

ABSTRACT

Language and Cultural Barriers in the United States Healthcare System

Amanda Kaye Sutton

Director: Jennifer Good, Ph.D.

This Honors Thesis aims to examine and address the insufficient provision of language accommodation services for non-English-speaking patients and patients with limited English proficiency seeking care in the United States, as well as to provide suggestions to mitigate the issue. First, I relay stories of documented instances in which language barriers have led to negative outcomes for patients and derive from these stories a list of the greatest challenges associated with the presence of language barriers in U.S. health care. Next, I provide an overview of the current standards and laws at the federal and state level associated with language accommodation in healthcare settings to provide readers a glimpse into the United States' current status in response to the issue. Then, I present a comparison study comparing the United States to Australia, a country with an advanced system of language accommodation services from which the U.S. can learn. Finally, I review suggestions, recommendations, and steps that the United States can use to improve its current system of language accommodation services in healthcare settings.

APPROVED BY DIRECTOR OF HONORS THESIS:

Dr. Jennifer Good, Department of Modern Languages and
Cultures

APPROVED BY THE HONORS PROGRAM:

Dr. Elizabeth Corey, Director

DATE: _____

LANGUAGE AND CULTURAL BARRIERS IN THE UNITED
STATES HEALTHCARE SYSTEM

A Thesis Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the Requirements for the

Honors Program

By

Amanda Sutton

Waco, Texas

January 2022

TABLE OF CONTENTS

ACKNOWLEDGMENTS	v
CHAPTER ONE: Introduction: The United States' Changing Demographics and Need for Linguistic and Cultural Accommodation	1
<i>Literature Review</i>	2
<i>Introduction to the Following Chapters</i>	5
CHAPTER TWO: Greatest Challenges.....	11
<i>Laws and Standards and Enforcement</i>	11
<i>Ad Hoc and Other Unlicensed Interpreters</i>	13
<i>Lack of Time</i>	16
<i>Lack of Resources</i>	18
CHAPTER THREE: Federal and State Laws and Standards.....	23
<i>CLAS Standards</i>	24
<i>Implementation</i>	25
<i>New CLAS Standards</i>	28
<i>Dynamicity of Culture</i>	28
<i>Complexity of Health</i>	29
<i>Intended Audience</i>	29
<i>Action Words</i>	30
<i>All Standards are of Equal Importance</i>	30
<i>Organization of Standards</i>	31

<i>Audiences</i>	32
<i>The Future</i>	33
<i>Federal Laws</i>	35
<i>The Public Health Service Act</i>	35
<i>Title VI of the Civil Rights Act of 1964</i>	36
<i>The Affordable Care Act</i>	37
<i>State Laws</i>	39
<i>Georgia</i>	39
<i>California</i>	41
<i>Public and Private Organizations</i>	42
<i>Training and Qualifications</i>	43
<i>Particular Populations</i>	43
CHAPTER FOUR: International Comparison: Interpreting and Translating Services in Australia's Healthcare System	46
<i>National Accreditation</i>	47
<i>Federal Government</i>	49
<i>Federal Legislations</i>	50
<i>Federal Services</i>	52
<i>Material Incentives</i>	53
<i>New South Wales Government</i>	54
<i>State Services</i>	54
<i>State Legislations</i>	54
<i>Solutions/Recommendations for U.S. Implementation</i>	56

CHAPTER FIVE: Conclusion: The Future of Interpreting and Translating Services in United States Health Care	60
<i>Laws and Standards and Enforcement</i>	60
<i>Ad Hoc and Other Unlicensed Interpreters</i>	63
<i>Lack of Time</i>	65
<i>Lack of Resources</i>	67
APPENDICES.....	71
APPENDIX A.....	72
APPENDIX B.....	76
APPENDIX C.....	78
APPENDIX D.....	79
APPENDIX E.....	86
BIBLIOGRAPHY.....	87

ACKNOWLEDGMENTS

I would like to sincerely thank Dr. Jennifer Good, Associate Professor of German and Division Director for German and Russian. She has helped me tremendously with undergraduate advising, my Honors Thesis, and scholarship applications—the National Security Education Program (NSEP) David L. Boren Scholarship, which I was awarded for study in Kyrgyzstan during Spring 2022, and the Fulbright Scholarship. I would especially like to thank her for excellence and expertise in helping me write my Honors Thesis and for meeting with me every two weeks, including during the holidays!

