers by posting multi-lingual signs of these rights. The statute imposes penalties on the pharmacy if language services not provided both for first and subsequent violations. This law will go into effect in May 31, 2010.

Conclusion

Both federal and state laws strongly support the provision of language services, both oral interpreting and written translations, in the pharmacy. Conversely, no federal or state law prohibits the provision of language services to LEP persons.

Title VI of the Civil Rights Act of 1964 has been interpreted by the federal government and the courts to prohibit discrimination against persons who are LEP. Any pharmacy that receives Medicaid or Medicare funds, or any other federal funds, must comply with Title VI. In addition, OBRA 1990 established standards for patient counseling and recording important information for Medicaid patients. These provisions have been expanded to broader groups of patients in most states. Both of these federal laws support the provision of language services in pharmacy settings.

In addition, every state supports the provision of language services during patient counseling, the distribution of written information, or both. Many states go further and establish mandatory counseling requirements in specific situations, such as for a new prescription, when a generic prescription is being substituted for a brand name drug, or when a patient is not in the pharmacy. While a few states exclude LEP patients from requirements for oral counseling, even those states provide for communication in another manner, such as through written information, for which language services likely should be provided.

Three states — California, North Carolina and Texas — specifically require the distribution of certain written materials to LEP persons in languages other than English. Additionally, California is developing a "standard" label. In developing the label, the Pharmacy Board is required to consider LEP persons, among other populations. Many other states require the distribution of written information to patients in certain circumstances.

Recent developments in New York, both the settlements between New York state and seven large chains, as well comprehensive city legislation requiring language services be provided in pharmacy chains, include specific legal requirements to provide language services in pharmacies.

In sum, federal and state laws provide significant support for the provision of language services in the pharmacy setting.

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Using the State Charts

The charts present information for each state along four columns. The first column provides a three-letter code that signifies the *type* of provision being cited. The second column indicates *how* the provision affects language services. The third column provides the citation to the provision, and the last column offers a brief summary of the provision. The first and second columns' coding is as follows:

Types of Provision:

DEF	Definition of practice of pharmacy or patient counseling that addresses effective communication
PCE	Patient counseling and education — general counseling or oral counseling specifically
RPL	Replacement of oral counseling with alternative types of information in certain situations
SUP	Supplement to oral counseling with alternative types of information
GEN	Generic substitution counseling requirements
OSM	Out-of-state, mail, or patient generally not present in the pharmacy
REM	Remote sites or telepharmacy services
DIS	Distribution of written information
PST	Notice or information for posting in the pharmacy
LAB	Prescription label
MIS	Misbranding
PMR	Patient Medication Records — documentation or recording of information
COC	Code of Conduct
OTH	Other

Codes:

M	Mandates language services
S	Supports language services
S-	Supports, with limitations in some cases, language services
L	Limits language services
P	Prohibits language services

N.B.:

Listing is in alphabetical order by state name, not state abbreviation.

Alabama

Type	Code	Provision	Description
PCE	S	Ala. Admin. Code r. 680-X-2.21(1),(4); Ala. Admin. Code r. 560-X-16.24(8)	Pharmacists must offer counseling for all new prescriptions. This requirement also applies to pharmacists in institutional settings and to patients participating in state Medicaid programs.
PCE	S-	Ala. Admin. Code r. 680-X-2.21(1)	For refills, pharmacists must offer counseling when appropriate.
PCE	S	Ala. Code § 34-23-159	A pharmacist must consult or have a professional interaction with a patient prior to selling directly to a customer an over-the-counter compounded drug product (i.e., a product prepared by the pharmacist using ingredients that do not require a prescription).
PCE, COC	S	Ala. Admin. Code r. 680-X-2.22(a), (c), (g)	The pharmacist code of professional conduct provides that a pharmacist should strive to provide information to patients regarding professional services truthfully, accurately and fully.
RPL	S-	Ala. Admin. Code r. 680-X-2.21(1)	The offer to counsel must be made orally and in-person unless in the professional judgment of the pharmacist, it is deemed inappropriate or unnecessary, in which case the offer can be made in writing, by telephone or in a manner deemed appropriate by the pharmacist.
DIS	S	Ala. Admin. Code r. 680-X-2.21(1)	Written information must be included with any dispensed prescription, including the pharmacy's telephone number for patients to call with any questions about their medication.
PMR	S	Ala. Admin. Code r. 680-X-2.21(5), (6)	Pharmacies must maintain patient medication profiles with patient information, including pharmacist comments.
OTH	S-	Ala. Admin. Code r. 680-X-2.21(9)	The pharmacist can charge and be reimbursed for counseling.

Alaska

Type	Code	Provision	Description
PCE	S	Alaska Admin. Code tit. 12, § 52.585(a)	With each new prescription dispensed, the pharmacist must verbally provide counseling to the patient or the patient's agent on matters considered significant, in the pharmacist's professional judgment.
PCE	S	Alaska Admin. Code tit. 12, § 52.585(d)	The pharmacist is not required to provide counseling when the patient refuses such counseling.
PCE	L	Alaska Admin. Code tit. 12, § 52.585(c)	The patient counseling requirements do not apply to a pharmacist who dispenses drugs for inpatient use in a hospital or other institution if the drug is to be administrated by a nurse or other health care provider.
RPL, DIS	S-	Alaska Admin. Code tit. 12, § 52.585(b)	Patient counseling should be in-person, but if such counseling is not possible, a pharmacist must make a reasonable effort to provide the counseling by using a telephone, two-way radio, or written information. The pharmacist does not have to develop the written information, but can use abstracts of the Patient United States Pharmacopoeia Drug Information or comparable information.
GEN	S	Alaska Admin. Code tit. 12, § 52.510(a)(2)	A pharmacist can substitute a generic drug if certain requirements are met, including that the patient must be notified and consent to the substitution.
OSM, LAB	S	Alaska Stat. § 08.80.158(a), (c)	A pharmacy located outside of the state that regularly ships, mails, or delivers prescription drugs to patients in the state must, during its regular hours of operation, provide a toll-free telephone service to facilitate communication between patients and a pharmacist. The toll-free number and the hours that the service is available must be on a label on each container of drugs dispensed to patients in the state. The telephone service must be available at least 40 hours a week and at least 6 days a week.

Arizona

Type	Code	Provision	Description
PCE	S	Ariz. Admin. Code R4-23-402(B)	Oral consultation is required whenever: the prescription medication has not previously been dispensed to the patient in the same strength or dosage form or with the same directions; the pharmacist, through exercise of professional judgment, determines that oral consultation is warranted; or the patient or caregiver requests oral consultation.
PCE, PMR	S	Ariz. Admin. Code R4-23-402(F), (G)	The pharmacist is not required to provide counseling when a patient refuses consultation. The pharmacist must document, or assume responsibility to document, that oral consultation is or is not provided.
PCE	L	Ariz. Admin. Code R4-23-402(B), (J)	The oral counseling requirements do not apply to prescription drugs delivered to a patient at a location where a health care professional is responsible for administering the drugs.
RPL, DIS, PMR	S-	Ariz. Admin. Code R4-23-402(D)	Oral consultation can be omitted if the pharmacist: personally provides written information summarizing the information that would normally be orally communicated; documents the circumstance and reason for not providing oral consultation; and offers the opportunity for communication at a later time and provides a method to contact the pharmacy.
GEN	S	Ariz. Rev. Stat. Ann. § 32-1963.01(B), (C)	When a prescription is filled with a generic equivalent drug, the pharmacist must notify the patient of the amount of the price difference between the brand name and generic drug.
MIS, LAB	S	Ariz. Rev. Stat. Ann. § 32-1967(A)(6)(b)	A drug or device is misbranded unless its label contains adequate warnings in a manner and form necessary for the protection of patients.
OSM, DIS	S	Ariz. Admin. Code. R4-23-402(I)	When a prescription is delivered outside the pharmacy and a pharmacist is not present, the prescription must be accompanied by written information that includes the information that would normally be orally communicated, as well as other specified information, including the phone number of the pharmacy or another method that allows the patient to consult with a pharmacist.
OSM, LAB	S	Ariz. Admin. Code R4-23-673(F)	Limited-service mail-order pharmacies must, during regular hours of operation but not fewer than 5 days and a minimum 40 hours per week, provide toll-free telephone service to facilitate communication between patients and a pharmacist. The limited-service pharmacy must disclose this toll-free number on a label on each container of drugs dispensed from the limited-service mail-order pharmacy.
PMR	S	Ariz. Admin. Code R4-23-402(A)	The pharmacist must obtain and record demographic and medical information, including pharmacist's comments relevant to the patient's drug therapy and other information specific to the patient.

Arkansas

Type	Code	Provision	Description
DEF	S	09-00 Ark. Code R. § 0001(d)	Patient counseling is defined as effective communication by the pharmacist to the patient to improve the therapeutic outcome by encouraging proper use of prescription medications and drug delivery devices.
PCE	S	09-00 Ark. Code R. § 0001(c), (d)	Patient counseling is required for original prescriptions and when medications are dispensed on discharge from a hospital or institution.
PCE	S-	09-00 Ark. Code R. § 0001(d)(2)	For refills, the pharmacist must present the opportunity for the patient to ask questions. Counseling is not required for refills, except when needed in the professional judgment of the pharmacist.
PCE	L	09-00 Ark. Code R. § 0001(c)(4)	Patient counseling is not required for patients who are receiving inpatient services from a hospital or institution where a health care professional is authorized to administer the medications.
OSM	S	09-00 Ark. Code R. § 0001(c)(1)	If a patient is not in the pharmacy, a pharmacist must make a reasonable effort to counsel the patient.
SUP	S	09-00 Ark. Code R. § 0001(c)(2)	Alternative forms of patient information may be used to supplement, but not replace, oral in-person counseling.
GEN, LAB	S	Ark. Code Ann. § 17-92-505(a)(2)	If a pharmacist dispenses a generic drug, the patient must be informed prior to dispensing, or the label should appropriately indicate the substitution.
PMR	S	09-00 Ark. Code R. § 0001(a)	The pharmacist must make a reasonable effort to obtain, record, and maintain demographic and medical patient information, including pharmacist comments.
COC	S	02-04 Ark. Code R. § 0001	Pharmacists have a duty to qualify themselves by attaining and maintaining an acceptable level of professional competence, and by using such skill and precaution in the dispensing, labeling, and distribution of drugs and medical devices, whether on prescription or not, so as to prevent injury or death to all patients.

California

Type	Code	Provision	Description
PCE, COC	S	Cal. Code Regs. tit. 16, § 1707.2(a), (b)	A pharmacist must provide oral consultation to patients in all care settings when the patient is present in the pharmacy for new prescriptions and when a prescription has not been dispensed to the patient in the same dosage, form, strength, or with the same directions. Further, a pharmacist must provide counseling in all care settings upon request or when the pharmacist deems it is warranted in his/her professional judgment. [Note: this provision is entitled "Notice to Consumers and Duty to Consult."]
PCE, DIS	S	Cal. Bus. & Prof. Code § 4074(1); Cal. Code Regs. tit. 16, § 1744	Pharmacists must inform patients orally or in writing of harmful effects of certain prescription drugs, if the drug poses a substantial risk when taken in combination with alcohol or the drug may impair the person's ability to drive.
DIS, LAB	S	Cal. Code Regs. tit. 16, § 1707.4(3)	For refills, the patient must be provided with written information, either on the prescription label or with the prescription container that describes which pharmacy to contact if the patient has any questions about the prescription or medication.
PCE	S	Cal. Code Regs. tit. 16, §§ 1751.5(a), 1751.2	Counseling must be available to a patient regarding the proper use of the sterile injectable products and related supplies. The labels must include the telephone number of the pharmacy.
PCE	S-	Cal. Code Regs. tit. 22, § 53214(c)(2)	Medicaid managed care recipients are required to have access, when appropriate, to counseling with a pharmacist. The purpose of the counseling is to assure that the patient understands the proper use and instructions for taking the medication.
PCE	S	Cal. Bus. & Prof. Code § 4181(a), 4191(a)	Non-profit, free clinic and surgical clinic pharmacies must also follow patient counseling, labeling, and recordkeeping requirements set forth for other pharmacists.
PCE	S	Cal. Code Regs. tit. 16, § 1707.2(e)	A pharmacist is not required to provide oral consultation to a patient who has refused consultation.
PCE	L	Cal. Code Regs. tit. 16, § 1707.2(b)(3)	A pharmacist is not required to provide oral consultation to patients in health care facilities, or inmates of adult or juvenile correctional facilities, unless the patient is being discharged.
OSM, LAB	S	Cal. Bus. & Prof. Code § 4112(f)	Nonresident pharmacies must provide a toll-free telephone service to facilitate communication between local patients and a pharmacist who has access to patient records. This toll-free telephone number must be on a label on each prescription drug container.
OSM, DIS	S	Cal. Code Regs. tit. 16, § 1707.2(b)(2)	If a patient is not present in the pharmacy (including drugs shipped by mail), a pharmacy must ensure that the patient receives written notice of his/her right to request consultation, and a telephone number from which the patient may speak to a pharmacist.
GEN, LAB	S	Cal. Bus. & Prof. Code § 4073(e)	When a generic substitution is made, the use of the generic drug must be communicated to the patient, and the name of the generic drug must be indicated on the prescription label.
LAB	M	Cal. Bus. & Prof. Code § 4076.5(a), (c)(5)	The Board of Pharmacy must promulgate regulations, on or before January 1, 2011, that require a standardized label on all prescription medicine dispensed to patients in California. When developing the regulations, the board must consider the needs of patients who are limited English proficient.
DIS	M	Cal. Health & Safety Code § 120970	If the California Department of Public Health uses a contractor to administer any aspect of its HIV program, the contractor must operate a toll-free telephone number for pharmacy counseling regarding medications and translate information regarding program policies and procedures, including enrollment procedures, eligibility guidelines, and lists of drugs covered, into Spanish, Mandarin/Cantonese, Tagalog, and in other languages, as determined by the Department.

California continued

Type	Code	Provision	Description
DIS, PST	S	Cal. Bus. & Prof. Code § 4122(a); Cal. Code Regs. tit. 16, § 1707.2(f)	Pharmacies must have a prominent and conspicuous notice, readable by prescription drug consumers, that includes information about the availability of prescription drug prices, generic drugs, services provided by pharmacies, and a statement of patients' rights. The notice must also encourage patients to talk to their pharmacists with concerns or questions.
DIS	S	Cal. Bus. & Prof. Code § 4052.3(e); Cal. Code Regs. tit. 16, § 1746	A pharmacist who furnishes emergency contraception drugs must provide the recipient with a standardized fact sheet that includes specific information. The Pharmacy Board provides the fact sheet in 10 languages other than English. http://pharmacy.ca.gov/consumers/emergency_cont.shtml.
PMR	S	Cal. Code Regs. tit. 16, § 1707.1	Pharmacies must maintain medication profiles for all patients that contain demographic and medical information, as well as additional information the pharmacist deems appropriate in his/her professional judgment.

Colorado

Type	Code	Provision	Description
PCE, COC	S	3 Colo. Code Regs. § 719-1 (1.00.18)	The pharmacist must offer to advise the patient regarding a prescription when a patient seeks advice, or when, in the pharmacist's professional judgment, the best interest of the patient will be served. [Note: this provision is contained within Colorado's Rules of Professional Conduct for pharmacists.]
PCE	S	10 Colo. Code Regs. § 2505-10-8.838.3(A)	Pharmacists or their designees must offer to counsel Medicaid patients with new prescriptions.
PCE, PMR	S	10 Colo. Code Regs. § 2505-10-8.838.3(D)	For Medicaid patients, counseling is not required when the patient refuses the consultation. The pharmacist must keep records indicating when the consultation was not or could not be provided.
PCE	L	10 Colo. Code Regs. § 2505-10-8.838.3(C); Colo. Rev. Stat. § 12-22-124	For Medicaid patients, counseling is not required for patients of a hospital or institution where other licensed health care professionals administer the prescribed drugs. Specifically, communication of generic substitution for a brand name drug is not required for institutionalized patients.
SUP, DIS	S	10 Colo. Code Regs. § 2505-10-8.838.3(B)	Alternative forms of patient information may be used to supplement counseling for Medicaid patients when appropriate, but not to be used in lieu of oral counseling. Examples of these forms of information include written information leaflets, pictogram labels, and video programs.
GEN, DIS, LAB	S	Colo. Rev. Stat. § 12-22-124	If a generic substitution is made, the substitution must be communicated to the patient orally and in writing. The container must be labeled with the name of the drug dispensed, and the pharmacist must indicate on the file copy of the prescription both the name of the prescribed drug and the name of the drug generic drug dispensed.
PMR	S	10 Colo. Code Regs. § 2505-10-8.838.1	For Medicaid patients, pharmacists must make reasonable efforts to obtain and maintain patient medical and demographic information, including comments the pharmacist determines are relevant to the patient's pharmaceutical care.

Connecticut

Type	Code	Provision	Description
PCE, RPL, DIS	S-	Conn. Gen. Stat. § 20-620(c)	For Medicaid recipients, the pharmacist must, whenever practicable, offer in person to discuss the drugs to be dispensed and to counsel the client on drug usage, except when the person obtaining the prescription is not the patient or the pharmacist determines it is appropriate to make such an offer in writing. Any written offer of counseling must include an offer to counsel the patient in person at the pharmacy or by telephone.
PCE, PMR	S	Conn. Gen. Stat. § 20-620(e)	For Medicaid recipients, pharmacists are not required to counsel patients who refuse counseling services. The pharmacist must document the provision of counseling, a refusal by the patient, or the inability of the patient to accept counseling.
PCE	L	Conn. Gen. Stat. § 20-620(f)	Counseling provisions do not apply to persons receiving prescription drugs in certain nursing homes.
GEN	S	Conn. Gen. Stat. § 20-619(b)	Pharmacists must inform the patient of the substitution of a generic for the prescribed drug at the earliest reasonable time.
OSM, LAB	S	Conn. Gen. Stat. § 20-627	A nonresident pharmacy must, during its regular hours of operation but not less than 6 days per week and for a minimum of 40 hours per week, provide a toll-free telephone number to facilitate communication between patients in this state and a pharmacist at the nonresident pharmacy. The toll-free telephone number must be disclosed on a label on each prescription drug container dispensed to a patient.
PMR	S	Conn. Gen. Stat. §20-620(a)	For Medicaid recipients, the pharmacist must make a reasonable effort to obtain and maintain patient demographic and medical information, including comments relevant to the individual's drug therapy.

Delaware

Type	Code	Provision	Description
PCE	S	24-2500 Del. Code Regs. § 5.3.2	A pharmacist must provide counseling to the patient with each new medication dispensed.
PCE, PMR	S	24-2500 Del. Code Regs. § 5.3.4	Counseling is not required when a patient refuses the counseling. A record must be in a uniform place that documents a patient's acceptance or refusal of counseling. If the patient refuses to give all or part of the information, that must also be recorded.
PCE	L	24-2500 Del. Code Regs. § 5.3.3	Counseling is not required when a pharmacist dispenses drugs for inpatient use in a hospital or other institution where the drug is to be administered by a nurse or other appropriate health care provider.
PCE	S	40-850-026 Del. Code Regs. §§ 5.3.3.1-5.3.3.2	For Medicaid patients, pharmacists must offer to discuss the prescription drugs they are taking when filling prescriptions for them.
GEN	S	24 Del. Code Ann. § 2549	A pharmacist may engage in generic substitution if, among other things, the pharmacist informs the patient.
OSM, DIS	S	24-2500 Del. Code Regs. § 5.3.5	Written information must be included with the prescription, if the dispensed prescription is delivered when the pharmacist is not present (i.e. home delivery and non-resident pharmacies). The patient must be informed that the pharmacist will be available for consultation.
OSM, LAB	S	24 Del. Code Ann. § 2537(a)(4)	Nonresident pharmacies must provide a local or toll-free telephone service staffed by a registered pharmacist during its regular hours of operation, but not less than 6 days per week for a minimum of 40 hours per week, to facilitate communication between patients in the state and pharmacists at the nonresident pharmacy who have access to patient records. The toll-free telephone number must appear on the label on each container of prescription drugs dispensed to patients.
PMR	S	24-2500 Del. Code Regs. §§ 5.7.2.10	Pharmacists are required to maintain patient demographic and medical information, including pharmacist comments relevant to the patient's drug therapy, any other information peculiar to the specific patient, and any idiosyncrasies of the patient.

District of Columbia

Type	Code	Provision	Description
PCE	S	D.C. Code Ann. § 3-1210.06a; D.C. Mun. Regs. tit. 22, § 1919.1	A pharmacist must make a verbal offer to counsel the patient when there is a new prescription, a change in dosage form or strength, annually for maintenance medications, and whenever pharmacist deems otherwise necessary.
PCE	S	D.C. Mun. Regs. tit. 22, § 1919.7	A pharmacist must assess, to the best of his/her ability, that the patient understands the counseling information provided to the patient.
PCE, PMR	S	D.C. Code Ann. § 3-1210.06a(c), (d)	A pharmacist is not required to counsel patients who refuse the consultation. Any refusal of the pharmacist's offer to counsel must also be recorded in a patient's medication profile.
PCE	L	D.C. Mun. Regs. tit. 22, § 1919.9	A pharmacist is not required to counsel a patient in an inpatient health care facility where other licensed health care professionals are authorized to administer drugs.
OSM, DIS	S	D.C. Mun. Regs. tit. 22, § 1919.5	When the patient is not present in the pharmacy, as in the case of prescription deliveries, the pharmacist must ensure that the patient receives written notice of his/her right to request consultation and a telephone number from which the patient may obtain oral consultation from a pharmacist.
SUP, DIS	S	D.C. Mun. Regs. tit. 22, § 1919.4	A pharmacist must provide written information to reinforce the pharmacist's consultation. Such information may include information leaflets, pictogram labels or video programs.
PMR	S	D.C. Mun. Regs. tit. 22, § 1913.11; D.C. Code Ann. § 3-1210.06a(d)	Pharmacies must make a reasonable effort to obtain, record, and maintain patient demographic and medical information and pharmacist's comments relevant to the individual's drug therapy, any other information peculiar to the specific patient, and any other information that the pharmacist, in his/her professional judgment, deems appropriate.

Florida

Type	Code	Provision	Description
PCE, DIS	S-	Fla. Stat. Ann. § 465.003(6)	If in the pharmacist's judgment counseling is necessary, a pharmacist must provide written or oral counseling on proper drug usage.
PCE, DIS	S	Fla. Admin. Code Ann. r. 64B16-27.820	The pharmacist must ensure that an offer of verbal and printed counseling be made to the patient when new or refilled prescriptions are filled.
PCE	S-	Fla. Stat. Ann. § 465.0255(2), (4)	A community pharmacist must provide information about the expiration date, if requested by the patient, and appropriate instructions about proper use and storage of medicinal drugs. The pharmacist will not be liable if a patient does not follow the notice or follow the instructions for storage.
PCE	S	Fla. Admin. Code Ann. r. 64B16-27.820(3)	Patient counseling is not required when the patient refuses the consultation.
PCE	L	Fla. Admin. Code Ann. r. 64B16-27.820(2)	Patient counseling is not required for patients in a hospital or institution where other practitioners are authorized to administer prescription drugs.
PCE	S	Fla. Stat. Ann. § 465.026	If a prescription is transferred from another pharmacy, the pharmacist must advise the patient (verbally or by electronic means) that the prescription on file at the other pharmacy must be cancelled before the prescription may be filled or refilled.
GEN	S	Fla. Stat. Ann. § 465.025(3)(a); Fla. Admin. Code Ann. r. 64B16-27.530	If a generic drug is substituted for the prescribed drug, the pharmacist must inform the patient of the substitution, of any retail price difference between the two, and of the patient's right to refuse substitution. This information must be communicated at a meaningful time to allow the patient to make an informed choice as to whether to exercise the option to refuse substitution. The manner with which this information is conveyed is left to the discretion and judgment of the pharmacist.
OSM, DIS	S	Fla. Admin. Code Ann. r. 64B16-27.820(1)	If the drugs are not dispensed to patients at the pharmacy, then the offer of counseling must be provided in writing with a toll free number.
OSM, LAB	S	Fla. Stat. Ann. § 465.0197	Registered internet pharmacies must maintain a toll-free number at least 6 days per week for a minimum of 40 hours per week to facilitate communications between patients and a pharmacist who has access to the patient's records. The telephone number must be on the container label of the dispensed drug.
PMR	S	Fla. Admin. Code Ann. r. 64B16-27.800(1)	The pharmacist must ensure that a reasonable effort is made to obtain and maintain demographic and medical patient information, including pharmacist's comments and any other information peculiar to the specific patient.

Georgia

Type	Code	Provision	Description
PCE	S	Ga. Code Ann. § 26-4-85; Ga. Comp. R. & Reg. 480-31-.01(c)	After receiving a prescription drug order, the pharmacist must offer to discuss information that will enhance or optimize drug therapy.
PCE	S	Ga. Code Ann. § 26-4-85(e)	Patient counseling is not required if the patient refuses the counseling.
PCE	L	Ga. Code Ann. § 26-4-85(d); Ga. Comp. R. & Regs. 480-31-.01(c)	Patient counseling is not required for patients in hospitals or institutions, inmates at correctional facilities, or patients receiving drugs from the Department of Human Resources Division of Public Health.
OSM, DIS	S	Ga. Code Ann. § 26-4-60(a)(11)	Mail-order pharmacies that distribute prescription drugs to health benefit plan enrollees must provide an electronic, telephonic, or written mechanism through which a pharmacist can offer counseling to the enrollee.
SUP, DIS	S	Ga. Comp. R. & Regs. 480-31-.01(c)	Additional forms of patient information may be used to supplement verbal patient counseling when appropriate or available.
PMR	S	Ga. Code Ann. § 26-4-83; Ga. Comp. R. & Regs. 480-31-.01(a)	All pharmacies must maintain a patient record system and must make reasonable efforts to obtain, record, and maintain demographic and medical patient information, including pharmacists' comments and any other information peculiar to the specific patient or drug.
OTH	S-	Ga. Comp. R. & Regs. 480-31-.01(d)	The pharmacist is not prohibited from being compensated for counseling services.

