The increasing number of patients with limited English proficiency (LEP) in the United States is an important issue for patients, physicians, federal and state government agencies, and insurance carriers. Physicians can actively address this healthcare barrier by becoming familiar with established state and federal guidelines and determining when appropriate linguistic services are required for their LEP patient populations. Physicians can ensure that appropriate care is administered to LEP patients by developing and monitoring plans that include training staff to identify and work with LEP patients, providing language assistance to LEP patients, and notifying LEP patients of special services.

According to the 2001 Supplementary Survey by the US Census Bureau, 33% of individuals aged 18 to 64 years who speak Spanish, and 22% of individuals in this age category who speak Asian or Pacific Island languages, reported that they spoke English either “not well” or “not at all.” Of course, not all patients who primarily speak non-English languages are foreign-born. Some of these patients may be US-born but live in relatively isolated ethnic enclaves.

To eliminate healthcare barriers experienced by the growing number of LEP patients, it is imperative that physicians and office staff comprehend federal, state, and private-sector requirements regarding LEP patients. It is also important for physicians to assess the multicultural populations living within their practices’ geographic areas and to incorporate appropriate interpretation and translation services within their practices.

Healthcare Barriers

There are many important and practical reasons for patients and physicians to communicate effectively and to understand each other. For example, physicians need to obtain accurate medical histories, and patients need to understand physician instructions and become an integral part of the patient-physician partnership. More often than not, LEP patients are hampered in these efforts because of language barriers. These barriers are likely to result in fewer visits to providers and delays in preventative services, fostering acquisition and exacerbation of chronic conditions and deterioration of acute symptoms leading to hospitalization.

Unresolved linguistic and cultural barriers can contribute to misunderstandings among patients regarding diagnosis, treatment, and self-care options. Other implications of these barriers can include inappropriate use of medications, lack of informed consent for procedures, longer hospital stays, poor patient satisfaction, and poor comprehension by patients of follow-up care plans. Temporary or permanent confusion, fears, and concerns among the rapidly expanding LEP population are compounded by difficulties these individuals have in accessing healthcare resources and providers.

Federal and State Regulations

A number of federal and state regulations are designed to protect LEP patients from encountering healthcare barriers. All
In New Jersey, mandatory cultural competency training, including physicians who participate in Medicare Part A or federally funded clinical trials or who provide treatment to certain other patient categories. Physicians enrolled only in Medicare Part B and who do not otherwise receive federal funds are not subject to the HHS requirements.

The CLAS standards also apply to patients needing services in American Sign Language and those covered by the Americans With Disabilities Act. The CLAS standards apply to any entity receiving funds from the HHS, including physicians who participate in Medicare Part A or federally funded clinical trials or who provide treatment to certain other patient categories. Physicians enrolled only in Medicare Part B and who do not otherwise receive federal funds are not subject to the HHS requirements.

The CLAS standards also apply to patients needing services in American Sign Language and those covered by the Americans With Disabilities Act. Figure 1 shows a comprehensive list of the CLAS standards.

Individual states vary in their quantity and scope of laws related to caring for LEP patients. All states have antidiscrimination laws that at least broadly encompass Title VI, Executive Order 13166, and the CLAS standards. In New Jersey, mandatory cultural competency training, including content for treating LEP patients, is required for all physicians and podiatrists before relicensure. Curricular integration of cultural competency is required in all New Jersey medical schools. California and Washington State require varying degrees of cultural competency training or continued medical education regarding LEP patients before physician relicensure. Many other states currently have legislation in various stages of development involving integration of cultural competency and LEP proficiency training for healthcare providers.

In addition to federal and state laws, the American Osteopathic Association, Accreditation Council for Graduate Medical Education, and American Board of Medical Specialties have all mandated the implementation of core competencies in medical training programs. These requirements include competencies in communication skills and professionalism, such as sensitivity to patient age, culture, disability, and sex, and recognition of cultural diversity among patient populations in served communities.

Although no finite numbers or time frames are recommended in the HHS guidelines, the following is noted about these factors and a physician’s obligation to provide services to LEP patients:

As clarified by the guidance, the extent of Title VI obligations will be evaluated based on a four-factor test including the nature or importance of the service. In this regard, the guidance points out that documents deemed “vital” to the access of LEP persons to programs and services may often
CLAS Standards

- **Standard 1**—Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

- **Standard 2**—Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

- **Standard 3**—Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

- **Standard 4**—Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

- **Standard 5**—Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

- **Standard 6**—Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

- **Standard 7**—Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

- **Standard 8**—Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

- **Standard 9**—Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

- **Standard 10**—Health care organizations should ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated.

- **Standard 11**—Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

- **Standard 12**—Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

- **Standard 13**—Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

- **Standard 14**—Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Figure 1. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, developed by the Office of Minority Health, US Department of Health and Human Services.27
have to be translated. Whether or not a document (or the information it contains or solicits) is “vital” may depend upon the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner.

Providers with small practices will have considerable flexibility in determining precisely how to fulfill their obligations to ensure meaningful access for LEP patients, as noted in the following excerpt from the HHS guidelines43:

There is no “one size fits all” solution for Title VI compliance with respect to LEP persons, and what constitutes “reasonable steps” for large providers may not be reasonable where small providers are concerned. Thus, smaller recipients with smaller budgets will not be expected to provide the same level of language services as larger recipients with larger budgets. [The HHS Office for Civil Rights] will continue to be available to provide technical assistance to HHS recipients, including sole practitioners and other small recipients, seeking to operate an effective language assistance program and to comply with Title VI.