Hawaii

Type	Code	Provision	Description
PCE	S	Haw. Rev. Stat. § 328-17.6	If a prescription is transferred from another pharmacy, the dispensing pharmacist must advise the patient that the prescription on file at the other pharmacy may be cancelled.
GEN	S	Haw. Rev. Stat. § 328-92	When filling a prescription, a pharmacist must offer the patient the generic version, inform the patient of the right to refuse substitution, and inform the patient of the cost savings, if requested.
REM	S	Haw. Rev. Stat. § 461-10.5; Haw. Code R. § 17-1737.51.1	Remote dispensing pharmacies (pharmacies that are at least five miles from any other pharmacy) can dispense prescriptions through a remote dispensing machine that must be supervised and quality assured by a licensed pharmacist in the state. The remote pharmacy staff must offer patients the option to receive counseling by a pharmacist at the responsible pharmacy. Remote dispensing machines must have video and audio components that allow the patient to have a "face-to-face" consultation with the pharmacist at the responsible pharmacy. Medicaid recipients are also specifically allowed to obtain their prescriptions through a telehealth system.
DIS	S	Haw. Code R. § 16-95-130	The pharmacist must obtain a signed informed consent form when dispensing emergency contraception therapy. The pharmacist and patient must also sign a screening checklist for emergency contraception.

Idaho

Type	Code	Provision	Description
PCE	S	Idaho Code Ann. § 54-1749	When filling a prescription, a pharmacist must offer to counsel the patient face-to-face. If this is not possible, the pharmacist must make a reasonable effort to counsel the patient by phone.
PCE	S	Idaho Code Ann. § 54-1749	Patient counseling is not required if the offer to counsel is refused.
PCE	L	Idaho Code Ann. § 54-1749	Patient counseling is not required for patients in a hospital or institution.
OSM, LAB	S	Idaho Code Ann. § 54-1747	All out-of-state mail order pharmacies must maintain a toll-free number at least 6 days per week for a minimum of 40 hours per week to facilitate communication between patients and a pharmacist who has access to the patient's records. The telephone number must be on the label on the prescription drug container dispensed to the patient.
PMR	S	Idaho Code Ann. § 54-1735	To effectively counsel patients, pharmacists must make a reasonable effort to obtain and maintain demographic and medical information about the patient, including pharmacists' comments.

Illinois

Type	Code	Provision	Description
PCE	S	Ill. Admin. Code tit. 68, § 1330.65	Upon receipt of a new or refill prescription, an offer to counsel the patient must be made. A pharmacist in a hospital or nursing home must also follow these counseling requirements when medications are provided upon discharge from such a facility.
PCE, PMR	S	Ill. Admin. Code tit. 68, § 1330.65	A pharmacist is not required to provide counseling when a patient has refused the offer to counsel. A patient's refusal to accept counseling must be documented.
RPL	S-	Ill. Adm. Code tit. 68, § 1330.65(b)	If, in the pharmacist's professional judgment, oral counseling is not practicable for the patient or patient's caregiver, the pharmacist must use alternative forms of patient information. When used in place of oral counseling, alternative forms of patient information must advise the patient or caregiver that the pharmacist may be contacted for consultation by toll-free or collect telephone service.
OSM, LAB	S	225 Ill. Comp. Stat. Ann. 85/16a	Nonresident pharmacies must operate a toll-free telephone service during its regular hours of operation, but not less than 6 days per week, for a minimum of 40 hours per week, to facilitate communication between patients in the state and a pharmacist at the pharmacy who has access to the patients' records. The toll-free number must be disclosed on the label on each container of drugs dispensed to patients.
PMR	S	Ill. Adm. Code tit. 68, § 1330.65(c)	A pharmacist must make a reasonable effort to obtain and maintain patient profiles that include demographic and medical information, including pharmacist's comments relevant to the individual's therapy.

Indiana

Type	Code	Provision	Description
DEF	S	Ind. Code Ann. § 25-26-13-2; 856 Ind. Admin. Code 1-33-1	The practice of pharmacy is defined as a patient-oriented health care profession in which pharmacists interact with and counsel patients. Counseling is defined as "effective communication between a pharmacist and a patient . . . to improve the therapeutic outcome of the patient through the effective use of the drug or device."
PCE, DIS	S	856 Ind. Admin. Code 1-33-2, 1.5	For both new and refill prescriptions, the pharmacist must offer to counsel the patient. An offer must be oral or, if necessary for an individual patient, in writing. The offer must inform the patient that a pharmacist is available to counsel the patient at the time the offer is made including, but not limited to, giving information to or answering questions of the patient. Use of an intermediary to convey the offer of counseling is specifically allowed for translations and persons who are hearing impaired.
PCE	S	856 Ind. Admin. Code 1-28.1-7	Pharmacists in institutional pharmacies are also required to provide counseling and education of patients.
OSM, DIS	S	856 Ind. Admin. Code 1-33-1.5	When a patient is not present in the pharmacy, written information is required, and it must contain the pharmacy's telephone number and an offer to counsel the patient.
SUP, DIS	S	856 Ind. Admin. Code 1-33-2(c)	Alternative forms of patient information may be used to supplement verbal counseling when appropriate. Examples include written information leaflets, pictogram labels and video programs. Supplementary information may not be used as a substitute for verbal counseling when verbal counseling is practicable.
PMR	S	Ind. Code Ann. § 25-26-13-31	A pharmacist may obtain and maintain patient drug histories and other pharmacy records related to drug therapies.
PMR	S	856 Ind. Admin. Code 1-33-3	A pharmacist must obtain and maintain patient drug profiles with demographic and medical patient information, including pharmacist's comments relevant to the individual's drug therapy.

Iowa

Type	Code	Provision	Description
PCE	S	Iowa Admin. Code r. 657-6.14(1)	For new prescriptions, a pharmacist must counsel each patient or patient's caregiver. An offer to counsel does not fulfill the requirements of this rule.
RPL, SUP, DIS	S-	Iowa Admin. Code r. 657-6.14(4)	Oral counseling does not have to be provided if the pharmacist decides it is not practicable. "Not practicable" is defined to include those patients with a hearing impairment or a language barrier. If oral counseling is not provided, the pharmacist must provide alternative forms of patient information to communicate with the patient or caregiver that explains the pharmacist may be contacted for consultation at the pharmacy by toll-free or collect telephone call. Alternative forms of patient information may include written information leaflets, pictogram labels, video programs or information generated by electronic data processing equipment. A combination of oral counseling and alternative forms of counseling is encouraged.
PCE, PMR	S	Iowa Admin. Code r. 657-6.14(6)	Counseling is not required if a patient or caregiver refuses the consultation. The pharmacist must document any refusal of consultation by the patient.
PCE	L	Iowa Admin. Code r. 657-6.14(5)	Counseling is not required for inpatient of an institution where other licensed health care professionals are authorized to dispense drugs.
PCE	S	Iowa Admin. Code r. 441-78.2	For Medicaid recipients, pharmacists are required to offer to discuss information regarding the use of the medication with each recipient or caregiver presenting a prescription.
OSM, LAB	S	Iowa Admin. Code r. 155A.13A	A nonresident pharmacy must provide, during its regular hours of operation for at least 6 days and for at least 40 hours per week, a toll-free telephone number to facilitate communication between a patient and a pharmacist who has access to the patient's records. The toll-free number must be printed on the label on each container of prescription drugs delivered, dispensed or distributed in the state.
REM, PST	S	Iowa Admin. Code r. 657-9.5, 9.18	Telepharmacy services are established when a managing pharmacy is designated to provide quality assurance, supervision and counseling to a remote pharmacy site. The remote site is considered an extension of the managing pharmacy, and can only be established when there is not a general pharmacy in the same community or within 15 miles of the remote site. A pharmacist at the managing pharmacy must use video and audio components of the automated pharmacy system to counsel each patient on all new prescriptions. Further, a sign must be posted at the remote site to ensure that all patients are informed that a pharmacist will counsel a patient for any prescription dispensed from the remote site.
REM	S	Iowa Admin. Code r. 653-13.6	Automated dispensing systems, which allow technology to assist in the dispensing of the medication without a pharmacist or physician present, may be used as long as certain quality control measures are utilized by the physician responsible for the system. A physician using the automated system to dispense a prescription must provide counseling to a patient about that prescription drug.
PMR	S	Iowa Admin. Code r. 657-6.13(1)	The pharmacist is responsible for obtaining, recording, and maintaining demographic and medical information about each patient, including pharmacist comments relevant to the individual's drug therapy.
OTH	S	Iowa Admin. Code r. 657-6.2	Each pharmacy is required to have an ongoing, systematic program for achieving performance and quality improvement of pharmaceutical services. A supervising pharmacist in each pharmacy is also required to ensure that a pharmacist is providing patient counseling, as required by these rules.

Kansas

Type	Code	Provision	Description
PCE	S	Kan. Admin. Regs. § 68-2-20(a), (b)	The pharmacist must offer to counsel the patient or patient's agent for new prescriptions and once yearly for maintenance medications.
PCE	S-	Kan. Admin. Regs. § 68-2-20(a), (b)	For refill prescriptions, a pharmacist must offer to counsel the patient only if the pharmacist deems it appropriate.
PCE	S	Kan. Admin. Regs. § 68-2-20(c)	Patient counseling is not required when the patient or the patient's agent refuses the counseling.
PCE	S-	Kan. Admin. Regs. § 68-2-20(b)(2), (c)	A pharmacist can decide not to provide verbal counseling on a case-by-case basis for refills, maintenance medications, or continuous medications for the same patient. Patient counseling is not required if the pharmacist, based on professional judgment, determines that the counseling may be detrimental to the patient's care or the relationship with the patient's prescribing provider.
GEN	S	Kan. Admin. Regs. § 68-2-20; Kan. Admin. Regs. § 30-5-92	The pharmacist must notify the patient or the patient's agent if a generic drug has been substituted for a brand name drug. For Medicaid recipients, the pharmacist must also inform the patient that a generic drug is available, if it is in stock at that time, and it is less expensive than the brand name drug prescribed.
OSM, LAB	S	Kan. Stat. Ann. § 65-1657	Nonresident pharmacists are required to provide toll-free telephone communication consultation between patients and a pharmacist at the pharmacy who has access to the patient's records. The telephone number must be placed upon the label on each prescription drug container dispensed.
SUP, DIS, LAB	S	Kan. Admin. Regs. § 68-2-20(b)(3)	The pharmacist may provide alternative forms of patient information to supplement oral patient counseling. These supplemental forms of patient information may include written information, leaflets, pictogram labels, video programs and auxiliary labels on the prescription vials. The supplemental patient information must not be used as a substitute for the oral counseling required.

Kentucky

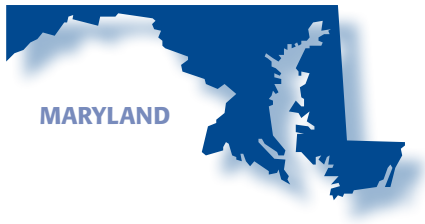
Type	Code	Provision	Description
PCE, RPL, DIS	S-	201 Ky. Admin. Regs. 2:210, Secs. 2, 5	Pharmacists must offer to counsel a patient on new prescriptions and, only at the pharmacist's discretion, for refills. The offer must be made face-to-face unless impractical or inappropriate, in which case the offer may be made by telephone (with reasonable effort), written communication or by other appropriate manner determined by the pharmacist.
PCE, PMR	S	201 Ky. Admin. Regs. 2:210, Sec. 6 (2)	Counseling is not required if the patient refuses the consultation. Any refusal of consultation must be documented.
PCE	L	201 Ky. Admin. Regs. 2:210, Sec. 6 (1)	Counseling is not required to be offered to patients in a hospital or institution where other licensed healthcare professionals are authorized to administer the drug.
SUP	S	201 Ky. Admin. Regs. 2:210, Sec. 5	Pharmacists may supplement patient counseling with additional forms of information.
OSM, LAB	S	Ky. Rev. Stat. Ann. § 315.0351(6)	Registered out-of-state pharmacies must maintain a toll-free number at least 6 days per week for a minimum of 40 hours per week to facilitate communication between patients and a pharmacist who has access to the patient's records. The number must be disclosed on the container label for dispensed drugs.
REM	S	Ky. Rev. Stat. Ann. § 315.310	Pharmacists who provide or facilitate the use of telehealth (using audio, video, or electronic means to provide health care) must ensure that the patient's informed consent is obtained before telehealth services are provided.
DIS	S	Ky. Rev. Stat. Ann. § 217.896	Pharmacists must display pamphlets that explain certain provisions of the Pharmacy Act in a prominent place and must make them available without charge.
PMR	S	201 Ky. Admin. Regs. 2:210, Sec. 1(e)(6)	A pharmacist must obtain, record, and maintain patient demographic and medical information, including comments or other information as may be relevant to the specific patient.

Louisiana

Type	Code	Provision	Description
DEF	S	La. Admin. Code tit. 46, § 517(A)	Patient counseling is defined as the "effective communication of information by a pharmacist to a patient. . . to ensure proper use of drugs and devices."
PCE	S	La. Admin. Code tit. 46, § 517(E)	When possible and appropriate, patient counseling should occur face-to-face, but if not possible or appropriate, pharmacists can use alternatives, including telephone or electronic communication. Pharmacists are required to counsel patients discharged from hospitals or other institutions.
PCE	S	La. Admin. Code tit. 46, § 517(F)	No pharmacist may encourage blanket waivers for patient counseling. A patient may decline an offer of patient counseling.
PCE	L	La. Admin. Code tit. 46, § 517(A), (B), (C), (E)	Counseling is not required for patients in a hospital or institution where a licensed healthcare professional is authorized to administer medication.
SUP, DIS	S	La. Admin. Code tit. 46, § 517(C)	Pharmacist may supplement oral information with written information but may not use written information alone to fulfill the counseling requirement.
DIS	S	La. Admin. Code tit. 46, § 517(E)	The pharmacist must maintain appropriate patient-oriented drug information materials.
OSM	S	La. Admin. Code tit. 46, § 2309	The state's pharmacy laws and regulations are applicable to the regulation of out-of-state pharmacies.

Maine

Type	Code	Provision	Description
PCE, SUP, DIS	S	Me. Rev. Stat. Ann. tit. 32, § 13784; 02-392-25 Me. Code R. § 1	With each new prescription, the pharmacist must orally explain to the patient the directions for use and any additional information to assure proper use of the drug/device. Information in writing may be provided if necessary.
PCE, LAB, DIS	S	02-392-25 Me. Code R. § 2	With each refill prescription, the pharmacist must offer to counsel the patient. The offer may be made by face-to-face communication, a telephone conversation, a notation on the prescription container, or a notation on the prescription bag.
PCE	L	Me. Rev. Stat. Ann. tit. 32, § 13784	Counseling is not required for patients in hospitals or institutions where medication is administered by a health care professional licensed to do so.
GEN	S	Me. Rev. Stat. Ann. tit. 32, § 13781	When a pharmacist substitutes a generic drug for a brand name drug, the pharmacist must inform the patient of the substitution. If a patient is paying for the drug with his/her own resources, the pharmacist must ask the patient whether he/she would prefer a generic drug and dispense the drug that the patient prefers.
PCE, GEN	S	Me. Rev. Stat. Ann. tit. 32, § 13782-A	A pharmacist must inform a patient, by telephone or in person, the price of any brand name or generic drug, if that information is requested by the patient.
OSM, DIS	S	Me. Rev. Stat. Ann. tit. 32, § 13784; 02-392-25 Me. Code R. § 1	For those prescriptions delivered outside the pharmacy, the explanation must be made over the telephone or in writing. When the prescription is not dispensed to the patient or caregiver, the pharmacist must make the counseling available to the patient through a toll-free telephone service.
DIS	S	Me. Rev. Stat. Ann. tit. 22, § 2682	For persons who have no prescription drug coverage and are purchasing brand name drugs, information about the Maine Rx Program and how to get help with high cost of drugs must be distributed with each such prescription dispensed.
PMR	S	Me. Rev. Stat. Ann. tit. 32, § 13785	The pharmacist must obtain, record, and maintain patient demographic and medical information, including specific characteristics about the patient that may relate to drug utilization.



Maryland

Type	Code	Provision	Description
PCE, DIS, LAB, PST	S	Md. Code Ann., Health Occ. § 12-507(a), (b)	For Medicaid recipients, a pharmacist must offer to counsel patients for new prescriptions for covered outpatient drugs. The offer may be a face-to-face communication or at least two of the following: a posted sign, notation on the prescription bag, notation on the prescription container, or communication by phone.
PCE	L	Md. Code Ann., Health Occ. § 12-507(e),(f)	No counseling is required for refill prescriptions or when it is not an outpatient drug.
PCE	S	Md. Code Ann., Health Occ. § 12-507(c)	No counseling is required when the Medicaid recipient or caregiver has refused the offer to counsel.
GEN, DIS	S	Md. Code Ann., Health Occ. § 12-504	A pharmacist must inform patients of the availability of a generic version and of the cost difference between the generic and brand name drug. If the generic version is substituted for the prescribed drug/device, the pharmacist must notify the patient in writing that the drug/device dispensed is a generic equivalent of the prescribed product.
DIS, SUP	S	Md. Code Regs. 10.34.26.02	In addition to any other patient counseling requirements, pharmacies must provide patients with information about preventing medication errors, including the patient's rights when receiving medications, the patient's role and responsibility in preventing medication error, and procedures for reporting suspected medication errors to healthcare providers and the Board of Pharmacy. This information must be provided to patients before or at the time the drug/device is provided to the patient.
PMR	S	Md. Code Ann., Health Occ. § 12-507(d)	For Medicaid recipients, a pharmacist must make a reasonable effort to obtain, record, and maintain patient demographic and medical information, including a pharmacist's comments relevant to the individual's drug therapy.

Massachusetts

Type	Code	Provision	Description
PCE, RPL	S-	Mass. Gen. Laws Ann. ch. 94C, § 21A; 247 Mass. Code Regs. 9.07(3)(a)(e)	A pharmacist must offer to counsel a patient who presents a new prescription. Such offer must be made either by face-to-face communication or by telephone, except when the patient's needs or availability require an alternative method of counseling.
PCE, PMR	S	Mass. Gen. Laws Ann. ch. 94C, § 21A	Counseling is not required if a patient refuses the offer to counsel. A patient's refusal of the pharmacist's offer to counsel should be recorded.
PCE	L	Mass. Gen. Laws Ann. ch. 94C, § 21A	Counseling is not required for drugs dispensed to a patient in a hospital or nursing home or any other setting where medication is administered by an authorized individual.
OSM, LAB	S	Mass. Gen. Laws Ann. ch. 94C, § 21A	If the patient does not pick up the prescription at the pharmacy, a patient must be provided access to a toll-free telephone number. The toll-free telephone number must be on a label on each container of a prescription drug dispensed.
PMR	S	247 Mass. Code Regs. 9.07(1)(a)	The pharmacist must make a reasonable effort to obtain, record and maintain certain information about the patient, including a pharmacist's comments relevant to the patient's drug use.

Michigan

Type	Code	Provision	Description
PCE, COC	S	Mich. Admin. Code r. 338.490(4)	To encourage intended, positive patient outcomes, pharmacists must communicate with a patient regarding safe and effective medication use at the time a new prescription is dispensed. [Note: This provision is entitled "Professional Responsibility."]
PCE	S-	Mich. Admin. Code r. 338.490(4)	For refill prescriptions, a pharmacist may counsel the patient if the pharmacist deems it appropriate.
PCE, RPL, OSM, DIS	S-	Mich. Admin. Code r. 338.490(4)	Counseling must be performed orally and in person, except when the patient or patient's caregiver is not at the pharmacy or when a specific communication barrier prohibits oral communication. In either situation, providing printed material designed to help the patient use the medication safely and effectively satisfies the counseling requirement.
PCE	S	Mich. Admin. Code r. 338.490(4)(d)	Counseling is not required if the patient refuses the consultation.
PCE	L	Mich. Admin. Code r. 338.490(4)	Counseling not required for prescriptions dispensed for administration to a patient while the patient is in a medical institution.
GEN, LAB	S	Mich. Comp. Laws Ann. § 333.17755(1); Mich. Admin. Code r. 338.479(3)	If a drug is dispensed that is not the prescribed brand, the patient must be notified, and the prescription label must indicate the name of the brand prescribed and the name of the generic drug dispensed.

Minnesota

Type	Code	Provision	Description
PCE	S	Minn. R. 6800.0910(1), (2)	A pharmacist must provide oral counseling to a patient who is submitting a new prescription. Each licensed pharmacy must develop and maintain a written patient consultation procedure for providing oral communication between the patient and the pharmacist designed to improve the patient's understanding of and compliance with the patient's drug therapy. A pharmacist must initiate the discussion about the prescription and inquire about the patient's understanding of the use of the medication.
PCE	S-	Minn. R. 6800.0910(2)	For refills, the pharmacist must only counsel the patient if the pharmacist deems it necessary.
PCE, PMR	S	Minn. R. 6800.0910(2)	Oral counseling is not required if a patient has refused the consultation. If consultation is not provided, that fact and the circumstances surrounding it must be noted on the prescription, in the patient's records, or in a specially developed log.
PCE	L	Minn. R. 6800.0910(2)	Oral counseling is not required for patients in a hospital or other institution, such as a nursing home, where a licensed health care professional administers the drug.
GEN	S	Minn. Stat. Ann. § 151.21	Pharmacists must disclose to purchasers when a generic equivalent of a prescribed drug is available and must notify the purchaser if dispensing a drug other than the brand name prescribed. The purchaser may object to receiving the generic equivalent.
SUP, DIS	S	Minn. R. 6800.0910(2)	Oral counseling may be supplemented with written information.
OSM, DIS	S	Minn. R. 6800.0910(2)	For a prescription that is being delivered or mailed, counseling must still be provided. Written information may be provided to the patient to accomplish the counseling requirements. If written information is provided, it must include information regarding the medication and the availability of the pharmacist to answer questions through the provision of a toll-free telephone phone number.
OSM, LAB	S	Minn. Stat. Ann. § 151.19	Non-resident pharmacies must operate a toll-free telephone service during its regular hours of operation, but not less than 6 days per week, for a minimum of 40 hours per week, to facilitate communication between patients in the state and a pharmacist at the pharmacy who has access to the patients' records. The toll-free number must be on the label on each container of drugs dispensed.
PMR	S	Minn. R. 6800.3110	A reasonable effort must be made by the pharmacy to obtain, record, and maintain demographic and medical information regarding all patients who obtain prescription services at the pharmacy, including a pharmacist's comments relevant to the individual's drug therapy.
COC	S	Minn. R. 6800.2250	Unprofessional conduct is defined to prohibit a pharmacist or pharmacy from: discriminating in any manner between patients or groups of patients for reasons of race, creed, color, or national origin; refusing to consult with patients, attempting to circumvent the consulting requirements; or discouraging the patient from receiving consultation, among other prohibited conduct.
OTH	S-	Minn. R. 6800.0910(2)(B)	Pharmacists may charge for counseling services to patients.

Mississippi

Type	Code	Provision	Description
PCE, COC	S	50-018-001 Miss. Code R. § 8	It is the responsibility of the pharmacist to make an offer to provide oral counseling when dispensing an outpatient prescription drug. The pharmacist must provide the patient counseling.
PCE	S	50-018-001 Miss. Code R. § 8(4)(E)	Counseling is not required for patients who refuse a consultation.
PCE	L	50-018-001 Miss. Code R. § 8(4)(C)	Counseling is not required for patients in a hospital or institution where other licensed health care professionals are authorized to administer the drug.
SUP, DIS	S	50-018-001 Miss. Code R. § 8	Alternative forms of patient information may be used to supplement oral counseling such as written information, leaflets, pictogram labels, video programs, and auxiliary labels on the prescription vials.
GEN	S	Miss. Code Ann. § 73-21-117; 50-018-001 Miss. Code R. § 10	A pharmacist must advise patients of their options when a generic equivalent drug product is available and will result in lower costs to the purchaser.
OSM, LAB	S	Miss. Code Ann. § 73-21-106	A non-resident pharmacy that mails or delivers drugs into the state must operate a toll-free telephone service during its regular hours of operation, but not less than 6 days per week and for a minimum of 40 hours per week, to facilitate communication between patients and a pharmacist at the pharmacy who has access to the patient's records. The toll-free number must be on a label on each container of drugs dispensed.
OSM	S	50-018-001 Miss. Code R. § 8(4)(A)	If a patient is not available for counseling, the pharmacist must inform the patient that counseling is available and how to reach the pharmacist.
PMR	S	50-018-001 Miss. Code R. § 8	The pharmacist must make a reasonable effort to obtain and record demographic and medical patient information, including pharmacist's comments relevant to the individual's drug therapy and any other information peculiar to the specific patient.

Missouri

Type	Code	Provision	Description
PCE	S	Mo. Code Regs. Ann. tit. 20, § 2220-2.190(1)	Upon receipt of a prescription drug order, a pharmacist must personally offer counseling to each patient.
PCE	S	Mo. Code Regs. Ann. tit. 20, § 2220-2.190(5)	Counseling is not required when a patient or caregiver refuses consultation.
PCE	L	Mo. Code Regs. Ann. tit. 20, § 2220-2.190(4)	Counseling is not required for patients in a hospital, institution or other setting where health professionals are authorized to administer medications.
OSM, DIS	S	Mo. Code Regs. Ann. tit. 20, § 2220-2.190(1)	If patient or caregiver is not available, a written offer to counsel must be supplied with the medication, including a telephone number to reach a pharmacist.
REM, DIS	S	Mo. Code Regs. Ann. tit. 20, § 2220-2.900(1)(L); Mo. Code Regs. Ann. tit. 20, § 2220-2.190(1)	A pharmacy that maintains an automated dispensing system for remote dispensing in ambulatory settings must maintain a video camera and audio system to provide for effective communication between pharmacy personnel and patients that allows for the appropriate exchange of oral and written communications to facilitate patient counseling. Where automated systems are used for providing refill prescriptions, the offer to counsel may be provided within the information provided by the kiosk before the patient receives the medication.
SUP, DIS	S	Mo. Code Regs. Ann. tit. 20, § 2220-2.190(3)	Alternative forms of patient information can be used to supplement patient counseling when appropriate. Examples include written information leaflets, pictogram labels and video programs.

Montana

Type	Code	Provision	Description
PCE	S	Mont. Code Ann. § 37-7-406	The pharmacist should offer to counsel each patient on matters that are significant regarding the prescribed drug, as determined by the pharmacist.
PCE	S	Mont. Admin. R. 24.174.903(1)	For new prescription drug orders, a pharmacist must personally offer counseling to each patient.
PCE	S-	Mont. Admin. R. 24.174.903(1)	For refills, a pharmacist may counsel a patient, if the pharmacist deems it necessary.
PCE, PMR	S	Mont. Admin. R. 24.174.903(5)	Counseling is not required when a patient or caregiver declines it. A record of the refusal must be made.
PCE	L	Mont. Admin. R. 24.174.903(4)	Counseling is not required for patients in a hospital, institution or other setting where health professionals are authorized to administer medications.
SUP, DIS	S	Mont. Admin. R. 24.174.903(3)	Alternative forms of patient information may be used to supplement counseling when appropriate, including written information leaflets, pictogram labels and video programs.
PMR	S	Mont. Admin. R. 24.174.901	A pharmacist must make a reasonable effort to obtain, record, and maintain demographic and medical patient information, including a pharmacist's comments relevant to the individual's drug therapy, and any other information peculiar to the specific patient.

Nebraska

Type	Code	Provision	Description
DEF	S	Neb. Rev. Stat. Ann. § 38-2830	Patient counseling is defined to mean verbal communication by a pharmacist in a manner reflecting dignity and the right of the patient to information in order to improve therapeutic outcomes by maximizing proper use of prescription drugs and devices.
PCE	S	Neb. Rev. Stat. Ann. § 38-2869(2); 172 Neb. Admin. Code § 128-015.02	A pharmacist must provide a verbal offer to counsel the patient for each prescription, appropriate to the individual patient. Counseling must be provided in person whenever practical, or by telephone, at no cost to the patient.
PCE, PMR	S-	Neb. Rev. Stat. Ann. § 38-2869(2)(e); 172 Neb. Admin. Code § 128-015.03	Patient counseling must occur unless one of the following is documented: (1) patient refuses to be counseled; (2) pharmacist determines that counseling could harm or injure the patient; (3) drug is being administered by a health professional of a hospital or long-term care facility; or (4) if the prescribing provider asks to be contacted prior to counseling, in which case the pharmacist can decide whether to counsel the patient after the discussion with the provider.
SUP, DIS	S	Neb. Rev. Stat. Ann. § 38-2869(2)	Written information may be provided to supplement patient counseling but must not be used as a substitute for patient counseling.
GEN	S	172 Neb. Admin. Code § 128-015.04	When a pharmacist substitutes a generic drug, the pharmacist must advise the patient of the substitution. The patient or the patient's caregiver may refuse the substitution.
PMR	S	Neb. Rev. Stat. Ann. § 38-2869(1)	A pharmacist must ensure that a reasonable effort is made to obtain, record, and maintain demographic and medical patient information, including any comments of a pharmacist relevant to the patient's drug therapy.

Nevada

Type	Code	Provision	Description
PCE	S	Nev. Rev. Stat. Ann. § 639.266	After receipt of a prescription, a pharmacist must communicate with the patient information that will enhance the drug therapy.
PCE, PMR	S	Nev. Admin. Code § 639.707	A pharmacist must provide oral counseling to a patient or a person caring for the patient for each new prescription. The pharmacist must record that the counseling services were provided, unless the prescription drug was a refill or the patient refuses the counseling.
PCE	S-	Nev. Admin. Code § 639.707(1)	For refill prescriptions, the pharmacist or intern must verbally provide counseling if, in the professional judgment of the pharmacist or intern, such information would advance or improve the drug therapy of the patient, or a reasonable concern relating to the safety or efficacy of the drug therapy of the patient was raised by the review of the patient's record.
PCE	S	Nev. Admin. Code § 639.707 (5)	Counseling is not required if the patient or a person caring for the patient refuses the counseling.
PCE	L	Nev. Rev. Stat. Ann. § 639.266; Nev. Admin. Code § 639.707	Counseling is not required for persons who are patients in a hospital or health care facility where other licensed medical providers are authorized to administer the drugs.
OSM, DIS	S	Nev. Rev. Stat. Ann. § 639.266; Nev. Admin. Code §§ 639.707(3), 639.708(4)	If the prescription is going be mailed or delivered, the counseling information must be provided through written information that explains that the patient should read the information before taking the medication, as well as instructions about how and when to reach a pharmacist by telephone.
OSM, LAB	S	Nev. Rev. Stat. Ann. § 639.23286; Nev. Admin. Code § 639.708(3)	A pharmacy that delivers out-of-state or provides pharmacy services by mail must provide toll-free telephone service for its customers to a pharmacist who has access to the patient records during business hours. The service must be available for at least 5 days per week and at least 40 hours per week. The toll-free telephone number must be on the label on each container of drugs dispensed.
SUP, DIS	S	Nev. Rev. Stat. Ann. § 639.266	Additional information may be used to supplement counseling when appropriate, including leaflets, pictogram labels and video programs.
GEN	S	Nev. Rev. Stat. Ann. § 639.2583	Before a pharmacist dispenses a generic substitute, the pharmacist must advise the patient that the pharmacist intends to substitute a generic drug and that the patient may refuse to accept the substitution unless the pharmacist is being paid for the drug by a government agency.
GEN	S-	Nev. Rev. Stat. Ann. § 639.2583	If the pharmacist is being paid for by a governmental agency, the pharmacist must dispense the generic drug in substitution for the brand name drug, unless the prescribing provider has indicated that no substitution should take place.
PST	S	Nev. Rev. Stat. Ann. §§ 639.2802, 639.28025	A pharmacist or practitioner who dispenses drugs must make prescription drug prices available, upon request, and must notify customers that they can ask for this information by posting a sign in a conspicuous place that is easily accessible and readable by customers.
PMR	S	Nev. Admin. Code § 639.708	To facilitate counseling regarding a prescription, a pharmacy must make a reasonable effort to obtain, maintain, and retain demographic and medical information including any comments relevant to the drug therapy of the patient, and any other information that is specific to the patient.

New Hampshire

Type	Code	Provision	Description
PCE	S	N.H. Code Admin. R. Ph. 706.03	For a new prescription, a pharmacist must orally offer patient counseling. Counseling is also required to be provided by HMOs, mail-order pharmacies, hospital pharmacies providing out-patient prescriptions, and institutions providing inpatient services for persons who are discharged with prescription drugs.
PCE, PMR	S	N.H. Code Admin. R. Ph. 706.03(f)	Counseling is not required if a patient refuses a consultation. If a pharmacist does not record that a patient refused the consultation, it will be inferred that the counseling was provided.
PCE	L	N.H. Code Admin. R. Ph. 706.03	Counseling is not required for patients in a hospital, penal institution, or long-term care facility where administration of drugs is provided.
GEN	S	N.H. Code Admin. R. Ph. 704.06(e)	A pharmacist must advise the patient that the pharmacist is planning to substitute a generic drug and that the patient may refuse to accept the substitution.
OSM, LAB	S	N.H. Code Admin. R. Ph. 907.01	A mail-order pharmacy must provide for a toll-free telephone service to provide consultation between patients and a pharmacist at the mail-order pharmacy who has access to the patient's records. The toll-free telephone number must be on the label of each prescription drug container dispensed.
PCE	S	N.H. Code Admin. R. Ph. 404.06	A pharmacist must be available to provide counseling for proper use of perenterals and related supplies (food and drugs that enter the body other than through the digestive track, i.e. by injection or infusion).
DIS	S	N.H. Code Admin. R. Ph. 1001.04, 1001.05, 1001.06	A pharmacist must provide each patient seeking emergency contraception (EC) with an informed consent form developed by the Board of Pharmacy. After a patient has read and/or reviewed the statements on the informed consent form with the pharmacist, both the patient and the pharmacist must sign the form. A licensed pharmacist must conduct a patient assessment specific to EC. When dispensing EC, a pharmacist must also distribute a standardized fact sheet developed by the board.
SUP, DIS	S	N.H. Code Admin. R. Ph. 706.03(c)	Alternative forms of patient information may be used to supplement patient counseling, including written information leaflets, pictogram labels or video programs.
PMR	S	N.H. Code Admin. R. Ph. 706.01	The pharmacist must make a reasonable effort to obtain, maintain, and retain demographic and medical patient information, including a pharmacist's comments relevant to the drug therapy and any other information that is specific to the patient.

New Jersey

Type	Code	Provision	Description
PCE	S	N.J. Stat. Ann. § 45:14-67; N.J. Admin. Code § 13:39-7.19(e)	A pharmacist must offer to counsel a patient with a new prescription. When patient profile records indicate sporadic, erratic or irrational use of medication by a patient, the pharmacist must consult with the patient and/or the prescriber to determine if continued use is appropriate.
PCE, PMR	S	N.J. Admin. Code § 13:39-7.19(e)(3)	Counseling is not required if the patient or caregiver refuses it. The pharmacist must document if the patient has refused the pharmacist's offer to counsel. The absence of any record of a refusal of the pharmacist's offer to counsel must be presumed to signify that the offer was accepted and that the counseling was provided.
PCE	L	N.J. Admin. Code § 13:39-7.19(e)	Counseling is not required if the patient is receiving services in a hospital or long-term care facility where the patient is provided with 24-hour nursing care.
OSM, DIS	S	N.J. Admin. Code § 13:39-7.19(e)(4)	If the patient or caregiver is not present at the time of dispensing, the offer to counsel must be made by telephone or in writing on a separate document accompanying the prescription.
OSM, LAB	S	N.J. Stat. Ann. § 45:14-73	Non-resident pharmacies must provide a toll-free telephone service during its regular hours of operation, but not less than 6 days per week, and for a minimum of 40 hours per week, to facilitate communication between patients and a pharmacist who has access to the patient's records. This toll-free number must be on a label on each container of drugs dispensed.
PMR	S	N.J. Stat. Ann. § 45:14-68	Each pharmacy must maintain a patient profile record system containing patient medication information including the individual history, if significant, and any additional comments relevant to the patient's drug use.
OTH	S	N.J. Stat. Ann. § 17B:26-2.1i(6); N.J. Stat. Ann. § 17B:27-46.1i; N.J. Stat. Ann. § 17:48-6j; N.J. Stat. Ann. § 17:48A-7i; N.J. Stat. Ann. § 17:48E-35.7; N.J. Stat. Ann. § 26:2J-4.7(6)	A pharmacy must not impose any additional charges for patient counseling, or for other services required by state or federal regulations regarding individual health insurance, group health insurance, hospital pharmacies, medical services corporations, health service corporations, and HMOs.

New Mexico

Type	Code	Provision	Description
PCE	S	N.M. Code R. § 16.19.4.16E(1)	A pharmacist must personally offer counseling upon receipt of a new prescription drug order. A pharmacist must not circumvent or willfully discourage a patient from receiving counseling.
PCE	S-	N.M. Code R. § 16.19.4.16E(1)	For refill prescriptions, a pharmacy technician may ask the patient if he/she would like to obtain counseling from the pharmacist.
PCE	S	N.M. Code R. § 16.19.4.16E(5)	Counseling is not required when a patient has refused a consultation.
PCE	L	N.M. Code R. § 16.19.4.16E(4)	Counseling is not required for patients in a hospital or other institution where licensed professionals are authorized to administer the drugs.
OSM, DIS	S	N.M. Code R. § 16.19.4.16(E)(6)	If the patient is not present when the prescription is dispensed, the pharmacist must include written notice of available counseling. The notice must include: (1) the days and hours of availability; (2) the patient's right to request counseling; and (3) a toll-free telephone number in which the patient may obtain oral counseling from a pharmacist who has ready access to the patient's records. For pharmacies delivering more than 50 percent of their prescriptions by mail or other common carrier, the hours of availability must be at least 60 hours per week and not less than 6 days per week. The facility must have sufficient toll-free phone lines and personnel to provide counseling within 15 minutes.
OSM, LAB	S	N. M. Stat. Ann. § 61-11-14.1B	A nonresident pharmacy must provide a toll-free telephone service to facilitate communication between patients and a pharmacist who has access to the patient's records. The toll-free telephone service must operate during the pharmacy's regular hours of operation, but not less than 6 days a week and for a minimum of 40 hours a week. The toll-free telephone number must be on a label on each container that is dispensed.
SUP, DIS	S	N.M. Code R. § 16.19.4.16E(3)	Alternative forms of patient information, such as written information leaflets, pictogram labels and video programs may be used to supplement patient counseling when appropriate.
PST	S	N.M. Code R. § 16.19.4.16E(7)	Each pharmacy is required to prominently post a notice concerning available counseling that must be in a conspicuous location and readable by prescription drug consumers.
PMR	S	N.M. Code R. § 16.19.4.16C	Each pharmacist must make a reasonable effort to obtain, record, and maintain demographic and medical patient information that includes a pharmacist's comments relevant to the individual's drug therapy.

New York

Type	Code	Provision	Description
PCE	S	N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6(b)(8)(i)(a)	A pharmacist is required to counsel each patient prior to dispensing a prescription for the first time for a new patient, or a prescription for a new medication for an existing patient.
PCE	S-	N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6(b)(8)(i)(d)	For refill prescriptions, a pharmacist must be available to provide counseling upon request.
PCE, PMR	S	N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6 (b)(8)(i)(c)	Counseling is not required if a patient refuses counseling. The refusal must be documented in the records of the pharmacy.
PCE	S	N.Y. Comp. Codes R. & Regs. tit. 9, § 9800.1	To participate in New York's Program for Elderly Pharmaceutical Insurance Coverage (EPIC), a pharmacy providing prescription services must offer counseling to each patient.
PCE	S	N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6 (b)(8)(ii)(d)	If the pharmacist determines that there are potential drug therapy problems that could endanger the health of the patient, such as drug-drug interactions, the pharmacist must personally contact the patient by telephone or through an in-person, face-to-face meeting to offer counseling.
PCE	S	N.Y. Soc. Serv. Law § 367-a(h)	The Commissioner of Health is authorized to establish a medication therapy management pilot program in parts of the state for the purpose of improving compliance with drug therapies and improving clinical outcomes. Payments under such a program may be made to retail pharmacies for the provision of one-on-one medication counseling services for persons determined by the commissioner to be eligible to receive such services. The commissioner is authorized to establish fees for such counseling services.
OSM, DIS	S	N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6 (b)(8)(ii)	If a prescription is delivered off the pharmacy premises, the pharmacist must provide a written offer of counseling and a toll-free telephone number at which a pharmacist may be readily reached.
OSM, LAB	S	N.Y. Educ. Law § 6808-b	Nonresident pharmacies must provide a toll-free telephone number during normal business hours and at least 40 hours per week, to enable communication between a patient and a pharmacist at the pharmacy who has access to the patient's records, and place the toll-free telephone number on a label on each drug container.
MIS, LAB	S	N.Y. Educ. Law § 6815(2)(c)	A drug is misbranded if any information required to appear on the label is not prominently placed with such conspicuousness and in a manner that it is likely to be read and understood by the ordinary individual.
GEN, DIS	S	N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6 (b)(8)(ii)(c)	When substituting a generic equivalent by mail or delivery, the pharmacist must include with each prescription written notification that clearly advises the patient that a prescriber-approved alternative drug has been dispensed. The pharmacist must also, under some circumstances, make a reasonable effort to contact the patient by telephone to personally offer counseling.
DIS	S	N.Y. Comp. Codes R. & Regs. tit. 10, § 80.137 (d)(1)(iii)	A pharmacy authorized to prescribe the use of hypodermic needles or syringes to patients must include a safety information brochure for the purchaser at the point of sale. The safety brochure must be developed or approved by the Commissioner of Health.
PMR	S	N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6(b)(7)	Each pharmacist must maintain patient medication profiles, including patient demographic and medical information appropriate for counseling the patient.

North Carolina

Type	Code	Provision	Description
DEF	S	21 N.C. Admin. Code 46.2504	Patient counseling is the effective communication of information to the patient in order to improve therapeutic outcomes by maximizing proper use of prescription medications and devices.
PCE	S	21 N.C. Admin. Code 46.2504	An oral offer to counsel must be made on new or transfer prescriptions at the time the prescription is dispensed to the patient in the pharmacy. An offer to counsel must be communicated in a positive manner to encourage acceptance.
PCE	S-	21 N.C. Admin. Code 46.2504	For refills, a pharmacist may offer to counsel a patient, depending on the pharmacist's professional judgment.
PCE	S	21 N.C. Admin. Code 46.2504	Patient counseling is required for patients in outpatient settings, discharge from hospitals, health maintenance organizations, health departments and other institutions.
PCE	L	21 N.C. Admin. Code 46.2504	Counseling is not required for patients in hospitals or other institutions where a nurse or other licensed health care professional administers medications.
RPL, DIS	S-	21 N.C. Admin. Code 46.2504	Offers to counsel and patient counseling for inmates need not be in person, but rather, may be conducted through a correctional or law enforcement officer or through printed material.
PCE	S	21 N.C. Admin. Code 46.2507	When pharmacists administer vaccines, the pharmacist or pharmacist's agent must give the appropriate, most current vaccine information to the patient with each dose of vaccine. The pharmacist must ensure that the patient is available and has read, or has had read to him/her, the information provided and has had the patient's questions answered prior to administering the vaccine.
OSM	S	21 N.C. Admin. Code 46.2504	When delivery occurs outside of the pharmacy, by mail, delivery or other means, the offer must be made either orally and in person, or by telephone from the pharmacist to the patient. The pharmacist must provide the patient with access to a telephone service that is toll-free for long-distance calls.
RPL, DIS	S	21 N.C. Admin. Code 46.2504	Counseling may be conducted by the provision of written information in a language other than English, if requested by the patient or representative.
SUP	S	21 N.C. Admin. Code 46.2504	Alternative forms of patient information may be used to supplement patient counseling.
PMR	S	21 N.C. Admin. Code 46.2504	To counsel patients effectively, a pharmacist must make a reasonable effort to obtain, record, and maintain demographic and medical patient information, including comments relevant to the individual's drug therapy.

North Dakota

Type	Code	Provision	Description
PCE, PST	S	N.D. Admin. Code 61-04-07-01	Under a Pharmacy Patient's Bill of Rights, the patient has a number of enumerated rights, including: to be treated with dignity, consistent with professional standards, regardless of manner of payment, race, nationality, or other discriminatory factors; and to receive patient counseling, using the methods appropriate to the patient's physical, psychosocial, and intellectual status. The Bill of Rights must be posted prominently within each pharmacy such that it is readily visible to the patient.
PCE, DIS, SUP	S	N. D. Cent. Code § 43-15-31.2	For each prescription dispensed, the pharmacist must explain to the patient the directions for use and a warning of the potential harmful effect of combining any form of alcoholic beverage with the medication, and any additional information, in writing if necessary, to assure the proper use of the medication.
PCE	L	N.D. Cent. Code § 43-15-31.2	Counseling by telephone or writing is not required for prescriptions for patients in hospitals or institutions where the medication is administered by an individual licensed to administer medications, or to patients who are to be discharged from a hospital or institution.
GEN	S	N.D. Cent. Code § 19-02.1-14.1	The pharmacist must inform the patient when a pharmacist is intending to substitute the brand name drug for generic equivalent, and inform the patient of his/her right to refuse the generic drug.
OSM DIS	S	N.D. Cent. Code § 43-15-31.2	For prescriptions delivered outside the pharmacy, counseling must be provided by telephone or in writing.
OSM, LAB	S	N.D. Admin. Code 61-08-01-10	Out-of-state pharmacies must provide accessible telephone counseling during regular working hours. The pharmacy's telephone number must be on the prescription container. Telephone counseling must be provided consistent with the standard of due care.
REM	S	N.D. Admin. Code 61-02-08-02, 61-02-08-03	A telepharmacy system is a central pharmacy with one or more remote sites in which all sites are connected via computer link, videolink, and audiolink. Pharmacists must counsel patients on all new prescriptions and refills by using the video and audio link systems.
PMR	S	N.D. Cent. Code § 43-15-31.1	Pharmacists are required to record and maintain demographic and medical patient information, including any idiosyncrasies of the patient communicated by the patient to the pharmacy.
COC	S	N.D. Admin. Code 61-04-04-01(16)	It is considered unprofessional conduct for a pharmacist to discriminate in any manner between patients or groups of patients for reasons of race, creed, color or national origin.

Ohio

Type	Code	Provision	Description
PCE	S	Ohio Admin. Code 4729:5-22(A)	Pharmacists must offer to counsel patients for new and refill prescriptions.
PCE, PMR	S	Ohio Admin. Code 4729:5-22(A)	No counseling is required when the patient refuses an offer to counsel, does not respond to the written offer to counsel, or is a patient in an institutional facility. When counseling is refused, the pharmacist must ensure that the refusal is documented in the presence of the patient or caregiver.
OSM, DIS	S	Ohio Admin. Code 4729:5-22(A)	If the patient or caregiver is not physically present, the offer to counsel must be made by telephone or in writing on a separate document that accompanies the prescription. A written offer to counsel must include the hours a pharmacist is available and a telephone number where a pharmacist may be reached.
SUP, DIS	S	Ohio Admin. Code 4729:5-22(C)	Alternative forms of information may be used when appropriate to supplement the counseling by the pharmacist, including drug product information leaflets, pictogram labels and video programs.
PMR	S	Ohio Admin. Code 4729:5-18	A pharmacist must make a reasonable effort to obtain, record, and maintain patient profiles including patient demographic and medical information including pharmacist's comments and other necessary information unique to the specific patient.

Oklahoma

Type	Code	Provision	Description
PCE	S	Okla. Admin. Code § 535:10-9-2(1)	For new prescriptions, a pharmacist must offer to counsel a patient.
PCE	S-	Okla. Admin. Code § 535:10-9-2(1)	For refills or in additional situations, a pharmacist may offer to counsel a patient, when deemed appropriate in the pharmacist's professional judgment.
PCE	S	Okla. Admin. Code § 535:10-9-2(1)	Counseling requirements apply to outpatient pharmacies in hospitals and patients being discharged from the hospital with a prescription medication.
PCE, PMR	S	Okla. Admin. Code § 535:10-9-2(2), (6)	Patient counseling is not required if a patient refuses the consultation. The absence of a record of a patient's refusal will be presumed to signify that the offer to counsel was accepted and counseling was provided.
PCE	L	Okla. Admin. Code § 535:10-9-2(5)	Patient counseling is not required for patients in hospitals or other institutions where other health care professionals administer the drugs.
OSM	S	Okla. Admin. Code § 535:10-9-2(7)	If a pharmacy is out-of-state or fills prescriptions that are mailed out of state, the pharmacy must make a reasonable effort to call patients and counsel by phone. A toll-free telephone number must be provided for patients to call and interact with a pharmacist.
SUP, DIS	S	Okla. Admin. Code § 535:10-9-2(3)	Alternative forms of information may be used to supplement patient counseling when appropriate. Examples of alternative information include written leaflets, pictogram labels and video programs.
PMR	S	Okla. Admin. Code § 535:10-9-2(2)	Pharmacists must make a reasonable effort to obtain, record and maintain demographic and medical patient information, including comments relevant to the patient's drug use.

Oregon

Type	Code	Provision	Description
PCE	S	Or. Admin. R. 855-019-0230(1)	A pharmacist must orally counsel the patient for new prescriptions and any changes in drug therapy. For each patient, the pharmacist must determine the amount of counseling that is reasonable and necessary to promote a safe and effective use of the medication, and promote an appropriate therapeutic outcome.
PCE	S-	Or. Admin. R. 855-019-0230(2)	For refills, a pharmacist should counsel a patient when a reasonable and prudent pharmacist would find it necessary to do so, including when there are changes in strength or directions for the drug.
PCE	S	Or. Admin. R. 855-019-0230(5)	A pharmacist must ensure there is patient counseling when a patient is discharged from the hospital with a prescription.
PCE, PMR	S	Or. Admin. R. 855-019-0230(1)(b), (c)	Counseling is not required if the patient refuses it. However, if the patient requests not to be counseled and the pharmacist believes that the patient's safety may be affected, the pharmacist may choose not to release the prescription until counseling has been completed. A pharmacist must record that he/she has provided counseling or the patient has refused to be counseled.
RPL	S-	Or. Admin. R. 855-019-0230(3)	A pharmacist can provide counseling in a form other than oral counseling when, in her professional judgment, another form of counseling would be more effective.
GEN, PST	S	Or. Rev. Stat § 689.515(4)	Every pharmacy must post an easy-to-see sign that states that the pharmacy may substitute a less expensive drug that is therapeutically equivalent, unless the patient does not approve. If a pharmacist has reason to believe that a customer cannot read or understand the sign, the pharmacist must try to explain the meaning of the sign to the patient.
OSM, DIS	S	Or. Admin. R. 855-019-0230(1)(e)	For prescriptions delivered outside of the pharmacy, the pharmacist must dispense written information that includes information about the drug, an offer to provide oral counseling, as well as how to contact the pharmacist.
PMR	S	Or. Admin. R. 855-041-0060(5)	Pharmacists must make a reasonable effort to obtain, record, and maintain a patient demographic and medical information, including pharmacist's comments relevant to the individual's drug therapy and any other information peculiar to the specific patient.