Office Protocols
Providers can take several steps to establish procedures for identifying LEP patients. An easy identifier is the use of the US Census Bureau’s “I Speak” language identification cards.44 An I Speak card lists a phrase in numerous languages to allow the patient to identify his or her preferred language. These cards should be placed in an easily viewed area in the provider’s waiting room or front office. A sample format of an I Speak card can be seen at: http://www.usdoj.gov/crt/cor/Pubs/ISpeakCards2004.pdf.

Other key elements in implementing an effective LEP identification plan are language assistance measures, such as listing the language services available in the waiting room or front office, developing a plan to respond to phone calls or written communications from LEP patients, and selecting competent interpretation and translation services.45 Notices of the available healthcare resources provided at an office should also be displayed for LEP patients in the appropriate languages.

Because appropriate execution and eventual monitoring of the LEP protocol in the office is crucial,46 the provider must ensure that the office staff is thoroughly trained in LEP-related areas.

Interpretation and Translation Services
Professional interpreters are the conduit for effective, efficient, and reliable communication between healthcare professionals, LEP patients, and patients’ families.46 Trained medical interpreters have been shown to not only decrease clinically meaningful communication errors,47 but also to be an effective means of enhancing quality of care.48 The October 2009 launch of the first national certification program for medical interpreters aims to enhance patient safety by evaluating and ensuring the competency of medical interpreters.49

Although interpreters are involved in the communication aspects of patient care, translators are typically used to reproduce written or printed material in other languages. Informed consents, privacy guidelines, and blood test consent forms are examples of documents that may need to be translated.27

With regard to interpretation services, the CLAS standards provide the following recommendations27:

- Telephone language interpreters can be found via online searches using such key words as medical interpreter coupled with the provider’s city and state.
- Use of a patient’s family members or friends as interpreters is discouraged unless requested by the patient. Family members or friends may misinterpret or misrepresent medical discussions and may also compromise the patient’s privacy. Staff should suggest to the patient that a trained interpreter be present during the clinical encounter to ensure accurate interpretation. This offer and the patient’s acceptance or rejection of the offer should be documented in the patient’s file.27
- The use of a minor for interpretation is not acceptable because of privacy issues, the shift of power from the patient to the minor, and the potential for emotional trauma to the minor.
- Staff members should be used as interpreters only if they are fluent in the necessary language and trained in appropriate medical terminology—and if interpretation services are among the designated duties of their employment position. However, the provider should check with state health officials to find out if staff can legally be used in interpretation. Some states have laws that specifically define positions that can and cannot perform medical interpretation duties.50
Staff members not trained as interpreters may breach patient confidentiality, provide inaccurate communication, contribute to misdiagnosis and reduce quality of care. Although trained medical interpreters are a valuable part of the medical team, the provider should not assume that interpreters are aware of patients’ cultural values, beliefs, and behaviors.

Ideally, scheduling of patient visits should be coordinated to allow for interpreters to attend medical office visits with LEP patients. If onsite interpreter visits are not available, telephone-based interpretation by medically trained operators is provided by various commercial vendors. Although this telephone service is less expensive than onsite interpreters, lack of necessary dual headphone equipment and the potential of the interpreter missing nonverbal cultural cues over the phone are limiting factors.

Before committing to a particular interpretation service, providers should obtain certification records, check references, compare costs, and perform background research on all available options. Other practical suggestions regarding interpretation services include medical record documentation of every patient’s preferred language and the name of the interpreter or interpretation company used for each LEP patient. Figure 2 lists Web sites that provide more information about telephone interpretation and translation services.

Many physicians are concerned about the financial implications of providing language assistance services, especially interpretation. For example, physicians receiving Medicare or Medicaid reimbursement may believe that the cost of telephone or in-person interpretation services is more expensive than the reimbursement they would receive for the office visit—because the service provided by the interpreter cannot be billed to the patient in such cases.

A law effective in California as of January 2009 mandates that all health insurers in the state provide language assistance services to their members who have limited English proficiency. This law was passed to help alleviate both language and cultural barriers experienced by LEP patients in the state.

In the absence of reimbursement, physicians should consider the substantial hidden costs associated with misunderstood instructions, missed appointments, and other consequences of not eliminating language barriers for patients. Physicians should also consider the ethical and malpractice risks of treating patients with whom they cannot effectively communicate.

Conclusion
Providing interpretation and translation services to LEP patients is an important step in eliminating healthcare barriers and providing effective healthcare. Recognizing that—regardless of language barriers—patients may forget a substantial amount of medical information provided during medical office visits, we should at least attempt to ensure that our LEP patients have appropriate services to initially comprehend the information we give them.

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References

Figure 2. Web site resources for telephone interpretation and translation services and training.

| American Translators Association          | http://www.atanet.org |
| International Medical Interpreters Association | http://www.imiaweb.org |
| National Council on Interpreting in Health Care | http://www.nchc.org |


34. Calif Bus Prof Code §21901.0.

35. Wash Rev Code §43.70.615.


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