Pennsylvania

Type	Code	Provision	Description
PCE	S	49 Pa. Code § 27.19(e)(1)	A pharmacist must make an offer to counsel whenever he fills a new retail or outpatient prescription.
RPL, DIS	S-	49 Pa. Code § 27.19(e)(2)	If the patient comes to the pharmacy, the offer to counsel must be made orally, unless the pharmacist believes that a written offer would be more effective, in which case a written offer can be used. If the patient is not an English speaker, a pharmacist can substitute a written offer. A written offer to counsel must include the phone number of the pharmacy.
PCE, PMR	S	49 Pa. Code § 27.19(h)	A pharmacist is not required to counsel a person who refuses a consultation. The pharmacist must document the refusal of a patient to accept counseling or provide information.
PCE	L	49 Pa. Code § 27.19(d)	A pharmacist is not required to counsel a person who is a patient in an institution or emergency room, or receives a prescription drug from a medical practitioner.
OSM, DIS	S	49 Pa. Code § 27.19(e)(3)	If the patient does not come to the pharmacy, the offer to counsel must be made by: (1) the pharmacist telephoning the patient; (2) the pharmacy delivery person orally makes the offer to the patient; or (3) the pharmacist sends a written offer with the filled prescription to the patient. A pharmacy must provide toll-free telephone service if its primary patient population is beyond the local exchange.
OSM, DIS	S	49 Pa. Code § 27.19(e)(6)	A mail order pharmacy must make the offer to counsel either by phone or by sending a written offer together with the filled prescription. The written offer must include a toll-free telephone number for the pharmacy that the patient can use to obtain counseling.
GEN	S	35 Pa. Cons. Stat. Ann. § 960.3(b); 28 Pa. Code § 25.55(a)	When a generic substitution occurs, the pharmacist must notify the patient of the substitution with the amount of the price difference and must inform the patient that he/she may refuse the substitution. The notification can be oral or written.
PMR	S	49 Pa. Code § 27.19(g)	A pharmacist must make a reasonable effort to obtain, record, and maintain a significant amount of demographic and medical information, including a pharmacist's comments relative to the individual's drug therapy.

Rhode Island

Type	Code	Provision	Description
PCE	S	14-130-001 R.I. Code R. § 13.16	Upon receiving a new prescription, the pharmacist must provide counseling to patients.
PCE	S-	14-130-001 R.I. Code R. § 13.16	For refills, the pharmacist may counsel a patient, when deemed necessary in the professional judgment of the pharmacist.
PCE, PMR	S	14-130-001 R.I. Code R. § 13.19	Patient counseling is not required when a patient refuses the consultation. Such refusal must be documented in writing.
PCE	L	14-130-001 R.I. Code R. § 13.18	Patient counseling is not required for patients in hospitals or other institutions where other health care professionals administer the drugs.
GEN	S	R.I. Gen. Laws § 5-19.1-2(q)	A pharmacist must engage in appropriate communication with the patient before substituting a generic equivalent.
PCE, DIS	S	R.I. Gen. Laws § 5-19.1-309(c)	Upon request by a customer, each pharmacy must provide the current selling price for at least the top 10 selling maintenance prescription drugs, as determined by the Department of Health.
SUP, DIS	S	14-130-001 R.I. Code R. § 13.17	Alternative forms of patient information may be used to supplement patient counseling when appropriate. Examples include written information leaflets, pictogram labels and video programs.
PMR	S	14-130-001 R.I. Code R. § 13.12	A pharmacist must make a reasonable effort to obtain, record, and maintain patient demographic and medical information, including a pharmacist's comments relevant to the patient's drug therapy and any other information peculiar to the specific patient.

South Carolina

Type	Code	Provision	Description
PCE	S	S.C. Code Ann. § 40-43-86(L)	A pharmacist must offer patient counseling for new prescriptions. When practicable, these discussions must take place in person.
PCE	S	S.C. Code Ann. § 40-43-86(L)(4)	Patient counseling is not required when a patient has refused the consultation.
PCE	L	S.C. Code Ann. § 40-43-86(L)	Patient counseling is not required for patients in hospitals or institutions where other licensed healthcare principals are authorized to administer the drug.
PCE	S	S.C. Code Ann. § 40-43-88(N)	For sterile drugs distributed by a pharmacy and used in a home setting, if appropriate, the pharmacist must demonstrate or document the patient's training and competency in managing the therapy. The pharmacist must be involved in the patient training process. In addition, the pharmacist is responsible for seeing that the patient's competency in the above areas is reassessed on an ongoing basis.
GEN	S	S.C. Code Ann. § 40-43-86(H)(6)	Before generic substitution takes place, the pharmacist must advise the patient that the physician authorized the substitution and the patient must consent to substitution.
GEN	L	S.C. Code Ann. § 40-43-86(H)(6)	For generic substitution for Medicaid patients, no further consent is required. They are deemed to have consented to generic substitution.
SUP	S	S.C. Code Ann. § 40-43-86(L)	Alternative forms of patient information may be used to supplement patient counseling when appropriate.
PMR	S	S.C. Code Ann. § 40-43-86(J)(1)	Pharmacies must maintain a patient record system including patient demographic and medical information, including pharmacists' comments relevant to the individuals' drug therapy and other information peculiar to the specific patient.

South Dakota

Type	Code	Provision	Description
PCE	S	S.D. Codified Laws § 36-11-68	The pharmacist must offer to counsel the patient on each prescription.
PCE	S	S.D. Admin. R. 20:51:25:04	For new prescriptions, the pharmacist must orally counsel each patient whenever practicable.
PCE, RPL, DIS	S-	S.D. Admin. R. 20:51:25:04	For refills, pharmacists must offer to counsel each patient receiving a prescribed drug on matters that the pharmacist, in his/her professional judgment, deems significant. However, if there has been no change in the dosage, form, strength, or directions for use, the pharmacist may offer counseling to a patient in one or more of the following ways: face to face; by notation attached to or written on the bag in which the prescription is dispensed; or by telephone.
PCE	L	S.D. Codified Laws § 36-11-68	The pharmacist is not required to provide counseling for drugs administered to a patient in a health care facility or hospital, administered by a certified professional to outpatients of a hospital, or provided in less than a 72-hour supply upon discharge from a hospital.
OSM, RPL	S-	S.D. Admin. R. 20:51:25:04	If any drug is delivered or mailed, the pharmacist must initiate counseling by telephone. If the counseling cannot be completed by telephone, the pharmacist may use alternative forms of information.
RPL, DIS	S-	S.D. Admin. R. 20:51:25:05	When used to replace oral counseling, alternative forms of patient information must advise the patient that the pharmacist may be contacted in person at the pharmacy, by toll-free or collect telephone call.
SUP, DIS	S	S.D. Admin. R. 20:51:25:05	Alternative forms of patient information may also be used to supplement patient counseling. Alternative forms of patient information include written information leaflets, pictogram labels, video programs, or information generated by electronic data processing equipment.
OSM, LAB, DIS	S	S.D. Codified Laws § 36-11-19.8	A non-resident pharmacy must provide patients a written offer to consult and access to a toll-free telephone service to facilitate communications between the patient and the pharmacist. The toll-free service must be available for a minimum of 6 days a week and 40 hours a week. The number of the toll-free service must be printed on a label on each container of a prescription drug dispensed. Non-resident pharmacies must provide patients with written information about the medication on all new or changed prescriptions.
PCE	S	S.D. Admin. R. 20:51:26:10	If sterile products are provided to a patient in his/her home, the pharmacist must verify the patient's or caregiver's training and competence in managing therapy. The pharmacist must also be involved in training patients about drug storage and use. The pharmacist must verify that the patient's competence is reassessed at intervals appropriate to the condition of the patient and the type of drug therapy provided.
PMR	S	S.D. Admin. R. 20:51:24:02; S.D. Admin. R. 20:51:25:03; S.D. Codified Laws § 36-11-19.8	Pharmacists must make a reasonable effort to obtain, record, and maintain patient information, including the pharmacist's comments relevant to the individual's drug therapy and any other information peculiar to the specific patient or drug. Non-resident pharmacies must also obtain, record and maintain this same information.
PMR, PCE	S	S.D. Admin. R. 20:51:25:06	The pharmacist must record the failure to complete patient counseling in the following situations: patient or caregiver refusal to accept the pharmacist's personal oral counseling; counseling was impracticable; or counseling could not be accomplished by telephone contact. The absence of a record of counseling signifies that counseling was accepted and provided or that an offer was made.

Tennessee

Type	Code	Provision	Description
PCE	S	Tenn. Comp. R. & Regs. 1140-3-.01.(1)(a)	Upon receipt of a new prescription order, a pharmacist must personally counsel the patient face-to-face if the patient is present in the pharmacy.
PCE	S-	Tenn. Comp. R. & Regs. 1140-3-.01.(1)(f)	For refills, pharmacists must offer to personally counsel the patient. Counseling is not required unless requested by the patient or deemed necessary in the professional judgment of the pharmacist. [Note: while seemingly inconsistent, this is an accurate summary of the regulation.]
PCE	S	Tenn. Comp. R. & Regs. 1140-3-.01.(1)(c),(d)	Patient counseling is required for persons who are obtaining outpatient services from hospitals or other institutional facilities, and for patients who are prescribed medication upon discharge from a hospital or other institutional facility.
PCE	S	Tenn. Comp. R. & Regs. 1140-3-.01.(1)(g)	Counseling is not required when a patient refuses counseling.
PCE	L	Tenn. Comp. R. & Regs. 1140-3-.01.(1)(d)	Counseling is not required for patients in an institutional facility.
OSM	S	Tenn. Comp. R. & Regs. 1140-3-.01.(1)(a)	If the patient or caregiver is not present, pharmacists must make a reasonable effort to counsel through alternative means.
SUP	S	Tenn. Comp. R. & Regs. 1140-3-.01.(1)(b)	Alternative forms of communication may be used to supplement, but not replace face-to-face patient counseling.
PMR	S	Tenn. Comp. R. & Regs. 1140-3-.01.(2); Tenn. Code Ann. § 63-10-204(27)	A pharmacist must make a reasonable effort to obtain, record, and maintain demographic and medical patient information, including a pharmacist's comments, as deemed relevant by the pharmacist.

Texas

Type	Code	Provision	Description
PCE	S-	22 Tex. Admin. Code § 291.33(c)(1)	A pharmacist must provide oral patient counseling in-person with each new prescription and upon request by the patient when a patient is present in the pharmacy, unless a specific communication barrier prohibits such oral communication. For a refill, a pharmacist must offer written information to a patient about the prescription, including that the pharmacist is available to discuss the prescription wit the patient.
PCE, PMR	S	22 Tex. Admin. Code § 291.33(c)(1)	Effective June 1, 2010, counseling must be documented in the dispensing record.
PCE, PMR	S	22 Tex. Admin. Code § 291.33(c)(1)	Counseling is not required for patients who refuse a consultation. A pharmacist must document a refusal of consultation.
PCE, DIS	S	25 Tex. Admin. Code § 414.404	The registered pharmacist, treating physician, registered nurse, licensed vocational nurse, or physician's assistant must explain to the patient receiving mental health services and the patient's legally authorized medical representative information regarding the medication and treatment in simple, nontechnical language in the person's primary language, if possible. Consent to treatment with psychoactive medications is required. The patient must also be provided a summary of the information in writing, along with an offer to answer any questions concerning the treatment.
GEN, DIS, PST	M	22 Tex. Admin. Code § 309.4(a)	Before dispensing a generically equivalent drug, a pharmacist must inform the patient that a less expensive generically equivalent drug is available for the brand prescribed, and ask the patient to choose between the generic and the brand prescribed. The pharmacist must display in a prominent place in clear public view a sign in both English and Spanish that explains generic substitution notification process, including that the patient has a right to accept or refuse the generic substitution.
GEN, OSM, DIS	S	22 Tex. Admin. Code § 309.4(c)	Pharmacies that supply prescriptions by mail are considered to have complied with the generic substitution notification rules if they include written information that gives the patient the opportunity to choose a generic or brand name drug and a place for the patient to indicate his/her choice. If the patient does not indicate a choice, the pharmacy may dispense the generic.
OSM	S	Tex. Occ. Code Ann. § 562.104 22 Tex. Admin. Code 22 § 291.33(c)(1)	If prescriptions are routinely delivered outside of the area covered by the pharmacy's local telephone service, the pharmacy must provide a toll-free telephone number that is answered during normal business hours to enable communication between a patient and a pharmacist who has access to the patient's records.
OSM, DIS, LAB	M	22 Tex. Admin. Code 22 § 291.33(c)(1)	If prescriptions are delivered to the patient, written information must be issued with the prescription. The pharmacist must place on the prescription container or on a separate sheet delivered with the prescription container in both English and Spanish the local and/or toll-free telephone number of the pharmacy and the statement, "Written information about this prescription has been provided for you. Please read this information before you take the medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer these questions at [telephone number]."
DIS	S	Tex. Occ. Code Ann. § 562.0061	The Board must adopt regulations regarding the information a pharmacist must provide to a consumer when dispensing a prescription for self-administration. The information must be written in plain language and printed in an easily readable font size.
DIS	S	22 Tex. Admin. Code § 291.33(c)(1)	Effective June 1, 2010, counseling must be reinforced with written information relevant to the prescription and provided to the patient or patient's agent. It must be in plain language designed for the consumer and printed in easily readable font size.

Texas continued

Type	Code	Provision	Description
PST	M	22 Tex. Admin. Code § 291.33(c)(1)	Pharmacies must post a sign of a certain size in clear public view at all locations in the pharmacy where patients pick up prescriptions. The sign must contain in both English and Spanish in a font that is easily readable: "Do you have questions about your prescription? Ask the pharmacist."
DIS	S	22 Tex. Admin. Code § 291.131(d)(6), (d)(8)	Written drug information about the compounded prescription or its major active ingredients must be given to the patient at the time of dispensing. If there is no written information available, the patient should be advised that the drug has been compounded and how to contact a pharmacist concerning the drug.
PMR	S	22 Tex. Admin. Code § 291.34(c)	Pharmacists must make a reasonable effort to obtain, record, and maintain demographic and medical patient information including pharmacist's comments relevant to the individual's drug therapy and other information unique to the specific patient.

Utah

Type	Code	Provision	Description
PCE	S	Utah Code Ann. § 58-17b-613	Every pharmacy facility is required to orally offer to counsel a patient in a face-to-face discussion for each prescription dispensed, if the patient is present in the pharmacy.
PCE, OSM	S-	Utah Admin. Code r. §58-17b-610	Counseling must be provided to a patient with each new prescription drug order, once yearly on maintenance medications, and if the pharmacist deems appropriate with prescription drug refills. Counseling must be communicated verbally in person unless the patient is not at the pharmacy or a specific communication barrier prohibits such verbal communication.
PCE, PMR	S	Utah Admin. Code r. §156-17b-610(4)	The offer to counsel must be documented and must be available to the Division of Occupational and Professional Licensing.
RPL, DIS	S-	Utah Code Ann. § 58-17b-613	For incarcerated patients, a written communication must be used for patient counseling, in lieu of face-to-face or telephonic communication.
PCE, PMR	S	Utah Admin. Code r. 156-17b-610(3)	A pharmacist is not required to provide counseling when the patient refuses such consultation.
PCE	L	Utah Admin. Code r. 156-17b-610(2)	A pharmacist is not required to provide counseling for patients in a hospital or institution where other licensed health care professionals are authorized to administer the drugs.
OSM, DIS	S	Utah Code Ann. § 58-17b-613; Utah Admin. Code r. 156-17b-610	If the prescription is delivered to a patient outside of the pharmacy, a pharmacist is required to provide counseling to each patient. The counseling information must be delivered with the drugs in writing. The pharmacy must provide the patient with a toll-free telephone number by which the patient may reach the pharmacist during normal business hours to receive oral counseling and a statement informing the patient to call the pharmacy to reach a pharmacist to answer any questions about the prescription.
GEN, OSM, DIS	S	Utah Code Ann. § 58-17b-605	A pharmacist may substitute a generic drug equivalent for a brand name drug, if the pharmacist counsels the patient about the prescription and the patient consents to the substitution, among other requirements. An out-of-state mail service pharmacy that is substituting a generic equivalent drug for a brand name drug must inform the patient of the substitution either by telephone or in writing.
PMR	S	Utah Admin. Code r. 156-17b-609	Pharmacists are required to obtain demographic and medical patient information, including any comments relevant to the patient's drug use.
COC	S	Utah Admin. Code r. 156-17b-502; Utah Admin. Code r. 156-17b-402(39)	Unprofessional conduct includes failure to offer to counsel a person receiving a prescription medication. Administrative penalties in disciplinary proceedings are set forth for pharmacists, including for individual personnel when there is a failure to offer to counsel for an initial offense and a subsequent offense. There is a penalty on the pharmacy for failure to offer to counsel per occurrence.

Vermont

Type	Code	Provision	Description
DEF	S	04-030-230 Vt. Code R. § 19.10.1	Patient counseling is defined as the effective oral consultation by the pharmacist with a patient.
PCE	S-	04-030-230 Vt. Code R. § 19.10.2	Pharmacists may initiate a discussion with patients for each prescription drug order submitted.
PCE, PMR	S	04-030-230 Vt. Code R. § 19.10.6	A pharmacist is not required to provide counseling when the patient refuses such consultation and that refusal is documented.
PCE	L	04-030-230 Vt. Code R. § 19.10.5	Patient counseling is not required for patients in a hospital or institution where other licensed health care professionals are authorized to administer the drugs.
RPL, SUP, DIS	S-	04-030-230 Vt. Code R. § 19.10.3	Alternative forms of patient information may be used to replace counseling in an emergency when in-person counseling is not possible. Alternate forms may also be used to supplement patient counseling when appropriate. These alternate forms may include written information leaflets, pictogram labels and video programs.
PMR	S	04-030-230 Vt. Code R. § 19.8.1	A pharmacist must maintain a patient record system, which should include demographic and medical patient information, and a pharmacist's comments relevant to the patient's drug therapy, including any other information peculiar to the patient.

Virginia

Type	Code	Provision	Description
PCE, RPL, PST, DIS, LAB	S	Va. Code Ann. § 54.1-3319(B)	Pharmacists must offer to counsel each person who presents a new prescription. The offer to counsel may include any one or a combination of the following: face-to-face communication with the pharmacist; a sign posted so that that it can be seen by patients; a notation attached to or written on the bag in which the prescription is to be delivered; a notation on the prescription container; or by telephone.
PCE	S-	Va. Code Ann. § 54.1-3319(B)	For refills, a pharmacist may offer to counsel to the extent deemed appropriate by the pharmacist.
PCE	S	Va. Code Ann. § 54.1-3319(C)	A pharmacist is not required to provide counseling when the patient refuses the pharmacist's offer to counsel.
PCE	L	Va. Code Ann. § 54.1-3319(C)	A pharmacist is not required to provide counseling for a drug dispensed to a patient in a hospital or nursing home.
GEN, LAB, PMR	S	Va. Code Ann. § 54.1-3408.03(C)	If the pharmacist substitutes a generic equivalent, the pharmacist must inform the patient of the substitution. The pharmacist must also note the substitution in the record and on the label of the prescription container.
OSM	S	Va. Code Ann. § 54.1-3319(C)	If the prescription is delivered to a person residing outside of the local telephone calling area of the pharmacy, the pharmacist must either provide a toll-free or local telephone number, or accept reasonable collect calls from patients.
OSM, LAB	S	Va. Code Ann. § 54.1-3434.1(B)	Any non-resident pharmacy must, during its regular hours of operation, but not less than 6 days per week and for a minimum of 40 hours per week, provide a toll-free telephone service to facilitate communication between patients and a pharmacist at the pharmacy who has access to the patient's records. This toll-free number must be on a label on each container of drugs dispensed to patients in the Commonwealth.
OSM, DIS	S	Va. Code Ann. § 54.1-3420.2	A pharmacy that mails or delivers prescriptions must issue written information with the prescription that provide a toll-free telephone number designed to respond to consumer questions concerning chemical degradation of the drugs.
PMR, PCE	S	Va. Code Ann. § 54.1-3319(D); 12 Va. Admin. Code § 30-130-310	A pharmacist must make reasonable efforts to obtain, record, and maintain patient demographic and medical information including comments relevant to the patient's drug use. A pharmacy must also record any refusal of the pharmacist's offer to counsel.

Washington

Type	Code	Provision	Description
PCE	S	Wash. Admin. Code § 246-869-220	The pharmacist must directly counsel the patient on the use of drugs or devices for every prescription.
PCE	L	Wash. Admin. Code § 246-869-220	Counseling is not required when a medication is to be administered by a licensed health professional authorized to administer medications.
GEN, PST	S	Wash. Rev. Code § 69.41.160	Each pharmacy must post a sign in a location that is readily visible to patients: stating that a less expensive, but equivalent drug may be dispensed to a patient and suggesting a patient consult a pharmacist or doctor for more information.
OSM, DIS	S	Wash. Admin. Code § 246-869-220	For prescriptions delivered outside of the pharmacy, the pharmacist must make a written offer to provide counseling and information about the drug, including information about how to contact the pharmacist.
OSM, LAB	S	Wash. Rev. Code § 18.64.360	Non-resident pharmacies must provide a toll-free telephone service to facilitate communication between patients and a pharmacist. The telephone number must be on the label of each drug container.
PMR	S	Wash. Admin. Code § 246-875-020; Wash. Admin. Code § 246-875-030	Patient-automated and manual medical records must be maintained, and include demographic and medical information and any patient idiosyncrasies that may relate to drug utilization.

West Virginia

Type	Code	Provision	Description
PCE, RPL, DIS, PMR, COC	S-	W. Va. Code R. § 15-1-19.13.6	The rules of professional conduct require an oral offer to counsel be made by the pharmacist with each new prescription unless, in the professional judgment of the pharmacist, it is considered inappropriate. In those instances, a written communication, by telephone, in person, or in a manner determined by the pharmacist to be appropriate, may be used. The exercise of and reasons for this judgment must be documented. An offer to counsel has not been made by a mere question of whether the patient has any questions.
PCE, PMR	S	W. Va. Code R. § 15-1-19.13.6(b)	The pharmacist is not required to provide counseling if the patient does not accept the offer to counsel. If counseling is refused it must be documented.
PCE	L	W. Va. Code R. § 15-1-19.13.6(b)	Patient counseling is not required for patients in a hospital or institution where other licensed health care workers are authorized to administer the drugs.
GEN	S	W. Va. Code R. § 15-7-5	A pharmacist who substitutes any drug must notify the person presenting the prescription of such substitution. The person presenting the prescription must have the right to refuse the substitution.
PMR	S	W. Va. Code R. § 15-1-19.13.7	A pharmacist must make a reasonable effort to obtain, record, and maintain patient medical and demographic information, including a pharmacist's comments regarding the patient's drug therapy.
COC	S	W. Va. Code R. § 15-1-19.14.2	Any violation of professional conduct, which includes counseling requirements, must result in disciplinary action.

Wisconsin

Type	Code	Provision	Description
PCE	S	Wis. Admin. Code [PH] § 7.01(1)(e), (2)	A pharmacist is required to provide appropriate consultation to patients for original and refill prescriptions. The consultation requirement is not satisfied by offering to provide consultation, except when a prescription is delivered to a patient's residence. Counseling requirements apply to institutional pharmacies serving persons receiving outpatient services, including prescriptions for discharged patients.
PCE	S	Wis. Admin. Code [DHS] § 107.10(5)(b)	For Medicaid recipients, a pharmacist is required to offer counsel patient for each prescription presented.
OSM	S	Wis. Admin. Code [PH] § 7.01(1)(e)	If the prescription is delivered to the patient outside of the pharmacy, the prescription must be accompanied by directions about the prescription and an explanation that consultation with a pharmacist is available.

Wyoming

Type	Code	Provision	Description
PCE	S	Wyo. Stat. Ann. § 33-24-136(c)	For new prescriptions, pharmacists must personally orally offer to counsel and must counsel patients, if requested.
PCE	S	Wyo. Code R. § 9-5(a)	Upon receipt of a prescription, pharmacists, including non-resident pharmacists, must personally offer to counsel patients. Counseling should be performed in person, whenever practicable, or by telephone.
PCE, PMR	S	Wyo. Code R. § 9-5(b)	A pharmacist is not required to counsel a patient who has refused a consultation. Every refusal must be documented.
SUP, DIS	S	Wyo. Code R. § 9-5(e)	Alternative forms of patient information may used to supplement patient counseling when appropriate. This may include, but is not limited to, written information leaflets, pictogram labels or video programs.
PMR, PCE	S	Wyo. Stat. Ann. § 33-24-136(d); Wyo. Code R. § 9-5(c), (d)	Pharmacies are required to maintain patient profile records for each patient. Each pharmacy must make a reasonable effort to obtain patient demographic and medical information, including comments relevant to the patient's drug use. Absence of any record of a refusal of the offer to counsel must be presumed to mean that an offer to counsel was made and the counseling was provided.

APPENDIX:

Survey Methodology

To identify state pharmacy statutes and regulations that directly or indirectly address language services, researchers manually reviewed the state Pharmacy Act of each of the 50 states, plus the District of Columbia, using NABPLAW® Online, a pharmacy-specific, online, licensed resource produced by the National Association of Boards of Pharmacy (NABP). Additionally, electronic searches were conducted in Westlaw of all state statutes and regulations concerning any provision that may limit or support language services. Researchers examined a range of areas including counseling, distribution of information, labels, generic substitution, out-of-state pharmacies, misbranding, and emergency contraception. These searches were designed to be over-inclusive to capture any pharmacy law provision that might affect the provision of language services, directly or indirectly.

Since there are federal provisions establishing minimums for counseling, distribution of information, and patient medication profiles for Medicaid beneficiaries, as well as labels generally, this analysis only contains provisions that are *different* from the federal law and related to the provision of language services directly or indirectly. For example, a state that required elements of a patient medication profile to include patient name, medication name, and expiration date, but had no further requirement to capture comments by the pharmacist or patient history, was not included as not sufficiently related to the scope of the research.

Additionally, the analysis does not include a number of provisions related to the *definition* of the practice of pharmacy or counseling because there is not a close enough intersection between the general definition provision and the delivery of language services. The standard definitions explain the practice of pharmacy in very general terms and the information a pharmacist should convey. Generally these provisions define patient counseling as an aspect of pharmacy practice, but the requirement to counsel is contained in separate provisions. All provisions containing the requirement to counsel or the requirement to offer to counsel a patient have been included.

Additional provisions excluded from the analysis are sunshine laws (addressing the release of drug pricing information), and provisions that specify certain English words that must be contained on a notice or poster or label. These too were not closely enough related to the provision of language services to be included. No provision that specified particular English words or language to be printed on a label or poster contained a prohibition of translating the words into another language. When a provision contained no affirmative requirement to do so, the relationship was not sufficiently related to the scope of this research.

Note that references to a "pharmacist" throughout the analysis mean that the requirement applies at least to the pharmacist. States differ as to whether other pharmacy staff is allowed to perform certain functions.

Additionally, references to "patient" mean at least the requirement is as to a patient. States differ here too as to whether counseling may be conducted with a caretaker, guardian or other representative. Neither of these distinctions has been tracked, as they are not closely enough related to the scope of the analysis. To get more information about a particular provision, please review the provision text in full. Citations of all provisions are included in the accompanying chart.

This research is current as of January 2009.

Endnotes

1 IMS National Prescription Audit PLUS ™

2 U.S. Bureau of the Census, American Community Survey, 2008, Table S0501, *available at* **http://factfinder.census.gov/servlet/STTable?_bm=y&-qr_name=ACS_2008_1YR_G00_S0501&-ds_name=ACS_2008_1YR_G00_&-state=st&-_lang=en**

3 Limited English Proficiency refers to people age 5 and above who report speaking English less than "very well." We use the standard of persons who speak English "less than very well" for purposes of discussing their health care given the complexity of medical terminology and the importance of the issues that are that are discussed.

4 D. Andrulis, N. Goodman, C. Pryor, *What a Difference an Interpreter Can Make* (April 2002), *at* **http://www.accessproject.org**.

5 Knowlton CH, Penna RP, *Pharmaceutical Care*, New York: Chapman and Hall, 1996.

6 For the ease of the reader, this analysis refers to "states" to include all 50 states, plus the District of Columbia.

7 *See* Appendix A for the Survey Methodology.

8 Language services include both oral interpretation (during the oral communication between patients and pharmacists or clinical staff), as well as written translations of labels or written information distributed to patients.

9 Throughout, this analysis refers to particular provisions applying to "pharmacists." When using the term pharmacist, we mean pharmacist, *at a minimum, and* any other required pharmacy staff. States differ on whether pharmacists can delegate counseling obligations to pharmacy technicians and other pharmacy staff. This analysis has not tracked that delegation of responsibilities. For more specifics about whether other staff might be obligated, review the full text of the provision.

10 42 U.S.C. § 2000d.

11 The United States Supreme Court has treated discrimination based on language as national origin discrimination. *See Lau v. Nichols*, 414 U.S. 563 (1974). *See also* 45 C.F.R. § 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants); Executive Order 13166, 65 Fed. Reg. 50121 (Aug. 11, 2000) (requiring the federal agencies to evaluate their accessibility to those who cannot speak English well, develop a plan to make agency activity and programs available to persons who don't speak English well and required each federal agency that distributes federal funds to issue guidance specifically tailored to its recipients); *see also* 65 Fed. Reg. 50123 (Aug. 16, 2000), *reissued* 67 Fed. Reg. 41455 (June 18, 2002) (setting forth guidance by DOJ to implement EO 13166); *see also* 65 Fed. Reg. 52762 (Aug. 30, 2000), *revised* 67 Fed. Reg. 4968 (Feb. 1, 2002), *reissued* 68 Fed. Reg. 47311 (Aug 8, 2003) (guidance issued by DHHS to implement EO 13166).

12 *See id.* For more information on Title VI and its implementation, *see* National Health Law Program, "Federal Laws and Policies to Ensure Access to Health Care Services for People with Limited English Proficiency" *available at* **http://www.healthlaw.org**.

13 42 U.S.C. §1396r-8(g).

14 *See id.*

15 "(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this subchapter by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this subchapter or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following . . ." 42 U.S.C. §1396r-8(g)(2)(A).

16 This includes a retrospective Drug Use Review, application of standards, and education of pharmacists. *See id.*

17 *See id.*

18 (II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this subchapter:

(aa) Name, address, telephone number, date of birth (or age) and gender.

(bb) Individual history where significant, including

disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individual's drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this subchapter or caregiver of such individual refuses such consultation. *See id.*

19 21 C.F.R. §§ 1306.14(a) and 1306.24. The information required on the label includes basic information such as the date of filling; pharmacy name and address; serial number of the prescription; name of the patient; name of the prescribing practitioner; and directions for use and cautionary statements, if any contained in such prescription or required by law.

20 21 C.F.R. § 201.15.

21 The exceptions are HI, LA, and VT. Louisiana law requires a pharmacist to counsel, but only when possible or appropriate. Hawaii discusses counseling as a part of the practice of pharmacy, but does not have a clear requirement. Vermont also suggests counseling in certain situations, but does not require the pharmacist to counsel or offer to counsel.

22 For ease of the reader, this analysis refers to information or counseling for "patients." States differ as to whether information may be provided to patients, caregivers, guardians, or other patient representatives. For more detail with respect to a particular provision, see the full text of the provision.

23 AZ, AK, AR, CA, DE, IA, ME, MI, MN, NV, NY, ND OR, RI, TN, TX, UT, WA, and WI.

24 AL, CO, CT, DC, FL, GA, ID, IL, IN, KS, KY, MD, MA, MS, MO, MT, NE, NH, NJ, NM, NC, OH, OK, PA, SC, SD, VA, WV, and WY.

25 Some courts have found that a pharmacist is held to a higher duty of care to their patients or have a duty to warn their patients in certain situations, such as when the pharmacist has provided counseling about the medication, recently dispensed a contra-indicted prescription to the patient, or had specific knowledge about the patient's history, such as a drug allergy or frequent use of alcohol (*Pittman v. Upjohn Co.*, 890 S.W.2d 425 (Tenn. 1994) (discussing a duty to the patient because the manufacturer gave special warning to the pharmacy to provide instructions on the use and potential complications, and it was reasonably foreseeable that the patient was at risk of injury); *Riff v. Morgan Pharmacy*, 508 A.2d 1247 (Pa. Super. 1986), (holding that a pharmacist was negligent for having breached the duty to exercise due care where the pharmacist filled a prescription in quantities inconsistent with recommended guidelines and failed to warn the patient or notify the physician of the prescription's inadequacies). Other jurisdictions, however, have held that a pharmacist does not have an independent duty to warn a patient in other situations. *Moore ex rel. Moore v. Memorial Hospital of Gulfport*, 825 So.2d 658, 664 (Miss. 2002) (holding that similar to a pharmaceutical company, which is only required to warn a prescribing physician of the dangers of its products, a pharmacist does not have a duty to warn a patient, although the Court recognizes exceptions when a pharmacist may have such a duty). Courts have discussed how the failure to provide interpreter services for an LEP person can be a key issue in a case, as well as the basic importance of communication between medical providers and patients. *Wellman v. Faulkner*, 715 F.2d 269 (7th Cir. 1983) (holding that medical care at a prison was inadequate and negligent and thus a violation of 8th Amendment because, in part, the physicians were LEP and could not effectively communicate with patients. The court stated that "an impenetrable language barrier between doctor and patient can readily lead to misdiagnoses and therefore unnecessary pain and suffering"); *Anderson v. County of Kern*, 45 F.3d 1310 (9th Cir. 1995) (relying on *Wellman*, to find that the District Court did not abuse its discretion in requiring the County to provide an interpreter for Spanish-speaking prison inmates during medical and mental health encounters in an 8th Amendment deliberate indifference case); *Ruff v. Bossier Medical Center*, 952 F.2d 138 (5th Cir. 1992) (concluding that the physician had a duty to take adequate steps to be certain that he fully understood the patient's complaint where the physician was LEP).

26 CT, FL, GA, ID, IL, IN, MS, MO, NE, ND, OH, VT, WA, and WI.

27 AL, AK, AZ, AR, CA, CO, DE, DC, IA, KS, KY, ME, MA, MD, MI, MN, MT, NV, NH, NJ, NM, NY, NC, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, and WV.

28 N.H. Code Admin. R. Ph. 404.06.

29 N.J. Admin. Code § 13:39-7.19(e).

30 N.Y. Comp. Codes R. & Regs. tit. 9, § 9800.1.

31 21 N.C. Admin. Code 46.2507.

32 S.C. Code Ann. § 40-43-88(N); S.D. Admin. R. 20:51:26:10.

33 Tex. Admin. Code tit. 25 § 414.404.

34 AK, AZ, AR, CA, CO, CT, DE, FL, HI, KS, ME, MD, MI, MN, MS, NE, NH, NV, NY, ND, OR, PA, RI, SC, TX, UT, VA, and WV.

35 Effective communication is critical to informed consent. While informed consent is usually raised in situations such as medical treatment or surgery, there are multiple situations in a pharmacy where this issue arises, including generic substitution, immunizations, prescribing authority, and Emergency Contraception. Generally, courts have found that informed consent requires more than just providing a "form" and a patient must understand the issues and information that is material the decision at hand. *Macy v. Blatchford*, 8 P.3d 204 (Or. 2000) (discussing whether a physician failed to obtain a patient's informed consent for surgery, the court stated "a physician can mouth words to an infant, or to a comatose person, or to a person who does not speak his or her language but, unless and until such patients are capable of understanding the physician's point, the physician cannot be said to have explained anything to any such person"); *McQuitty v. Spangler*, 976 A.2d 1020 (holding that an informed consent violation can be based on the omission of important information the patient needs to make decisions about her medical care. The court said, "the gravamen of an informed consent claim, therefore, is a health care provider's duty to communicate information to enable a patient to make an intelligent and informed choice, after full and frank disclosure of material risk information and the benefit of data regarding a proposed course of medical treatment").

36 42 U.S.C. §1396r-8(g)(2)(A).

37 AK, AZ, CA, DE, DC, FL, GA, ID, IL, IA, KS, KY, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WV, and WY. Louisiana provides that a patient may refuse patient counseling.

38 AZ, CO, CT, DE, DC, IL, IA, KY, MA, MN, MT, NE, NJ, NY, OH, OR, PA, RI, SD, TX, UT, VA, VT, WV, and WY. In Utah, records of patient refusal of counseling must both be documented and available to the pharmacy licensing division.

39 *See infra*, footnote 25.

40 AL, AK, AZ, CT, IL, IA, KY, MA, MI, NC, OR, PA, SD, VT, VA, and WV.

41 *See infra*, footnote 11.

42 AK, AZ, AR, CA, DE, DC, FL. GA, IN, ME, MA, MI, MN, MS, MO, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, SD, TN, TX, UT, VA, WA, and WI.

43 AK, AZ, CA, CT, DE, ID, IL, IA, KS, KY, MA, MN, MS, NV, NH, NJ, NM, NY, ND, PA, SD, TX, VA, and WA. Florida establishes the same type of requirement of internet-based pharmacies.

44 21 N.C. Admin. Code 46.2507.

45 AL, AZ, CA, CO, DE, DC, FL, HI, IN, KY, ME, MD, MN, MO, NV, NH, NM, NY, OR, SD, TX, UT, VA, and WA.

46 AZ, CA, DE, DC, FL, IN, NV, NM, NY, OR, SD, TX, VA, UT, and WA.

47 Note that in deciding in what languages to translate materials, Title VI guidance allows providers to consider the number of persons being served or eligible to be servedwho speak that language, how frequently these persons are served or eligible to be served, and cost. For more information on this analysis, *see* National Health Law Program, "*Language Services in Pharmacies: What is Required?*" (2008), *available at* **www.healthlaw.org**.

48 Haw. Code R. § 16-95-130; N.H. Code Admin. R. Ph. 1001.04; 1001.05, 1001.06.

49 Ky. Rev. Stat. Ann. § 217.896.

50 Me. Rev. Stat. Ann. Tit. 22, § 2682.

51 Md. Code Regs. 10.34.26.02.

52 N.Y. Comp. Codes R. & Regs. tit. 10, § 80.137 (d)(1).

53 22 Tex. Admin. Code § 291.131(d).

54 AR, CO, DC, GA, IN, IA, KS, KY, LA, ME, MD, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, RI, SC, SD, TN, VT, and WY.

55 09-00 Ark. Code R. § 0001(c).

56 09-00 Ark. Code R. § 0001(c).

57 AL, AZ, AR, CA, DE, DC, FL, GA, ID, IL, IN, IA, KY, ME, MA, MN, MS, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, and WY. Note: CT, CO, and MD also have state patient medication profile provisions, but the provisions only apply to Medicaid beneficiaries.

58 50-018-001 Miss. Code R. § 8.

59 Iowa Admin. Code r. 657-6.2.

60 ADC 20-620 to 20-625 (New York City Administrative Code 2010), *available at* **http://public.leginfo.state.ny.us/menugetf.cgi**.

61 This research and analysis did not comprehensively review local or city laws. However, this is the only statute of its kind of which we are aware.

E

Appendix E. Linguistically Appropriate Access and Services: An Evaluation and Review for Health Care Organizations

Charles C. (Mike) Anderson, M.P.A. Santa Rosa, CA: The National Council on Interpreting in Health Care (2002).

http://www.ncihc.org/NCIHC_PDF/LinguisticallyAppropriateAccessandServicesAnEvaluationandReviewforHealthcareOrganizations.pdf

This tool has a fairly long introductory section followed by a highly detailed assessment form. Excerpts from both are included below.

Excerpts

Why is an Evaluation Process Needed?

Both federal and state laws mandate that health care organizations provide appropriate linguistic access for limited English proficient (LEP) patients. Accreditation agencies such as the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the National Committee on Quality Assurance (NCQA) set standards and monitor compliance in language services, as in all other areas of operation. What is needed is a nationally uniform approach for health care organizations to guide them in successfully complying with the task set before them. The Office for Civil Rights' Guidance Memorandum on Language Access, most recently released in August of 2000, states that "Recipients (those health care providers who are recipients of federal dollars) are more likely to utilize effective communication if they approach this responsibility on a structural rather than an ad hoc basis." The DHHS Office of Minority Health funded project "CLAS" (Cultural and Linguistic Competence Standards and Research Agenda Project), also published in 2000, recommends that organizations have a "comprehensive management strategy to address culturally and linguistically appropriate services."[1,2,3]

Currently across the United States, the level of preparedness of health care organizations to serve diverse language needs is much more developed in some regions than in others. In some parts of the country with older immigrant populations, such as California and Massachusetts, many institutions took the steps to establish "language services programs" over twenty years ago. In areas with more recently arrived immigrant populations, such as Georgia, the first hospital language services program was not formed until early 2000. The establishment of language services programs in health care organizations is the first step in a complex process of addressing language needs. Such programs can quickly become fragmented and inefficient without a comprehensive organizational plan.

This evaluation tool walks health care organizations through their systems in a way that addresses all points of service, answering to the needs of patients and the organization's staff. It is a comprehensive approach, the development of which draws on the experience and expertise of leaders in the field of medical interpretation. It should be evident that creating a linguistically accessible health care organization requires a review of relevant policies at all levels as well as support from the senior leadership.

This evaluation tool does not dictate how each organization should respond to its patient

population, but rather points to the questions that need to be asked to fully explore, examine and anticipate how the arrival of patient groups of diverse languages and cultures invite a broadening of the concept of patient care. Further, the evaluation tool does not prescribe the "right way" services should be provided; that is left up to the institution. Hopefully a thorough evaluation will lead the institution to develop the best approach for its own unique LEP patient population. The evaluation tool also does not evaluate the wider theme of general cultural competency and cultural awareness training. While the tool does refer to these elements, the proper evaluation is left to a more specialized process. Also, this evaluation does not address other technologies such as video interpreting or electronic translation to provide communication. These areas may need to be added at a later date, as more understanding of their efficacy and cost efficiency is determined.

What are the Expected Outcomes?

It is the intent of the evaluation process to provide hospitals and health care organizations a means to identify:

1. the strengths and limitations of existing linguistic services,
2. risks to the organization,
3. cost drivers,
4. qualitative issues in care delivery,
5. the impact on care outcomes,
6. regulatory compliance issues across ethnic patient populations,
7. a better understanding of ethnic community needs, and
8. internal and external resource availability and allocation.

The list of questions is designed to assure that key parameters are addressed in the evaluation process. It takes into consideration not only the provision of services but also the cost effectiveness and efficiency of service delivery. In today's health care environment, the total cost of providing care is a key element in an organization's ability to provide access to a culturally diverse community.

Parameters and Considerations for Evaluation

The development of the evaluation categories and questions is a synthesis of current thinking about what comprises a competent medical interpreting program. It also draws on work done by such organizations as the DHHS Office of Minority Heath (OMH), the Office for Civil Rights (OCR), the National Health Law Program, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Quality Improvement System for Managed Care (QISMIC) standards released by HCFA (**http://www.hcfa.gov/quality/3a.htm**), the Massachusetts Medical Interpreting Association (MMIA) Standards of Practice for Health Care Interpreters (**http://www.mmia.org**) and others. This evaluation tool however, is not static and will continue to evolve.

The evaluation tool is divided into four major sections that examine the myriad issues in providing comprehensive multilinguistic

services. The questions establish a framework with which to identify both structural and substantive issues in meeting the needs of LEP patients. The framework includes an organizational overview towards services and resources for LEP patients and helps organizations identify the issues involved in the requirements, operation and capabilities of bilingual staff and providers along with face-to-face and telephonic interpreting and translation services. External interpretation agencies, providing both face-to-face and telephonic interpreting services are also incorporated into the evaluation.

Organizational Evaluation Instrument

Organizational Overview

This section is the largest and covers the global approach taken by the organization in addressing the multilingual needs of the patient, including an evaluation of the demographics in the community the institution serves and that of the patient population receiving care within the institution. It further takes into consideration the organization's approach and commitment towards cultural diversity both in terms of organizational structures, as well as the ways in which staff and physicians interact with limited-English-speaking patients on the organizational "front line." By "structures" we mean questions relating to organizational leadership, policies on cultural and linguistic competencies, providers as champions, training, performance appraisals, quality assurance criteria, language tracking of LEP patients/clients, protocols for accessing interpreters, interpreter protocols, hiring and training, and ethno-cultural community involvement.

Bilingually Provided Services

One model of the provision of linguistic access depends on the use of bilingual professionals who provide their particular service directly in the language of the patient. The bilingually provided services section will help shed light on the actual practices of organizational staff members and providers in their interactions with LEP patients/clients. Further, it evaluates how training and testing of language proficiency, if any, is conducted.

Health Care Interpreting Services

Face-to-face Interpreting Evaluation

The predominant way that LEP patients meet their communication needs is through an on-site or face-to-face interpreter. The evaluation process focuses on the quality of the interpretation as well as the attitudes of staff towards interpreters, all of which are key elements in providing an effective

interpreter program. It also looks at the relationship and integration of internal staff interpreters (if available) to those of agency staff that may be utilized. A key issue for organizations is the disparity in the quality of interpretation across various language groups, and how these discrepancies are addressed.

Telephonic Interpreting Evaluation

With the ever-present pressure placed on health care institutions to lower the total cost of care to their patients, there is a movement toward a greater reliance on the use of telephonic technology. Often, telephonic interpreting makes the interpreter more immediately accessible to the provider, particularly in time sensitive situations. In addition, telephonic services can often find interpreters in less common languages. As more institutions look to control their cost of providing interpreting services they are looking at ways to reduce the encounter cost. Telephonic interpreting can help control costs, depending on the per-minute pricing structure. However, little is known about how the shift to a telephonic mode of interpreting may affect the quality of the interpretation, the content of the patient-provider communication, the ability of the patient to navigate the health care system, or patient/provider satisfaction.

How to decide when telephonic or face-to-face interpretation is most appropriate is, at this time, an open question. The evaluation process included here asks questions about the way in which telephonic service is provided, however, how staff utilizes it and under what situations it is limited in scope. The questions asked look at the institution's written policy and procedures to assess if there is any criteria established to provide guidance in determining when telephonic interpreting is used. Further, the evaluation looks at the training and understanding of its use by staff and the level of instruction given the patient who is involved in the interpretation. The tool also directs questions at the level of assessment established to evaluate the training of interpreters used for telephonic interpreting. Whether provided internally or externally assessing training and competency is critical to the successful use of telephonic interpreting.

External Interpreter Agency Evaluation

Most large hospitals and health care organizations today utilize multiple means to meet the growing need for language interpreting. In addition to internal resources, they may include external interpreter agencies, both for-profit and not-for-profit, individually-owned and community-based agencies, to help meet their interpreting and translation needs. External agencies may provide a full-service approach in which all interpreting or translation needs are managed through one or more agencies, or the external agency may function only in a back-up capacity. In any case, there are few institutions that can internally meet the total need for interpreting and translation

services by virtue of the increasing demand for many more languages resulting from changes in immigrant and refugee demographics.

The need to evaluate external interpreter agencies is a critical component in assessing an organization's ability to meet the needs of its LEP patient population. A primary reason for this is the variety in the levels of services and the pool of resources available to meet the demand. Smaller agencies, providing services for a limited number of languages, may not have the resources of mid-size or larger language service agencies to provide the sustained level of testing and training necessary to assure that the interpreter meets the qualifications needed to provide quality interpreting in the medical environment. However, since there are only incipient national standards for medical interpreting, a thorough evaluation of any agency is still needed since the approach and measurement of quality can vary dramatically from agency to agency. In addition, some agencies only specialize in certain areas (e.g. telephonic interpreting), which may limit their ability to comprehensively meet the institution's needs.

While evaluating an external agency's capability it may become apparent that not all of the institutions needs may be met by selected agencies. It is important to work with agencies to foster the quality and service needed by the institution. This will lead to the development of long-term collaborative relationships that are in the best interest of both organizations. Consistency over time is a key component in developing such relationships, leading to higher levels of service and quality in meeting the institutions interpreting needs. This evaluation tool has folding questions about agencies into the sections on face-to-face and telephonic interpreting.

Translation Services Evaluation

Translation of written materials is a vital component in providing LEP Patients access to health care services. Unfortunately, it is often inadequately addressed, particularly for documents such as consent forms, advanced directives, financial materials, and discharge information. In addition, training and education materials commonly provided English-speaking patients are often overlooked. The evaluation tool treats translation in the same context and with the same emphasis as interpreter services, evaluating not only the availability of the material but the process through which new material is identified for translation and made available to patients.

Further, the evaluation looks not only at whether the material is translated, but also the accuracy of the translation. Translation from English to another language is not merely a question of changing from one text to another; it is a very complex process involving consideration of cultural meaning and understanding in a variety of contexts. Assuring accurate translation may involve not just one translation but may in fact require two or three to assure that the proper meaning is conveyed depending on the country and cultural community form which

the patient came. While resources may be limited for translating all materials, a careful evaluation will help an institution determine which documents are most critical to assuring quality of care delivery and will help to determine what alternatives may be available.

In addition, an evaluation of how non-translated material is interpreted and by whom is important. Face-to-face interpreters are often utilized to provide on-site translation of documents, yet may not be qualified as translators, leading to misrepresentation of the printed material. Further, this can add to the cost of the interpreting encounter.

Conclusion

The evaluation tool that follows, then, is designed to help institutions take stock of how well their systems are providing accurate and timely language access services to LEP patient populations. Of course, an evaluation is only the beginning of the process. Once the institution has pinpointed its strengths and weaknesses, a decision must be made about how to improve services in the areas that are weak. This will be the topic of a separate NCIHC Working Paper. For now, we hope that this tool is useful in helping institutions to evaluate their existing language access programs.

Endnotes

1 U.S. Department of Health and Human Services, Office for Civil Rights. Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English. Washington, DC: Federal Register, August 2000. 65 Federal Register. 50123 (Aug. 16, 2000) This version as posted on the OCR website at **www.hhs.gov/ocr/lep/guide.html**.

2 U.S. Department of Health and Human Services, Office for Civil Rights, HHS provides written guidance for health and human services providers to ensure language assistance for persons with limited English skills." Press release, Wednesday, August 30, 2000. Washington, DC: OCR. **www.hhs.gov/ocr/lep/press.html**.

3 *Strategic plan to improve access to HHS programs and activities by limited English proficient (LEP) persons*. Formerly located at **http://www.hhs.gov/gateway/language/languageplan.html** but no longer available there.

Contents of Assessment Form

Excerpts from the Assessment Form

The assessment comprises 154 questions, many of them multi-part. The sampling below should provide an idea of the assessment's nature. The original form contains many more sections and questions than what appears here.

	Yes	No
I. ORGANIZATIONAL OVERVIEW		
Administrative Overview		
1. Is senior management, including the CEO, knowledgeable about cultural and linguistic issues, including the organization's policies and procedures?		
2. Is senior management knowledgeable about the business implications of cultural and linguistic access and services?		
Patient/Member Demographics		
20. Has the organization conducted a demographic analysis of the LEP populations that it serves? - What assessment tools were used?		
21. Are all ethnic and linguistic groups in your catchment area reflected in the profile?		
22. Are there demographic size thresholds for cultural and linguistic communities in your organization's catchment area that determine the organization's activities for providing linguistic services? - If so, explain what they are.		
23. Is each patient's primary language identified? - How and when is this information collected?		
Patient Services		
26. Are interpreters or bilingual providers available during:		
- the admissions process?		
- the enrollment process?		
- financial services?		
- member services?		
- grievance and complaint processes?		
- other non-care patient interactions?		
27. Are interpreters provided at no cost to the patient?		
28. Have there been any grievances filed due to lack of language access? - Please explain the nature and outcome of such grievances.		
29. Have there been any state or federal complaints filed due to language access questions? - Please explain the nature and outcome of such complaints.		
30. Are there records of complaints, grievances etc. specific to language or cultural issues? - Please explain the nature and outcome of such complaints.		
Regulatory Review		
36. Are linguistic services incorporated into accreditation compliance activities? Including the reporting requirements for:		
- NCQA		
- JCAHO		
- QISMIC (HEDIS 3.0)		
- Other (please describe)		

	Yes	No
37. Are patient satisfaction surveys conducted in any language other than English, including the primary languages served by the organization?		
II. BILINGUALLY PROVIDED SERVICES		
Provision of Service		
47. Do bilingual providers and staff utilize their bilingual skills in performance of their routine functions?		
48. What is the profile of bilingual staff? (Create a table by department) -Languages Spoken: Provider Type # of bilinguals Total # Primary Care OB/GYN Mental Health Emergency Medicine		
Policy and Procedures		
52. Are there policies and procedures in place for evaluating individual language skills of providers and staffs? - If so, do they specify when and under what conditions evaluations are conducted?		
53. Are there policy and procedures that specify under what conditions a bilingual provider or staff must use an interpreter in providing care or service?		
III. HEALTH CARE INTERPRETING SERVICES		
Face to Face Interpreting (if none is used, proceed to the next section)		
Overview		
58. Are policy and procedures in place related to the use of face-to-face interpreting? - If so do they specify when and under what conditions this form of interpreting is to be used?		
59. Is the use of an interpreter documented in the patient's medical record? - If yes, what is the frequency of compliance?		
60. Do providers and staff received training on the appropriate use of a face-to-face interpreter?		
61. Is the length of the interpreting encounter recorded? - If so, what is the average length of a face-to-face interpretation?		
62. For what types of encounters is face-to-face (as opposed to telephonic) interpreting utilized? [many examples listed for checking yes or no]		
63. Is there clear documentation to ensure that identified problems are addressed?		
64. Is client data collected in the utilization of face-to-face interpreter services? If so, is it broken down by:		
- Type of encounter		
- Language		
- Duration		
- Time of Day		
- Provider and department		
- Staff		
- Patient ID		
65. Is the interpreter no-show rate recorded? - If so, what is the rate?		
66. What are the driving factors for no shows?		
Bilingual Staff used as Interpreters (*if none are used proceed to the next section*)		
67. Are bilingual staff members used as interpreters?		
68. If staff members are used as interpreters, how does this affect their productivity in their normally assigned work?		
69. Is there qualification in language fluency and health care interpreting that is expected before staff can undertake an assignment?		

	Yes	No
70. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
- Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
73. Is there a continuing education program in place for bilingual staff used to interpret?		
Dedicated Staff Interpreters *(if none are used proceed to the next section)*		
75. Does your institution hire dedicated staff interpreters?		
76. What languages do your staff interpreters cover?		
77. Is there qualification in language fluency and health care interpreting that is expected of a staff interpreter before hire?		
78. Are the following elements assessed and monitored?		
- Understanding of the interpreter's role		
- Adherence to an interpreter code of ethics		
- Accuracy and completeness of the interpretation		
- Use of the first person in interpreting		
- Medical terminology in both languages		
- Grammar		
- Register and mode of interpreting		
- Professional demeanor and comportment		
- Patient satisfaction		
- Provider/staff satisfaction		
79. Is there organized and on-going recruitment of staff interpreters?		
80. Is there an ongoing training process in place? - If yes, how often is it presented?		
81. Is there a continuing education program in place for staff interpreters?		
82. Does the institution perform an annual review of staff interpreters?		
Agency Interpreters *(if none are used proceed to the next section)*		
92. Is there a contingency back-up system in place when the agency cannot provide services for a particular language? - If so, explain how arrangements are made.		
93. For which languages can the agency provide service on a regular basis?		
94. How does the agency recruit interpreters?		
95. Is there qualification in language fluency and health care interpreting that is expected of agency interpreters before they are contracted?		
104. Describe how the following elements are monitored by the agency?		
-How is information recorded and authenticated?		
-Adherence to interpreter standards, including confidentiality		

F

Appendix F. Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance

The Interagency Working Group on LEP. C/O Coordination and Review Section, United States Department of Justice, Civil Rights Division, **http://www.lep.gov/selfassesstool.htm**

Outline

Introduction

PART A: SELF-ASSESSMENT

Section I: **Demography:** the number or proportion of LEP persons eligible to be served or likely to be encountered

Section II: **Frequency of Contact:** the frequency with which LEP individuals come in contact with the program and/or activities

Section III: **Importance:** the nature and importance of the program, activity, or service to people's lives

Section IV: **Resources:** the resources available and costs

PART B: DEVELOPING A LANGUAGE ASSISTANCE PLAN

Section I: Goals

Section II: Planning

1. Identification of LEP Persons
2. Language Assistance Measures
3. Training Staff
4. Providing Notice to LEP Persons
5. Monitoring and Updating the LAP

Section III: LAP Evaluation

Excerpts and Sample Sections

This two-part document is intended to assist organizations that receive Federal financial assistance in their strategic planning efforts to ensure that program goals and objectives address meaningful access for all of the people they serve or encounter, including those who are limited-English proficient. First, this tool will assist recipients in assessing their current other-than-English language services capabilities and planning for the provision of language assistance to Limited English proficient (LEP) individuals they serve or encounter. As recipients may be developing performance measures to assist them in evaluating the effectiveness of their program and program delivery, by using this tool, they will be able to assess that effectiveness relative to individuals who are LEP.

The planning and self-assessment questions in Part A of this document are guided by the requirements of Title VI of the Civil Rights Act of 1964, as amended, and Title VI regulations, as set forth in guidance memoranda from the

U.S. Department of Justice (DOJ), Civil Rights Division. (See, e.g., 65 FR 50123 (August 16, 2000), and 67 FR 41466 (June 18, 2002), also available at **http://www.lep.gov**. Part B is intended as a follow-up to Part A, and provides a framework for the development of a Language Assistance Plan (LAP) also in light of general Title VI requirements.

PART A: SELF-ASSESSMENT

The questions in this part are intended for use by Federal recipients in conducting a self-assessment of their progress in providing language assistance to LEP persons. The questionnaire is divided into four sections and is designed to assist in a balanced assessment of the following four factors: (1) Demography — The number or proportion of LEP persons eligible to be served or likely to be encountered; (2) Frequency of Contact — the frequency with which LEP individuals come in contact with the program and/or activities; (3) Importance — the nature and importance of the program, activity, or service to people's lives; and (4) Resources — the resources available and costs.

Section I: Demography

The determination to provide language assistance services should include an assessment of the number or proportion of LEP persons from a particular language group served or encountered in the eligible service population. The greater the number or proportion of LEP persons served or encountered, the more likely language services are needed.

Has your organization developed a demographic profile of the population served or likely to be served by your Federally funded programs and activities?

YES NO

By primary language spoken?

YES NO

If so, list the language groups and the languages spoken.

If not, you can begin your efforts by going to **http://www.lep.gov**.

In addition to the Census and the Department of Education, you can help identify language needs by calling on community-based organizations in your service area.

Is your institution working with any community-based organization(s) that is (are) familiar with the language needs of individuals participating in any of your programs and activities, or to whom you provide services or encounter?

YES NO

If so, describe.

Once your organization has identified general demographic data, which will give you a good overview, you are in a

better position to move to the individual level for those people you serve.

Section II: Frequency of Contact

The following questions are designed to help recipients assess the frequency with which LEP individuals are contacted or encountered and the respective language groups. The more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed. It is also advisable to consider the frequency of different types of language contacts. For example, frequent contacts with Spanish-speaking people who are LEP may require certain assistance in Spanish. Less frequent contact with different language groups may suggest a different and less intensified solution. If a LEP person accesses a program or service on a daily basis, a recipient has greater duties than if the same person's frequency of contact with a recipient's program or activity is unpredictable or infrequent. Notwithstanding, recipients should consider whether appropriate outreach to LEP persons could increase the frequency of contact with LEP language groups.

Does your organization have a process for surveying, collecting and/or recording primary language data for individuals that participate in your programs and activities?

YES NO

If so, describe the categories used in the collection of data, where the data resides, and who can access the data.

Section III: Importance

Once you have assessed what languages to consider with regard to access, both through an analysis of the demography and frequency of contact, you can then look at the nature and importance of your programs, activities, or services.

As a rule of thumb, the more important the activity, information, service, or program, or the greater the possible consequences of the contact to the LEP individuals, the more likely language services are needed. You should then determine whether denial or delay of access to services or information could have serious implications for the LEP individual.

Do you conduct compulsory activities?

YES NO

(For example, do you require applications, consent, interviews, or other activities prior to participation in any of your programs and/or activities, in order to obtain some benefit, service, or information, or in order to participate in a higher level program?) Do you conduct involuntary programs or activities (like custodial interrogations, hearings, trials, evictions, etc.) or provide compulsory education or other mandatory programs or activities?

If so, what are they?

In addition to the above, do you conduct programs or activities that have serious

consequences, either positive or negative, for a person who participates? (including, but not limited to, for example: health, safety, economic, environmental, educational, law enforcement, housing, food, shelter, protection, rehabilitation, discipline, transportation, etc.).

YES NO

What are they?

Have you determined the impact on actual and potential beneficiaries of delays in the provision of services or participation in your programs and/or activities (economic, educational, health, safety, housing, ability to assert rights, transportation costs, etc.)?

YES NO

If so, what are they?

Section IV: Resources

Once you have reviewed your demographics, frequency of contact, and importance of your programs, activities, or services, a good self-assessment will identify the resources (dollars and personnel) available to ensure the provision of language assistance to LEP persons participating in your programs and/or activities. The level of resources and the costs may have an impact on the nature of the language assistance provided. Smaller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with large budgets. In addition, "reasonable costs" may become "unreasonable" where the costs substantially exceed the benefits.

Reduction of costs for language services can be accomplished by such options as the use of technology (such as sharing through the internet, telephonic language lines, etc.); the sharing of language assistance materials and services among and between recipients, advocacy groups, and Federal grant agencies; and reasonable business practices. You should carefully explore the most cost-effective means of delivering competent and accurate language services before limiting services due to resource concerns.

Have you identified the resources needed to provide meaningful access for LEP persons?

YES NO

Are those resources currently in place?

YES NO

Is there a staff member in your organization assigned to coordinate language access activities?

YES NO

If so, please identify by name or title, etc.

Have you identified the points of contact where a LEP person interacts with your organization?

YES NO

If so, please describe.

Given the identified points of contact, is language assistanceavailable at those points?

YES NO

If so, please describe.

By language spoken, how many employees in your organization fluently speak a language other than English?

What percent of the total employees in your organization are bilingual and able to competently assist LEP persons in the LEP person's language?

Do you utilize employees in your organization as interpreters? (Interpreting is a different skill than being bilingual and able to communicate monolingually in more than one language. Interpretation requires particular skills. For more information, see **www.lep.gov**.)

YES NO

Employees within our organization provide interpreter services (circle one):

- ☐ some of the time.
- ☐ most of the time.
- ☐ always.
- ☐ never.

What are the most common uses by your organization of other than employee (outside sources) language interpreter services?

What outside sources for interpreter services do you use?

- ☐ Contract interpreters
- ☐ Telephone services
- ☐ Community-based organizations
- ☐ Language banks
- ☐ Other (please specify)

For what languages other than English are outside sources of language interpreters most commonly used?

If so, how?

Although you should not plan to rely on an LEP person's friends, family members, or other informal interpreters to provide meaningful access, are there times when you appropriately allow use of such informal interpreters? (See DOJ LEP Guidance from June 18, 2002, **http://www.lep.gov**)

YES NO

If so, under what circumstances?

PART B: DEVELOPING A LANGUAGE ASSISTANCE PLAN

This section is intended to provide a general overview for the development of a Language Assistance Plan (LAP) for LEP beneficiaries or potential beneficiaries. Each Federal recipient may choose to develop an LAP differently. Regardless of the format selected, careful consideration should be given to whether the LAP is sufficiently detailed to address the answers to the questions set forth in Part A, Self-Assessment.

Section I: Goals

After completing the four-factor analysis and deciding what language assistance services are appropriate, a recipient should develop an implementation plan to address the identified needs of the LEP populations they serve. Recipients have considerable flexibility in developing this plan. The development and maintenance of a periodically-updated written LAP for use by recipient employees serving the public will likely be the most appropriate and cost-effective means of documenting compliance and providing a framework for the provision of timely and reasonable language assistance. Moreover, such written plans would likely provide additional benefits to a recipient's managers in the areas of training, administration, planning, and budgeting. These benefits should lead most recipients to document in a written LEP plan their language assistance services, and how staff and LEP persons can access those services. Despite these benefits, certain recipients, such as recipients serving very few LEP persons and recipients with very limited resources, may choose not to develop a written LEP plan. However, the absence of a written LEP plan does not obviate the underlying obligation to ensure meaningful access by LEP persons to a recipient's program or activities. Accordingly, in the event that a recipient elects not to develop a written plan, it should consider alternative ways to articulate in some other reasonable manner a plan for providing meaningful access. Entities having significant contact with LEP persons, such as schools, religious organizations, community groups, and groups working with new immigrants can be very helpful in providing important input into this planning process from the beginning.

Good LAPs should be:

(1) based on sound planning;

(2) adequately supported so that implementation has a realistic chance of success; and,

(3) periodically evaluated and revised, if necessary.

The first topic covered in this part is the establishment of goals in a LAP. The second topic in this part is a brief overview of points that may be considered in developing a comprehensive LAP.

Section II: Planning

Many Federal recipients have found that it is useful, when developing or revising a LAP, to establish a committee or work group that includes administrators, professional and administrative support staff, potential beneficiaries, and members of community

organizations. By working with a diverse group that includes stakeholders, you can receive more comprehensive input from those whose support and efforts may be important to the success of your LAP. Inclusive approaches in plan design and development tend to promote overall community awareness and support. In addition, these individuals will be valuable resources to draw upon during plan evaluation and plan improvement activities.

One of the first things to consider in developing a plan is taking the information you have gained in your self-assessment (Part A), with your goals, and converting it into a viable plan or roadmap that helps your organization identify and address gaps, while at the same time moving toward a coordinated and comprehensive approach to meeting the needs of your organization.

Have you developed a comprehensive plan for language assistance to LEP persons?

YES NO

If not, or if you just want more information to consider in assessing the comprehensiveness of your already existing plan, there are some useful pointers on **http://www.lep.gov**.

Briefly, in designing a comprehensive LAP you should follow the following five steps:

1) Identification of LEP Persons; 2) Language Assistance Measures; 3) Training Staff; 4) Providing Notice to LEP Persons; and, 5) Monitoring and Updating the LAP.

1. Identification of LEP Persons

This first step comprises your consideration of the information obtained from the first two self assessment factors: the number or proportion of LEP individuals eligible to be served or encountered, and the frequency of encounters. This information identifies LEP persons with whom you have contact.

In refining your assessment of your target LEP population, you can use language identification cards (or "I speak cards"), which invite LEP persons to identify their language needs to your staff.

2. Language Assistance Measures

In developing an effective LAP, you should also consider including information about the ways language assistance will be provided. For instance, you may want to include information on:

- Types of language services available
- How staff can obtain those services.
- How to respond to LEP callers.
- How to respond to written communications from LEP persons.
- How to respond to LEP individuals who have in-person contact with your staff.

3. Training Staff

It is essential for the members of your organization to know your organization's obligations to provide meaningful access to information and services for LEP persons. It is, therefore, recommended that your LAP plan include training to ensure that:

- Staff know about LEP policies and procedures.
- Staff having contact with the public (or those in a recipient's custody) are trained to work effectively with in-person and telephone interpreters.

4. Providing Notice to LEP Persons

- Posting signs in intake areas and other entry points.
- Stating in outreach documents (brochures, booklets, outreach and recruitment information) in appropriate languages that language services are available.
- Working with community-based organizations to inform LEP persons of the language assistance available.
- Using a telephone voice mail menu in the most common languages encountered.
- Including notices in local newspapers in languages other then English.
- Providing notices in non-English language radio and television stations about the availability of language assistance services.
- Presentations and/or notices at school and religious organizations.

5. Monitoring and Updating the LAP

One good way to evaluate your LAP is to seek feedback from the community, and assess potential LAP modifications based on:

- Current LEP populations in service area or population encountered or affected.
- Frequency of encounters with LEP language groups.
- Nature and importance of activities to LEP persons.
- Availability of resources, including technological advances, additional resources, and the costs imposed.
- Whether existing assistance is meeting the needs of LEP persons.
- Whether staff knows and understands the LAP and how to implement it.
- Whether identified sources for assistance are still available and viable.

Exemplary practices and further policies with regard to written LAPs can be found at **http://www.lep.gov**. The following questions are designed to assist in assessing your planning needs.

Does your organization have a written policy on the provision of language interpreter and translator services?

YES NO

If so, is a description of this policy made available to the general public?

YES NO

If so, how and when is it made available?

In what languages other than English is it made available?

Do you inform your employees of your policies regarding LEP persons?

YES NO

If so, how?

How often?

Are beneficiaries informed that they will be provided interpreting services at no cost?

YES NO

How are they informed and at what points of contact?

Do you ensure that your translators and/or interpreters are qualified to provide interpreting services (which is a different skill than being bilingual) and understand any confidentiality requirements?

YES NO

If so, how?

Section III: LAP Evaluation

The following information is provided to assist you in identifying methods and approaches for evaluating a LAP. You are encouraged to review your LAP annually and to develop approaches for evaluation that are consistent with your respective LAP designs, individual needs and circumstances. The evaluation process allows for quality feedback into your organization. Also, the evaluation process can be used as a sentinel to detect problems before they grow, and to confirm best practices.

Because Federal law does not prescribe a particular program model or evaluation approach, the approach to, and design of, an effective LAP evaluation will vary for each Federal recipient. The questions set forth below are provided as primers for you to use in developing your own approach.

Do you have and use a tool for collecting data on beneficiary satisfaction with interpreter services?

YES NO

Have any grievances or complaints been filed because of language access problems?

YES NO

If so, with whom?

Do you monitor the system for collecting data on beneficiary satisfaction and/or grievance/complaint filing?

YES NO

Are the data used as part of a review by senior management of the effectiveness of your organization's language assistance program implementation?

YES NO

Do you regularly update your LAP and assess for modifications given changing demographics, or changes or additions to your programs?

YES NO

Do you obtain feedback from the community?

YES NO

Generally, organizations measure "success" in terms of whether a plan, when implemented, leads to the achievement of the particular goals the organization has established. If the organization has established no particular goals, it can still be successful if the results are in concert with the organization's desired outcomes. In this case, the desired outcome is the provision of language assistance, when necessary, in order to ensure that LEP persons are able to participate meaningfully in the Federal recipients programs and activities.

You should modify your LAP if it proves to be unsuccessful after a legitimate trial. As a practical matter, you may not be able to comply with this Title VI requirement unless you periodically evaluate your LAP.

G

Appendix G. How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and CHIP Enrollees?

(revised January 2010)

How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and CHIP Enrollees?

(revised January 2010)

Federal funding to help states and health care providers pay for language services is primarily available through Medicaid and the State Children's Health Insurance Program (CHIP). This federal funding offers states a valuable opportunity to help providers ensure language access. However, the programs have technical requirements and vary from state to state. This document provides a brief overview to assist you in evaluating the best way for your state to offer language services reimbursement. For specific information on your state, see **http://www.statehealthfacts.kff.org/**.

What are Medicaid and CHIP?

Medicaid and the State Children's Health Insurance Program (CHIP) are health insurance programs for certain low-income individuals operated jointly by the federal and state governments.[1] Both programs operate as federal-state partnerships — they are jointly administered and jointly funded. Medicaid provides health insurance to over 58 million individuals, CHIP to almost 5 million.

To be eligible for Medicaid or CHIP, you must be low-income and fit within an eligible group. Medicaid primarily serves four groups of low-income Americans: the elderly, people with disabilities, parents and children. Medicaid is an "entitlement" program — everyone who meets the eligibility requirements must be provided health care and has the right to obtain needed services in a timely manner. CHIP primarily covers children and sometimes others. such as parents and pregnant women. CHIP is not an entitlement — its funding is limited to pre-set amounts determined by Congress.

How does the federal government pay its share of Medicaid and CHIP costs to the states?

The federal government pays states in three ways for their Medicaid and CHIP expenses:

- ***Covered Service*** — States get federal reimbursement for "covered services" provided to enrollees, such as a visit to a doctor or in-patient hospital stay. States must cover certain "mandatory" services, but they also have the option of covering certain additional services, such as language services.

- *Administrative Costs* — States also get federal funds to assist with the administrative costs of the program (e.g. costs of staff to determine eligibility and oversee contracts, and computer costs).
- *Disproportionate Share Hospitals* — States also get federal funding for payments made to "disproportionate share hospitals" — hospitals that serve a disproportionate share of Medicaid and uninsured patients.[2]

Why can states get (draw down) federal reimbursement for language services?

In 2000, the Centers for Medicare & Medicaid Services (CMS), a part of the federal Department of Health and Human Services and the agency overseeing Medicaid and CHIP, reminded states that they could obtain federal "matching" funds for language services provided to Medicaid and CHIP enrollees. In a letter to state health officials, CMS reminded states that

> Federal matching funds are available for states' expenditures related to the provision of oral and written translation administrative activities and services provided for CHIP or Medicaid recipients. Federal financial participation is available in State expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service.[3]

Why don't all states cover language services for Medicaid/CHIP enrollees?

While each healthcare *provider* who receives federal funds must provide meaningful language access, *states* do not have to reimburse providers for these expenses. Each state determines if and how it will provide reimbursement for interpreters. Individual providers cannot seek reimbursement **unless** their state has set up a mechanism to do so. Only fourteen states and the District of Columbia directly reimburse providers for language services.[4] States have an obligation, however, to ensure language access at Medicaid and CHIP eligibility offices.

The reasons states do not offer direct reimbursement vary, and you may need to take different steps to educate policymakers depending on the reason in your state. For example, some state officials do not know that federal funding is available. Informing them may be sufficient to build their interest in offering reimbursement. Faced with tight budgets, some states may not designate state funds to pay their share of the Medicaid/CHIP match. In these states, you may want to educate policy makers about the costs of non-compliance with federal requirements (such as Title VI), and the indirect costs of not providing language assistance to LEP patients (such as more medical errors, reduced quality of care, and unnecessary diagnostic testing). Finally, some states view language services as part of providers' costs of doing business, and bundle the cost of language services into the providers' general reimbursement rates, regardless of providers' actual costs. In these

states, changing state policies may require providing information about the utilization of language services, the actual costs of interpreters, and why a bundled payment rate is insufficient to cover these costs.

How much would my state get from the federal government for language services?

This depends on the state, the program, and how the state chooses to be reimbursed.

Covered Services — For covered services, the state pays part of the costs and the federal government pays the remainder. Each state has a different federal "matching" rate — that is, the percentage of the provider reimbursement for which the federal government is responsible. The federal contribution varies from 50% to 83%, depending upon a state's per capita income (states with higher per capita income receive less federal funding). States also have different matching rates for Medicaid and CHIP; CHIP services are reimbursed at a higher rate. For example, Iowa receives a 63.50% federal match for Medicaid services and 74.45% for CHIP services. For information on your state, *see* Kaiser Family Foundation's State Health Facts Online, **http://www.statehealthfacts.kff.org/**. As of April 2009, states would receive their FMAP for language services provided to adults in Medicaid but would receive the higher of 75% or a state's FMAP plus 5% for all CHIP enrollees and children in Medicaid.[5]

Administrative Costs — Some states may choose to cover the costs of language services as an administrative expense, rather than as a covered service. For language services paid as an administrative expense, the state would receive 50% of its costs for language services provided to adults and the higher of 75% or a state's FMAP plus 5% for all CHIP enrollees and children in Medicaid.[6] In CHIP, however, states can only spend 10% of their total federal allotment on administrative expenses. For states that are at or near their 10% administrative cap, it may thus be preferable to consider language services as a "covered service" rather than as an administration expense.

How does my state start drawing down federal reimbursement for language services?

Covered Services — States that wish to get federal funding as a "covered service" must add language services to their Medicaid "state plan." The state plan is the document that outlines how each state's Medicaid program works, including what services it covers. The state must submit this request — a "state plan amendment" or "SPA" — to CMS. Until a service is added to the "state plan" and approved by CMS, the state cannot receive federal reimbursement. In many states, because of the financial costs of covering a new service, the state legislature must approve the SPA prior to submission to CMS.

Administrative Costs — States that seek reimbursement for language services as an administrative expense do not need prior CMS approval. Thus, while the federal matching rate for administrative expenses may not be as high as the rate for covered services (e.g. 50% as opposed to 63.5% for Medicaid covered services in Iowa for language services for adults), a state may choose this option because it is easier to implement. However, this decision is also affected by the differing matching rates for Medicaid and CHIP. In some states, the federal matching rate for Medicaid covered services is 50%, the same as for administrative expenses. In these cases, the state does not have a financial incentive to add a covered service to its Medicaid state plan. But for CHIP, states are not allowed to spend more than 10% of their CHIP allotment on administrative expenses. So deciding to cover language services as an administrative expense in CHIP may produce fewer federal dollars if a state is close to the administrative cap and also create conflicts with other administrative priorities.

Disproportionate Share Hospital Costs — States can also use federal funding available for "disproportionate share hospitals" (DSH) — that is, hospitals that serve a disproportionate share of Medicaid and uninsured patients — to help pay for language services. States determine which hospitals are considered DSH and how much funding to distribute to them. States could consider a hospital's language services expenses in determining the allocations of DSH money.

Which providers can get reimbursed for language services?

Each state determines which Medicaid and CHIP providers can obtain reimbursement. States may choose to reimburse all providers or only some —for example, only "fee-for-service"[7] providers, or hospitals, or managed care organizations. Most states that provide reimbursement do so for fee-for-service providers. Two states reimburse hospitals. One state has added money to the "capitation rate" it pays to managed care organizations for each enrolled patient to cover the costs of providing interpreter services.[8]

The decision of which providers to reimburse will vary state by state. Factors to consider include whether a provider uses a staff member or contract interpreter, whether staff interpreters interpret full-time or have other job responsibilities, and whether bilingual providers are competent to provide services in a non-English language and should be compensated for their language skills.

How can my state reimburse providers who receive pre-set rates for services?

Some states set payment rates that "bundle" all of the costs of providing services to a patient into a single fee; the fee includes the costs of medical tests or procedures, as well as of other services and items — for example, consultation, medical supplies and medications. The payment rate also includes reimbursement for a share of the facility's overhead costs — salaries, utilities, maintenance of physical plant, etc. Such

bundling is particularly common for inpatient hospital services. The federal Medicare program bundles fees into "diagnosis related groups," or DRGs. Some states pay for inpatient hospital stays based on DRGs, while others pay on a per-case or per-diem basis. The cost of language services is implicitly included in whatever bundling method a state employs. For other health care providers, such as doctors operating small group practices, many states include all administrative and overhead costs — including language services — in the provider's payment rate. Federally qualified health centers receive bundled payments through a "prospective payment system," an advance payment that estimates the health centers' costs.

Since states set the Medicaid/CHIP payment rates for each service, states can modify the rates to add on direct reimbursement for interpreters when they are used.[9] States can have a separate "billing code" with a payment rate specifically for interpreters — each time a provider uses an interpreter, the provider receives both the payment rates for the covered service and for the interpreter. States can also add a "modifier" for an existing rate — each time a provider uses an interpreter, the modifier increases the payment rate by either a percentage or a specific amount. The rates or modifiers can vary by language (frequently encountered versus less frequently encountered), type of interpreter (staff interpreter, contract interpreter, bilingual provider, telephone language line), or other factors.

Many states include requirements to provide access to language services in their contracts with managed care organizations. If a state chooses to directly pay managed care organizations for the costs of these language services, they have two options — pay for language services separately from the managed care capitation rate[10] (i.e. "carve out" language services from the set of services the managed care organization must provide) or increase the capitation rate to include language services.

How much should the state pay for interpreters?

When a state decides to reimburse providers for language services, it determines the payment rate. Those currently in use vary from $12 to $190 per hour. The rates should reflect labor costs in the state and consider training or certification requirements. When setting the payment rate, the state should also consider travel time, waiting time, and other activities associated with providing interpretation; these circumstances vary by state, and often by region. For example, in rural areas where travel times can be lengthy, a state should evaluate whether the interpreter can receive reimbursement for travel time. (A state also needs to determine if and what to pay in a variety of circumstances: for example, what happens if the interpreter arrives but the provider or patient cancels the appointment.) To encourage the use of interpreters, it is important that states set a rate that will cover at least the interpreter's actual costs. The state should also set an

adequate reimbursement rate to ensure that a sufficient number of interpreters to meet the needs of its LEP population are willing to participate in the program.

How can states offer reimbursement?

Currently, states that provide reimbursement for language services use four payment models:

- require providers to hire interpreters and submit for reimbursement
- pay interpreters directly
- use "brokers" or language agencies — providers can call these designated organizations to schedule an interpreter; the state reimburses the broker/agency which in turn pays the interpreter
- provide access to a telephone language line for providers.

For more information on these models, see *Medicaid and CHIP Reimbursement Models for Language Services: 2009 Update*, available at **http://www.healthlaw.org**.

What about language services for individuals ***not*** enrolled in Medicaid/ CHIP?

Federal funding is only available for language services for Medicaid and CHIP enrollees (or to parents of Medicaid/CHIP enrolled children). It is also available for patients who receive Medicaid-covered emergency services.

Health care providers who receive federal funds, however, must ensure language access for *all* of their patients, not just Medicaid and CHIP enrollees. Thus, a gap exists between existing federal funding and the need for services. States could use state funds to provide language services for other individuals. Once a state has established a language assistance program for its Medicaid and CHIP beneficiaries and invested the initial resources necessary to implement it, the additional costs to expand the program to other LEP patients would probably be minimal.

Endnotes

1 For more information on these programs, *see* **www.healthlaw.org**, **http://www.kff.org/medicaid/7334.cfm** (*Medicaid: A Primer*) or **http://www.cms.hhs.gov/MedicaidEligibility/01_Overview.asp** (*Medicaid Eligibility Overview*).

2 Currently, hospitals that serve a "disproportionate share" of Medicaid and uninsured patients are eligible to receive supplemental Medicaid payments through the Disproportionate Share Hospital (DSH) program. In many states the DSH program represents one of the most significant sources of federal funding to support health care for the uninsured and Medicaid beneficiaries. More than 10% of all Medicaid funding is through DSH, amounting to more than $15.8 billion combined federal and state spending in 2001.

3 This letter is available at **http://www.cms.hhs.gov/smdl/downloads/smd083100.pdf**.

4 These fourteen are the District of Columbia, Hawaii, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington and Wyoming. For more information on the models these states are using, *see Medicaid/CHIP Reimbursement Models for Language Services: 2009 Update*, available at **www.healthlaw.org**.

5 This provision was enacted as part of the Children's Health Insurance Program Reauthorization Act.

6 This provision was enacted as part of the Children's Health Insurance Program Reauthorization Act.

7 "Fee-for-service" generally refers to services not provided through a hospital, managed care organization, or community health center. Providers agree to accept a state-set fee for the specific service provided to a Medicaid/CHIP enrollee.

8 For more information on the models these states are using, *see Medicaid/CHIP Reimbursement Models for Language Services: 2009 Update*, available at **www.healthlaw.org**.

9 States cannot, however, increase their Medicaid/CHIP reimbursement rates above Medicare reimbursement rates.

10 The "capitation rate" is the amount a state pays the managed care organization for each enrollee per month, which compensates the managed care organization for all the services covered by the contract. It is a set amount that does not vary depending on how many or few services the enrollee utilizes.

H

Appendix H. Medicaid and SCHIP Reimbursement Models for Language Services (2009 update)

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Medicaid/SCHIP Reimbursement Models for Language Services

(2009 update)

In 2000, the Centers for Medicare & Medicaid Services (CMS) reminded states that they could include language services as an administrative or optional covered service in their Medicaid and State Children's Health Insurance Programs, and thus directly reimburse providers for the costs of these services for program enrollees. Yet only a handful of states are directly reimbursing providers for language services. Currently, the District of Columbia and 13 states (Hawaii, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming) are providing reimbursement. Three states have initiated discussions about reimbursement. Connecticut enacted legislation requiring reimbursement but they have not yet been implemented. North Carolina expects to provide reimbursement after establishing interpreter credentialing. And a California Task Force established by the Department of Health Services issued recommendations for initiating reimbursement.

The remainder of this issue brief outlines existing state mechanisms for directly reimbursing providers for language services for Medicaid and SCHIP enrollees.[1] (For more information on funding for Medicaid and SCHIP services, see *How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and SCHIP Enrollees?*[2]). While only some states currently provide reimbursement, the examples below can help you identify promising ways to evaluate and establish reimbursement mechanisms to meet your state's needs and goals.

STATES CURRENTLY PROVIDING REIMBURSEMENT

State	For which Medicaid and SCHIP enrollees?	Which Medicaid and SCHIP providers can submit for reimbursement?	Who does the State reimburse?	How much does the state pay for language services provided to Medicaid/ SCHIP enrollees?	How does the state claim its federal share— as a service or administrative expense ?	What percentage of the state's costs does the federal government pay (FY 2009) ?
DC	Fee-for-service[5] (FFS)	FFS practice < 15 employees	language agencies[6]	$135–$190/hour (in-person); $1.60/min (telephonic)	Admin	Medicaid adults (MA-A) — 50% Medicaid kids (MA-K) — 75% CHIP — 84%
HI	Fee-for-service (FFS)	FFS	language agencies	$36/hour (in 15 min. increments)	Service	MA-A — 54.24% MA-K/CHIP — 75%
IA	FFS	FFS who do not submit cost reports	providers	$60/hour (in 15 min. increments, in-person); $1.70/min (telephonic)	Service	MA-A — 63.51% MA-K — 75% CHIP — 79.46%
ID	FFS	FFS	providers	$12.16/hour	Service	MA-A — 69.40% MA-K — 75% CHIP — 83.58%
KS	Managed care	not applicable (state pays for language line)	EDS (fiscal agent)	Spanish — $1.10/ minute; other languages — $2.04/ minute	Admin	MA-A — 50% MA-K — 75% CHIP — 77.27%
ME	FFS	FFS	providers	Lesser of $20/ 15 minutes or usual and customary fee	Service	MA-A — 64.99% MA-K — 75% CHIP — 80.49%
MN	FFS	FFS	providers	lesser of $12.50/ 15 minutes or usual and customary fee	Admin	MA-A — 50% MA-K/CHIP — 75%
MT	all Medicaid	all[7]	interpreters	lesser of $6.25/ 15 minutes or usual and customary fee	Admin	MA-A — 50% MA-K — 75% CHIP — 82.19%
NH	FFS	FFS	interpreters (who are Medicaid providers)	$15/hour $2.25/ 15 minutes after first hour	Admin	MA-A — 50% MA-K/CHIP — 75%
UT	FFS	FFS	language agencies	$28–35/hour (in-person); $1.10/minute (telephonic)	Service	MA-A — 71.68% MA-K — 76.68% CHIP — 85.18%
VA	FFS	FFS	Area Health Education Center & 3 public health departments	reasonable costs reimbursed	Admin	MA-A — 50% MA-K/CHIP — 75%
VT	All	All	language agency	$15/15 min. increments (in-person)	Admin	MA-A — 50% MA-K — 75% CHIP — 76.11%
WA	All	public entities	public entities	50% allowable expenses	Admin	MA-A — 50% MA-K/CHIP — 75%
WA	All	non-public entities	brokers; language agencies	brokers receive administrative fee language agencies receive $34/hour	Admin	MA-A — 50% MA-K/CHIP — 75%
WY	FFS	FFS	interpreters	$11.25/15 min	Admin	MA-A — 50% MA-K/CHIP — 75%

District of Columbia

Beginning in March 2006, the District of Columbia's Medical Assistance Administration (MAA) began providing access to a telephone language line that fee-for-service (FFS) Medicaid/SCHIP providers could use — at MAA expense — to obtain an interpreter. Only fee-for-service primary care providers who employ less than fifteen (15) persons are eligible to use this language line. All FFS providers with fifteen (15) or more employees must provide and pay for interpreter services themselves.

According to the MAA transmittal sent to all Medicaid providers, eligible providers must request interpreter services at least seven (7) business days prior to the date of service or appointment. The provider sends the request to MAA's designated language agency. MAA approves or disapproves each request and the language agency then confirms the availability of an interpreter and notifies the requesting provider and Medicaid beneficiary. If emergency interpreter services are required, the provider can contact the language agency directly.

Managed care organizations have a separate obligation to provide language services under both federal law and the terms of DC's Medicaid managed care contract. Health care providers serving Medicaid managed care enrollees must request an interpreter directly from the MCO. The MCO notifies the requesting provider and Medicaid beneficiary of the availability of an interpreter within three (3) business days of the request.

MAA contracts with one language agency and pays between $130–$190/ hour. The rate varies based on the language needed and how much advance notice is provided. For example, Spanish interpreters cost MAA $135/ hour if 3–5 business days' notice is provided and $160/hour if less notice is provided; the rates are between $160 and $190 for Amharic, Chinese, Korean, and Vietnamese interpreters. After the first hour, charges range from $3–$5/minute. All encounters are subject to a $25 administrative charge. MAA pays $1.60/minute for telephonic interpretation.

In the first six months the program was operational, MAA spent $895 on interpreters and $2723.09 for translation of written materials. In FY 2007,[8] MAA spent $235 for 1 interpretation encounter, and $990 for 3 translation encounters. In fiscal year 2008, $6,700 was spent for 20 interpretations, and $665 for 1 translation. As of July 2009, for FY 2009, MAA has spent $9,257 on 27 interpretations, and $1,285 on 3 translations. In total, MAA has spent $21,000 since January 1, 2006. The language services reimbursements are considered to be administrative costs and are split 50/50 with the federal government. These costs do not reflect interpreter and translation services that the Medicaid managed care organizations pay for.

Hawaii

The State of Hawaii has a Language Access Law that provides for a statewide language access office and advisory counsel. Each

State department must submit a language access plan updated every two years.

Hawaii receives reimbursement for the interpreter services as a "covered service" (similar to an office visit or other service covered by the State's Medicaid plan). The State receives Federal reimbursement for Medicaid patients (approximately 57 percent) and approximately 70 percent for CHIP patients. Interpreters who are staff or volunteer bilingual providers are not reimbursed. The costs of providing interpreters for in-patient hospital stays are included in hospitals' existing payment rates; separate reimbursement is not allowed.

The State has guidelines on billing procedures and utilization, and language service organizations are expected to monitor quality and assess the qualifications of the interpreters they hire.

Iowa

Iowa begin reimbursing for language services in July 2009 in its Medicaid and CHIP programs. The state pays a maximum of $15/15 minutes for in-person interpreting and $1.70/minute for telephonic interpreting. The state will pay for interpreters when:

- Interpreting is provided by interpreters who only provide interpretive services;
- Interpreters are employed or contracted by the billing provider; and
- Interpreting facilitates access to Medicaid covered services.

Providers can only bill for language services offered in conjunction with an otherwise covered Medicaid service; bilingual staff will not be reimbursed for interpreting. The Medicaid agency will pay for travel and wait time. Providers must determine the competency of interpreters, who should be guided by the National Council on Interpreting in Health Care's standards. Hospitals may submit for reimbursement of language services provided to in-patients but these must be billed separately and using an outpatient claim. Reimbursement is available for providers who are not reimbursed pursuant to cost reports. Providers who submit cost reports which include the costs of language services will be reimbursed pursuant to those cost reports; these providers may include hospitals, Federal Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, Remedial, Local Education Agencies, or Targeted Case Management.

The state agency implemented reimbursement for sign language interpreters at the same time. Since inception, Iowa has spent $726.02 for 21 recipients.

Idaho

Idaho began reimbursing providers for the costs of interpreters prior to 1990. The state reimburses for interpreter services provided to fee-for-service enrollees and those participating in the Primary Care Case Management program. Providers must hire interpreters and then submit claims for reimbursement. Providers must

use independent interpreters; providers can only submit claims for reimbursement for services provided by members of their staff if they can document that the staff are not receiving any other form of wages or salary during the period of time that they are interpreting. No training or certification requirements for interpreters currently exist.

Hospitals may not submit claims for reimbursement for language services provided during in-patient hospital stays. The costs of language services are considered part of the facilities' overhead and administrative costs.

Idaho reimburses the costs of language interpretation at a rate of $12.16/hour (this is the same rate for sign language interpreters). In 2008,[9] the state spent $99,287 on 8,600 units of interpretive services. These services were for 1,477 unduplicated clients. In FY 2006, the state spent $87,913 on 7,438 units of interpretive services. These services were for 768 unduplicated clients. In FY 2004, the state spent $37,621 on language services for 4137 encounters. These expenditures represent total state and federal cost.

Kansas

In 2003, Kansas began offering Medicaid managed care healthcare providers access to a telephone interpreter/language line. The service is provided to primary care providers (for example, individual doctors and group practices, rural health centers, federally qualified health centers, Indian health centers, advanced registered nurse practitioners, and Nurse Mid-wives) and specialists.

The state began providing this service in part because of federal Medicaid managed care regulations and in response to results from a provider survey. The survey results — collected from 87 providers — identified that Spanish is the most frequently spoken language requiring interpretation services. Other languages are less frequently encountered. Nineteen providers reported that they never needed access to an interpreter. Twenty-five providers reported needing an interpreter 1–10 times per month and seven providers responded they needed an interpreter over 100 times per month.

The state's Medicaid fiscal agent, EDS, administers the language line. The provider calls into the Managed Care Enrollment Center (MCEC) and provides a password to the customer service rep (CSR). The CSR then connects to the language line and the provider uses their services. The bill is returned to the MCEC who then passes it on to the state Medicaid agency for reimbursement. The state utilizes two language lines — Propio Language Services for Spanish interpretation (charging $1.10/minute) and Certified Languages International for other languages ($2.04/minute).

From January through December 2006, Kansas spent $46,479.74. The total minutes for calendar year 2006 was 41,193: 39,951 minutes for Spanish interpretation and 1,242 minutes for all other languages. For FY 07,[10] the reimbursement cost was $61, 998 for 54, 477 calls; in FY 08, the cost was $31,500.47 for 27,677 calls; and for FY 09, the cost was

$38,387.14 for 32,592 calls. These costs reflect total state and federal expenditures.

Maine

According to the National Conference of State Legislatures, interest in adding sign language as a reimbursable service under Medicaid paved the way for adding foreign language interpreters. In January 2001, after public hearings and public comment, Maine revised its Medicaid program manual to add interpreters for sign language and foreign language as covered services.[11]

The Medicaid Agency reimburses providers for the costs of interpreters provided to Medicaid and SCHIP enrollees. Interpreter services can only be covered in conjunction with another covered Medicaid service or medically necessary follow-up visit(s) to the initial covered service. The selection of the interpreter is left up to the provider, but interpreters must be licensed by the Maine Department of Professional and Financial Regulations. Providers are encouraged to use local and more cost-effective resources first, and telephone interpretation services only as a last resort. Providers then bill the Medicaid Agency for the service, in the same way they would bill for a medical visit, but using a state-established interpreter billing code. The Medicaid Agency will pay for two interpreters for patients who are deaf or hard of hearing who utilize non-standard signing and request both a deaf interpreter, for whom singing is his/her native language, and a hearing interpreter. When using telephone interpretation services, providers use a separate billing code and must submit the invoice with the claim for reimbursement.

The provider must include a statement of verification in the patient's record documenting the date and time of interpretation, its duration, and the cost of providing the service. The state reimburses the provider for 15-minute increments. The Medicaid Agency does not reimburse for an interpreter's wait time, but will reimburse for an interpreter's travel time. Interpreters who provide transportation to enrollees are not reimbursed for transportation. The Medicaid Agency requires that the provider bill the interpreter's usual and customary charge, but will not reimburse for more than $20/fifteen minutes. The provider must ensure that interpreters protect patient confidentiality and have read and signed a code of ethics. The state provides a sample code of ethics as an appendix to its Medical Assistance Manual.

The Medicaid Agency will not reimburse family members and/or friends for interpreter services. With the exception of those enrollees under the age of eighteen (18) years, a family member or friend may be used as an unpaid interpreter if: 1) the patient requests it; 2) the use of that person will not jeopardize provider-patient communication or patient confidentiality; and 3) the patient is informed that an interpreter is available at no charge.

Hospitals (for language services provided during an in-patient stay), private non-medical institutions, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities may not bill separately for interpreter costs.

Rather, costs for interpreters for these providers are included in providers' payment rates. (*MaineCare Benefits Manual, formerly Medical Assistance Manual*, Chapter 101, 1.06-3.) Also, the Medicaid Agency will not pay for interpreter services when there is a primary third party payor since the primary third party payor is required to cover the interpreter services.

In state FY 2007,[12] the combined state and federal reimbursement cost for interpreter services, including sign-language, was $341,016 (1192 members received language services, and 99 providers billed for services); in FY 2008, the cost of reimbursement was $377,622 (1384 members received language services, and 130 providers billed for services).

Minnesota

In 2001, Minnesota began drawing down federal matching funds for language interpreter services for Medicaid and SCHIP fee-for-service and managed care enrollees. All fee-for-service providers can submit for reimbursement for out-patient services. The state's managed care capitation rate includes the costs of language services.

Under Minnesota's provisions, providers must both arrange and pay for interpretation services and then submit for reimbursement. The state established a new billing code and pays lesser of $12.50 or the "usual and customary charge" per 15-minute interval.

Providers may only bill for interpreter services offered in conjunction with an otherwise covered service. For example, a physician may bill for interpreter services for the entire time a patient spends with the physician or nurse, and when undergoing tests, but not for appointment scheduling or interpreting printed materials. Providers serving managed care enrollees must bill the managed care plan. The managed care plan has the responsibility, pursuant to its contract with the state, to ensure language access; these costs are included in its payment rate.

Hospitals may obtain reimbursement for interpreter costs provided for out-patient care. The costs of language services in in-patient settings are bundled in the hospital payment rate. This payment rate, called the DRG (Diagnosis Related Group), does include a differential to address the costs of language services. When the DRG rates are set by the state, it considers historical data and makes rate adjustments. Although there are no specific adjustments for language services, these costs are generally assumed to be included in the hospital's overhead costs. But because the state bases the DRG on each hospital's own expenses (rather than peer groups or one DRG for the entire state), hospitals with particularly high language services costs will have those costs included in the hospital's overall expenses, resulting in a higher DRG rate to compensate.

In FY 2008, the state spent $2, 075, 629 on language services for a total of 53, 652 encounters. In FY 2007, the state spent $1,694, 905 on language services for a total of 48,396 encounters. In FY 2005,[13]

the state spent $1,644,400 on language services for fee-for-service enrollees. Approximately 15,000 distinct recipients received interpreter services for a total of approximately 42,400 encounters. In FY 2004, the numbers were $1,637,900 for 15,000 distinct recipients and 43,000 encounters.

Minnesota Health Care Programs are in discussions with Minnesota's Administrative Uniformity Committee to develop a uniform language interpreter service billing policy, which includes adding modifiers to the procedure code to distinguish between various types of language services (e.g. sign, spoken, telephone, etc.)

Website: **http://www.dhs.state.mn.us**

Montana

Montana began reimbursing interpreters in 1999 following an investigation by the federal HHS Office for Civil Rights. Montana pays for interpreter services provided to eligible Medicaid recipients (both fee-for-service and those participating in the Primary Care Case Management program) if the medical service is medically necessary and a covered service. The interpretation must be face-to-face; no reimbursement is available for telephone interpretation services. The interpreter must submit an Invoice/Verification form signed by the interpreter and provider for each service provided; Montana then reimburses the interpreter directly. Reimbursement is not available if the interpreter is a paid employee of the provider who provides interpretation services in the employer's place of business, or is a member of the patient's family. In addition, the interpreter and provider must attest that the interpreter is qualified to provide medical interpretation.[14]

The reimbursement rate is the lesser of $6.25 per 15-minute increment or the interpreter's usual and customary charge. Interpreters may not bill for travel or waiting time, expenses, or for "no-show" appointments. The interpreter can bill for up to one 15-minute increment of interpreter time outside the Medicaid provider's office (i.e., at the Medicaid client's home or pharmacy) for each separate interpreter service performed per day. This time is specifically used for the interpreter to exchange information and give instructions to the Medicaid client regarding medication use.

The state does not have any interpreter certification requirements. Thus it is the responsibility of the provider to determine the interpreter's competency. While a state referral service operates for sign language interpreters, no equivalent exists for foreign language interpreters. The state spent less than $2000 on interpreters in FY 2006.[15] Specific data on the costs of reimbursing for interpreter services for FYs 2007 and 2008 is not available at this time.

New Hampshire

New Hampshire has had policies to reimburse sign language and foreign language interpreters since the 1980's. While the state initially reimbursed for interpreters as a covered service, it currently reimburses interpreters as an administrative expense.[16]

The New Hampshire Department of Health and Human Services is preparing to transition to a new fiscal agent in October 2010 and anticipates that this will make the enrolling and billing process more efficient.

Currently, interpreters are required to enroll as Medicaid providers, although through an abbreviated process since they do not provide medical services. Each interpreter has a provider identification number and can bill the state directly for services provided. The state contracts with EDS — a company that oversees all provider enrollment and billing — which also oversees interpreter enrollment. The state reimburses interpreters $15 for the first hour, and $2.25 for each subsequent quarter hour ($25/hour for sign language interpreters).

Interpreters can bill directly or can work for an organization that coordinates interpreter services. Each interpreter, however, must individually enroll as a Medicaid provider regardless of who bills for reimbursement. Currently, interpreters (or language services organizations) can submit claims for reimbursement for language services only for clients of fee-for-service providers; interpreters cannot submit claims for hospital (in- or out-patient services) and community health center clients. At the present time, the state has 76 interpreters enrolled as Medicaid providers; training programs funded in part by the state have helped increase this number. The state is also examining ways to lessen the administrative burdens on interpreters and increase the availability of Medicaid interpreters.

In FY 2006[17], the state spent $17,809.75 on interpreters (both foreign language and sign language) for 1,763 encounters serving 331 distinct Medicaid recipients. In FY 2005, the numbers were $15,334.50, 1,116 encounters, and 233 Medicaid recipients. In FY 2004, the state spent $9,017 on 157 Medicaid recipients for 605 encounters. In FY 2003, the state spent $5,870 on interpreters. Eighty-two Medicaid recipients received interpreter services for a total of 310 encounters. Data for FY 2007 and 2008 is not available at this time.

Utah

Utah covers medical interpreter services as a covered service; as of April 2009, the state will receive a 76.6% federal matching rate for Medicaid interpretations for children (71.6% for adults) and 80% for SCHIP expenditures. The state pays for interpreters when three criteria are met: 1) the client is eligible for a federal or state medical assistance program (including Medicaid and SCHIP); 2) the client receives services from a fee-for-service provider; and 3) the health care service needed is covered by the medical program for which the client is eligible.

The state contracts with six language service organizations — two provide both in-person and telephonic,one only provides telephonic interpreter services to fee-for-service Medicaid, SCHIP, and medically indigent program patients, and three are specifically for the refugee program. The health care provider must call the language service organization to arrange for the service. The language

service organizations are reimbursed by the state between $28–$35/hour (with a one-hour minimum). The rates vary by company, time of day (higher rates are paid for after hours services) and less frequently encountered languages. If an in-person interpreter is not available, the provider may use a telephone interpretation service for which the state pays $1.10/minute.

Providers cannot bill Medicaid directly, and they do not receive any rate enhancements for being bilingual or having interpreters on staff. Rather, interpreters bill the Medicaid agency. Hospitals can utilize Medicaid-funded interpreters for fee-for-service Medicaid enrollees for all services covered by Medicaid, both in- and out-patient, but the hospital is required to cover interpreting costs for in-patients. Hospitals may not use the Medicaid language services for Medicaid managed care enrollees. For enrollees in managed care, Utah requires health plans to provide interpretation services for their patients as part of the contract agreements. For services covered by Medicaid but not the health plan,[18] the state will pay for interpreters.

Utah does not have training or certification for interpreters but does require the contracting language assistance service organizations to provide information on quality assurance measures, including ethics standards, confidentiality, cultural competence and training in medical terminology.[19]

In state FYs 2008 and 2007,[20] the combined state and federal expenditure for foreign language services were $365, 682.75 and $320,543.93, respectively. The combined state and federal expenditure for sign language services for FYs 2008 and 2007 were $49, 500 and $73, 500 respectively. There were approximately 10,135 encounters in FY 2008. In FY 2003, Utah spent $46,700 for interpretation although the amount nearly doubled in FY 2004 to $87,500. (Utah's costs for sign language interpretation were approximately $8,000 in FY 2003 and $13,000 for FY 2004 although these figures include non-Medicaid expenses as well). In calendar year 2006, the state spent approximately $263,000 on interpreting of which $180,000 was for foreign language interpreters and $83,000 for sign language interpreters.

Website: **http://health.utah.gov/medicaid/provhtml/language_services.html**, **http://health.utah.gov/medicaid/pdfs/InterpretGuide10-06.pdf**

Vermont

Vermont began reimbursing for interpreters provided to Medicaid clients a few years ago. Medicaid providers hire interpreters and can submit the costs of interpreters along with the medical claim. Reimbursement is limited to $15 for each 15-minute increment. The state does not reimburse for travel or waiting time. Further, reimbursement is not allowed for bilingual staff that serves as interpreters.

While providers may hire any interpreter, services are primarily provided by one language agency. The state Agency for Health Services has a contract with the

language agency to meet its interpretation needs and informs providers of this agency. However, providers must make their own arrangements with the agency. The agency also has a statewide telephonic interpretation contract to provide interpreters in rural areas, but providers who use telephonic interpretation cannot currently submit for Medicaid reimbursement. In FYs 2007 and 2008,[21] the total amount spent (combined state and federal expenditures) on language services reimbursement was $92,256.82 and $89,731.99, respectively.

Washington

Providers that are not public entities.[22] In 1998, the Department of Social and Health Services' (DSHS) Language Interpreter Services and Translation (LIST) program began contracting with language agencies through a competitive procurement process. Beginning in 2003, the state changed its system to contract with nine regional brokers for administrative scheduling of appointments. The brokers contract with language agencies. In FY 2004,[23] the Department provided interpreters for over 180,000 encounters. Interpreters are paid for a minimum of one hour; mileage is paid if an interpreter has to travel more than 10 miles.

Rather than require clients to schedule interpreters, providers — including fee-for-service providers, managed care organizations, and private hospitals — call a regional broker to arrange for an interpreter. The state requires providers to schedule interpreters to avoid interpreters independently soliciting work and/or acting as advocates rather than interpreters. Once services are provided, the language agency then bills the broker for the services rendered. For interpretation services provided in a health care setting, the claim form requires the name of the referring physician, as well as the diagnosis or nature of illness or injury.

The state pays the brokers an administrative fee; the brokers then pay the language agencies. For Medicaid and SCHIP enrollees, the state obtains federal reimbursement for these costs. Currently, payments to language agencies are $33.00 per hour, increasing to $34.00 per hour effective July 1, 2007. The state spends approximately $1 million a month on all DSHS language services; from November 2005 to October 2006, Washington provided 217,865 encounters. The Medicaid spending during this time period was $38,225.47. In FY 07, the total state and federal expenditures was $11, 639, 736.96 for 211, 844 encounters; in FY 08, the total state and federal expenditures was $12, 905, 629.85 for 221, 781 encounters.

Washington has a comprehensive assessment program for interpreters. Now called the "Language Testing and Certification program," the state requires medical interpreter certification for interpreters in the seven most prevalent foreign languages in Washington: Spanish, Vietnamese, Cambodian, Lao, Chinese (both Mandarin and Cantonese), Russian, and Korean. Interpreters for all other languages must be qualified rather than certified (because of limited resources available for full certification in all languages).

The state has given tests for 88 languages plus major dialects and offers statewide testing at five sites, with four days of testing per month per site. Additional tests are available upon request. The state also offers emergency/ provisional certification for those who have passed the written test but await oral testing, and in other limited situations.

Website: **http://www1.dshs.wa.gov/msa/LTC/index.html**

Public hospitals and health departments. Washington has a separate reimbursement program for interpreter services provided at government and public facilities, such as public hospitals or local health jurisdictions. These entities can receive federal reimbursement for expenses related to language services if they enter into a contract (e.g. interlocal or intergovernmental agreement) with the state and agree to:

- provide local match funds (locally generated private funds);
- ensure that the local match funds are not also used as matching funds for other federal programs;
- ensure that the local match funds meet federal funding requirements;
- ensure that the local match funds are within the facilities' control;
- use only certified interpreters (as certified by Washington's LIST program);
- coordinate and deliver the interpreter services as specified by the state;
- collect, submit and retain client data as required; and
- accept all disallowances that may occur.

These facilities receive reimbursement for both direct (e.g. interpreter services provided as part of the delivery of medical/covered services) and indirect (e.g. time spent coordinating or developing interpreter programs, billing, equipment purchasing) interpreter expenses. The facilities receive reimbursement for 50% of their costs — the federal administrative share. Because these entities act as the state for the purposes of reimbursement, the 50% state "match" is paid by the facility.

There are currently 20 public hospitals with interlocal agreements. Thus far, 12 have been reimbursed $393,414.09 for the 2006 calendar year (the remaining 8 are not current on their billing).

Website: **http://hrsa.dshs.wa.gov/InterpreterServices/FFP.htm**

Wyoming

Beginning in July 2006, Wyoming began paying for language services for its Medicaid enrollees. The interpretation may be provided in-person or via telephone language line.

To access interpreter services, a provider must: 1. determine a need for interpreter services; 2. utilize an agency-approved interpretation provider; 3. provide a medical service for which the interpretation is used. Interpreter services are not provided for in- and out-patient hospital services; intermediate care facilities for individuals with intellectual disabilities (ICF-IID); nursing facilities; ambulance services by public providers;

residential treatment facilities; comprehensive in- or out-patient rehabilitation facilities; and other agencies/ organizations receiving direct federal funding. Further, the state will not pay for interpretation provided by family members, friends or by volunteers.

Interpreters must abide by the national standards developed by the National Council on Interpreting in Health Care (**www.ncihc.org**). They can bill only for time spent with the client and are not reimbursed for travel.

Interpreters are paid in 15 minute increments (but interpreters can bill for the unit only after 10 minutes into the unit). Interpreters are reimbursed at $11.25/15 min. and are limited to billing no more than six units per date of service for any individual Medicaid recipient. In FY 2007 and 2008, the state spent $11,374.12 ($24, 154.00 total state and federal expenditure), and $27, 292.50 ($54,585.00 total state and federal expenditure), respectively. The total number of encounters was approximately 780 in FY 2007, and approximately 1700 in FY 2008.

STATES DEVELOPING REIMBURSEMENT

California

In December 2006, various stakeholders convened the Medi-Cal Language Access Services Taskforce (Task Force) and the Department of Health Care Services (DHCS) was charged to assist the Task Force in developing a system for the economical and effective delivery and reimbursement of language services in Medi-Cal. The Taskforce included 22 representatives from a wide range of stakeholders, comprised of one-third government officials, one-third providers and practitioners, and one-third consumer representatives.

The Task Force members used a consensus-oriented process to ensure widespread support from state representatives, providers and consumers organizations. In 2009, the Task Force Report was finalized and included provisions regarding the development of a pilot project of a proposed hybrid broker/direct reimbursement mechanism and the creation of a work group to implement other provisions of the recommendations, including a Quality Assurance Board to address certification and other patient safety issues. However, due to the budget crisis for the past several years, the Task Force recommendations have not yet been adopted by DHCS. Therefore, advocates have been educating advocates, consumers, public officials, including legislators, and other stakeholders about the need to adopt the Task Force recommendations to establish an effective funding mechanism to pay for language services in California's Medi-Cal program, and are directing efforts to increase support for the proposed reimbursement mechanism and create momentum for adoption by DHCS, when the budget makes it possible, or by the California state legislature.

Website: **http://www.dhcs.ca.gov/services/multicultural/Pages/LangAccessTaskforce.aspx**

Connecticut

On June 19, 2007, Public Act No. 07-185 became law, requiring the Commissioner of Social Services to amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program. While funds have been appropriated by the legislature for the past 3 years, the Governor has not implemented the program and has declined to submit a Medicaid State Plan amendment to provide language services. The Governor's most recent proposal is to implement a statewide administrative services organization (ASO) model, but implementation has not yet begun and is subject to further changes by the Governor and legislature.

North Carolina

In 2002, the federal Department of Health and Human Services' Office for Civil Rights entered into a Voluntary Compliance Agreement (VCA) with the North Carolina Department of Health and Human Services (DHHS) to identify and meet language needs at the state and county levels. In part because of the VCA and in part from suggestions from the DHHS Compliance Attorney and the Department's Title VI Advisory Committee,[24] North Carolina has embarked on plans to initiate reimbursement. The impetus for these discussions is to ensure competent interpreters are available to provide much-needed resources to healthcare providers.

The process is twofold – development of interpreter credentialing and establishment of reimbursement. The North Carolina Department of Health and Human Services is working on first implementing an interpreter credentialing policy before addressing the reimbursement component.

Credentialing

Two organizations have been training interpreters in North Carolina since the '90's. Originally, the Office of Minority Health through the NC Area Health Educational Center (AHEC) launched a Spanish language interpreter training project. Recognizing the additional needs for interpreter brought on by newly arrived refugees, the Center for New North Carolinians (CNNC) of the University of NC Greensboro contracted with Office of Refugee Resettlement /NCDHHS to train interpreters in languages other than Spanish. This contract lasted from the spring of 1999 through July of 2003. Following this contract, CNNC continued interpreter training on a fee for service basis. In 2004, AHEC partnered with CNNC statewide to provide interpreter training through the AHEC network. Last year, given CNNC's long history of providing interpreter training, DHHS requested CNNC develop an interpreter credentialing program for interpreters providing language services to DHHS and the healthcare providers it funds.[25]

The current CNNC training program has three levels: Level I is a two day introductory level; Level II is a one day practicum to reinforce the Level I; and Level III is an advanced two

day training, currently focused on Spanish medical vocabulary, including folk terms and colloquialisms used to refer to diseases and medical treatments. The new curriculum continues to include levels I and II but is based on recently released National Standards of Practice and Code of Ethics from the National Council on Interpreting in Health Care (NCIHC). The certification will start with an assessment of an individual's language competency and require a demonstration of interpreter competency. A basic credentialing process has been developed and will be followed by specialized credentialing (level III) in advanced areas such as social service, public health, and mental health, using the CNNC Level III construct. DHHS would only reimburse interpreters who are credentialed in the areas for which they interpret.

CNNC is currently completing a pilot test of trained interpreters in selected NC cities, with expected completion of the pilot phase by the end of 2009. The assessment is based on the National Standards of Practice as identified by NCIHC and has three components: 1) a language fluency assessment conducted by a national contractor such as the Center for Applied Linguistics, 2) a written test (composed of multiple choice questions and an open-ended question) developed by UNCG to measure knowledge and application of the National Standards, and 3) interpreter role plays to assess the candidate's ability to integrate the ethical principles using culturally appropriate communication and using accurate conversion from one language to another while conserving meaning, attitude and tone. Candidates who do not pass all components will have the opportunity to retake the component(s) after more preparation. The initial pilot has been built around Spanish, but is applicable to other prominent languages in the state, such as Hmong and Arabic; the assessment can be expanded to certify for different languages as the need arises.

Reimbursement

After the certification curriculum is approved by the agency, DHHS expects to submit a State Plan Amendment to include language services as a "covered service" in Medicaid. It is expected that reimbursement will include an array of Medicaid services and support the adequate provision of medically necessary care. DHHS will establish procedure codes and anticipates providing reimbursement for both in-person and telephonic interpreters. If an agency providing telephonic interpretation is used, it will be the responsibility of the agency to assure that training is at least equivalent to the requirements of the DHHS approved curriculum.

It is expected that reimbursement will include all types of Medicaid services — in- and outpatient as well as fee-for-service and managed care. Depending on the development, testing and implementation of certification, reimbursement may begin in 2010.

Virginia

Senate Joint Resolution 122 (2004) directed the Department of Medical Assistance Services (DMAS) to seek reimbursement

for translator and interpreter services from the Centers for Medicare and Medicaid Services. Virginia began a pilot project for reimbursement in 2006 which focused on a small part of Northern Virginia with a high proportion of non-English speakers. The pilot addressed the language needs of Medicaid recipients in this area accessing covered medical services under DMAS "fee-for-service" coverage. The initial contract for the pilot expired and the state has been in negotiations for a new contract.

Previously, DMAS had a contract with Virginia Commonwealth University (VCU) which was the contracting entity for the Virginia Statewide Area Health Education Centers program. The contract was modified to include the pilot as an addendum with the Northern Virginia AHEC participating. Among other capabilities, the Northern Virginia AHEC offers interpreter and translator services requiring that a proficiency standard be met for these professionals. Interpreter and translator training sessions are also offered. The Northern Virginia AHEC had contracts with three health departments and a hospital system for as-needed interpreter and translator services under the pilot. The role of the AHEC under the pilot was to provide language services and receive calls from recipients requesting language services; confirm that a covered medical service is involved; and schedule the language services. Northern Virginia AHEC had the responsibility to aggregate claims for interpreter and translator services and submit them to DMAS through VCU. Only one of the entities submitted claims under the pilot. Reimbursement by DMAS, utilizing administrative claiming, was federal matching funds based on total certified public expenditures as documented by the Northern Virginia AHEC and certified by the appropriate official. The contract with VCU expired in June 2008 for reasons unrelated to the pilot. A draft agreement is currently under discussion with another AHEC.

DMAS had required the participating interpreters and translators to meet proficiency standards, including a minimum 40-hour training for interpreters. The state reimbursed for the reasonable costs incurred by the providers. There was no formal budget for the pilot project but in FY 2006, Virginia spent $8546. for 507 hours of service.

Approximately 60 percent of the Virginia Medicaid population is enrolled with a managed care organization (MCO). Interpreter and translator services are included under the contracts with these organizations, as required under federal requirements at 42 Code of Federal Regulations 438.10. The *Smiles for Children* dental program meets interpreter needs for those enrolled in a MCO or under fee-for-service. Interpreter services for the fee-for- service population are offered through other avenues such as the enrollment broker (also serves MCO enrollees such as when changing plans) and the non-emergency transportation broker.

Website: **http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD222004/$file/SD22.pdf**

STATES PREVIOUSLY PROVIDING OR EVALUATING REIMBURSEMENT

Massachusetts

From FY 2002–2005, Massachusetts provided direct reimbursement for language services in Medicaid for hospital emergency rooms and in-patient psychiatric institutions The legislature did not include an appropriation in FY 2006, possibly because the state raised general hospital payment rates. Massachusetts now bundles payment for interpreter services into its payment rates. Massachusetts does not make discrete provider payments for interpreter services because such costs are incorporated in the fee-for-service payment and the agency considers interpreter services to be part of the cost of doing business for hospitals as well as other providers. The following describes the program as it had operated.

In April 2000, the legislature passed Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services." This law, effective July 2001, mandates that "every acute care hospital . . . shall provide competent interpreter services in connection with all emergency room services provided to every non-English-speaker who is a patient or who seeks appropriate emergency care or treatment." The law also applies to hospitals providing acute psychiatric services. The state attorney general is authorized to enforce the law, and individuals who are denied emergency services because of the lack of interpreters are also given legal standing to enforce their rights.

In 2003, Massachusetts received approval of three State Plan Amendments (one each for psychiatric hospitals, and in-patient and out-patient acute-care hospital care) to obtain federal reimbursement. In FY2005, the last year the program operated, the state budget included an appropriation of $1.1 million to reimburse hospitals and acute psychiatric facilities for the costs of language services. The state's Medicaid agency made "supplemental payments" to "qualifying" hospitals for interpreter services provided at hospital emergency departments, acute psychiatric facilities located within acute hospitals, and private psychiatric hospitals. The distribution was based on an "equity formula" comparing expenses submitted by each qualifying hospital to the total expenses submitted by all qualifying hospitals.

In addition, the state's Medicaid agency previously considered interpreter costs in its DSH (Disproportionate Share Hospital) distribution formula. Medical interpreter costs were identified by the hospitals on their cost reports, which were used to determine unreimbursed costs for DSH purposes. Distribution of DSH funds was then based on these unreimbursed costs.

As part of its comprehensive Health Care Reform plan, passed in April 2006 and approved by the federal government in July 2006, Massachusetts technically no longer has a DSH program. MA has transitioned its

federal DSH dollars, as well as other federal 1115 waiver-related dollars, into a new pool of money called the Safety Net Care Pool. Safety Net Care Pool funds are used to provide subsidies to low-income individuals to purchase private coverage through the Commonwealth Care program (which was implemented on October 1, 2006) and to fund a residual uncompensated care pool. For purposes of its Uncompensated Care Pool (UCP), Massachusetts allows hospitals to include the costs of language services in the base costs used to develop Medicaid rates and the UCP cost-to-charge ratio.

Texas

In 2005, Texas enacted legislation establishing a Medicaid pilot project for reimbursement for language services in five hospital districts.[26] The Health and Human Services Commission (HSSC) was tasked with developing the project. HSSC worked to identify the most appropriate model for the pilot. Initially, there were concerns because the majority of Medicaid enrollees in the designated hospital districts are in managed care. Since the managed care organizations' costs of language services are already included in their capitated rate, the pilot project could not cover them.

Thus, HSSC began working with the hospitals to identify the best methods to track language services provided to fee-for-service and emergency Medicaid recipients. Originally, HSSC offered two cost allocation methodologies — 1) a direct charge allocation method, meaning that the contractor must document that the entire cost is completely related to the performance of an allowable activity, or 2) a Medicaid Eligibility Ratio (MER) allocation method. Since the hospitals assert that both these approaches are administratively cumbersome, they requested consideration of a third approach — a documentation method called a random moment time study (RMTS) approach. HHSC was seeking approval for this approach with the federal Centers for Medicare and Medicaid Services (CMS). However, HHSC then determined that hospitals were including the costs of language services in their "cost reports" (the reports which are used by the state to set Medicaid hospital rates). Since these services were already included in the cost reports, hospitals were receiving some reimbursement (as part of the hospital's overall costs and not to directly cover language services). HHSC discontinued pursuit of the pilot project upon learning that hospitals were already claiming interpreter services in their hospital cost reports to the state.[27] And the legislative authority for the pilot expired in September 2009.

For more information, a status report on the pilot project was submitted to the State Legislature in January 2007: Medicaid Interpreter Services Pilot: Report on Program Effectiveness and Feasibility of Statewide Expansion is available at **http://www.hhsc.state.tx.us/reports/RPCMemo121906LangInterpretPilotRept.pdf**.

CONCLUSION

Given the requirements of Title VI of the Civil Rights Act of 1964 that health care providers who receive federal funds ensure access to services for people with limited English proficiency, more states should access available federal funds to ensure that their agencies — and the providers with whom they contract — have the means to hire competent medical interpreters. The use of competent interpreters can improve the quality of care, decrease health care costs by eliminating unnecessary diagnostic testing and medical errors, and enhance patients' understanding of and compliance with treatments.

Endnotes

1 This document outlines information gathered as of November 2009. Special thanks to Yue Pui Chin for assisting with the research for this update.

2 This document is available at **http://www.healthlaw.org**.

3 States can draw down Medicaid/SCHIP funding in two ways — as a "covered service" (paying for the cost of a service, such as a doctor's office visit or a hospital stay) or as an "administrative expense" (paying for the costs of administering the program). For information see *How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and CHIP Enrollees?* available at **http://www.healthlaw.org**.

4 For "covered services", the federal reimbursement rate varies from 50–83%, based on the state's per capita income. For "administrative" expenses, every state receives 50% of its costs from the federal government.

5 "Fee-for-service" generally refers to services *not* provided through a managed care organization, community health center or in-patient hospital settings. Providers agree to accept a state-set "fee" for the specific "service" provided.

6 Language agencies are organizations that contract with and schedule interpreters. They may also oversee assessment and/or training.

7 Providers who have staff interpreters cannot submit for reimbursement.

8 FY 2007 ran from October 1, 2006–September 30, 2007.

9 The state's fiscal year runs from July 1 through June 30.

10 The state's fiscal year runs from July 1 through June 30.

11 Language Access: Giving Immigrants a Hand in Navigating the Health Care System, NCSL's *State Health Notes*, volume 23, number 381, October 7, 2002).

12 The state's fiscal year runs from July 1 through June 30.

13 FY 2005 ran from July 1, 2004 through June 30, 2005.

14 Interpreter Services, Medicaid Services Bureau, 11/27/02, *available from* National Health Law Program.

15 FY 2006 ran from July 1, 2005 through June 30, 2006.

16 NH switched from a covered service to an administrative reimbursement due to a change in CMS policy; subsequently CMS clarified that states can get reimbursed at the covered service rate. Since New Hampshire's FMAP for medical services, 50%, is the same as for administrative expenses, no practical difference exists in New Hampshire. For SCHIP, considering language services as a covered service would increase the federal share of costs.

17 The state's fiscal year runs from July 1 through June 30.

18 For example, pharmacy, dental and chiropractic services.

19 Bau I, Chen A. Improving access to health care for limited English proficient health care consumers: Options for federal funding for language assistance services. *The California Endowment Health in Brief* April 2003.

20 The state's fiscal year runs from July 1 through June 30.

21 The state's fiscal year runs from July 1 through June 30.

22 Washington has two reimbursement mechanisms. The first is for non-public entities — this includes most fee-for-service providers, managed care providers, and non-public hospitals.

23 The fiscal year runs from July 1, 2003 through June 30, 2004.

24 The Title VI Advisory Committee composed of representatives from all divisions within the Department, including public health, social services, mental health, vocational rehabilitation, and Medicaid, and volunteers from the North Carolina Institute of Medicine, the Justice Center (legal aid) and several statewide advocacy groups. Its 25 members have a wide range of skills and hold various positions in and out of state government.

25 In 1999, NCDHHSDSS contracted with CNNC to train health and human service interpreters in languages other than Spanish (the state contracted with NC Area Health Education Centers (AHEC) to train Spanish interpreters) and provide refugee interpreter services in the state. Beginning three years ago, AHEC began contracting with CNNC for the bulk of its interpreter training services. CNNC also maintains an interpreter bank from which health care providers can contract trained interpreters.

26 S.B. No. 376 passed the Senate on March 17 and the House on May 9, 2005. A separate bill, H.B. No. 3235, was also enacted requiring provision of interpreter services to deaf and hard of hearing Medicaid patients subject to the availability of funds. The five hospital districts given preference are Harris County Hospital District; Bexar County Hospital District; El Paso County Hospital District; Tarrant County Hospital District; and Parkland Health and Hospital System.

27 Separate reimbursement could have been initiated if the Medicaid agency would allow hospitals to exclude these costs from the cost reports and separately pay for language services.

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