I would also like to thank Dr. Adrienne Harris, Associate Professor of Russian, for serving on my Thesis Defense Committee and teaching me in Russian film, Russian literature, and Medical Russian. Furthermore, I would like to thank her for influencing me to apply for and receive the Department of Education’s Foreign Language and Area Studies (FLAS) Award which allowed me to enroll in an Intensive Russian language program at Indiana University during Summer 2021.

Next, I would like to thank Dr. Karol Hardin, Professor of Spanish, for giving me valuable resources as I began my thesis—the CLAS blueprint, CLAS toolkit, and several others—and for agreeing to serve on my Thesis Defense Committee.

Finally, thank you to my family—mom, dad, sister, and brother—for being eager to read my Honors Thesis and offering feedback on ways to improve it.

CHAPTER ONE

Introduction: The United States' Changing Demographics and Need for Linguistic and Cultural Accommodation

According to the 2010 Census Bureau, nearly twenty percent of households in the United States use a language other than English, and roughly nine percent of the United States' population has limited proficiency in English (U.S. Department of Commerce). In addition, researchers predict that Hispanic, Black, Asian, and other non-white racial categories will make up fifty-three percent of the United States population in 2050 (Passel and Cohn).

The rapidly changing demographics of the United States, a country that continues to diversify in terms of its population's linguistic and cultural backgrounds, make it essential that the U.S. devise measures to accommodate *all* of its people. Health Care, a basic human right—according to Article 25 of the Universal Declaration of Human Rights—is an area in which linguistic and cultural accommodation is absolutely necessary (United Nations Human Rights: Office of the High Commissioner). This Honors Thesis documents the United States' current status related to providing linguistically and culturally appropriate services to Non-English-Speaking (NES) and Limited-English-Proficiency (LEP) patients and discusses solutions for how the United States can improve its provision of these services.

Literature Review

As I began my research, I became interested in exploring the ways in which culture affects people's views about health and how they approach health care. Focusing specifically on Russian immigrants, a group in which I am deeply interested, I explored the following studies: Mehler et al.'s "Russian Immigrant Cardiovascular Risk Assessment," Newhouse's "Working with Russian-Jewish Immigrants in End-of-Life Care Settings," Long's "The Effect of Russian Traditional Medicine on the Health Care of Russian Immigrants to America," Eckemoff et al.'s "End of Life Care for Older Russian Immigrants - Perspectives of Russian Immigrants and Hospice Staff," Purath et al.'s "Physical Activity: Exploring Views of Older Russian-Speaking Slavic Immigrants," and Duncan and Simmons' "Health Practices among Russian and Ukrainian Immigrants."

Eventually, I came across Ivanov and Buck's "Health Care Utilization Patterns of Russian-Speaking Immigrant Women Across Age Groups," which presented cultural differences between patients and providers as a barrier to healthcare access. My interest in Ivanov and Buck's study then led me to find real stories in which linguistic and cultural differences led to negative patient outcomes. I found these stories in KMUW's article "WSU Professor Champions Legislation Ensuring Kansas Hospitals Have Qualified Interpreters," Price-Wise's "Language, Culture, And Medical Tragedy: The Case Of Willie Ramirez," and Quan's "The High Cost of Language Barriers in Medical Malpractice." These articles demonstrated the severity of language and cultural barriers in health care and led me to research the current U.S. federal and state standards and laws that aim to mitigate these barriers.

In my exploration of standards and laws, I read two documents regarding the United States' standards for interpreting and translating (I/T) services in health care. First, I read the Office of Minority Health's "National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice," or the "CLAS Standards Blueprint." Then, I reviewed the University of Colorado Anschutz Medical Campus Center for Bioethics & Humanities' "A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Communication Climate Assessment Toolkit," or the "CLAS Standards Toolkit." Healthcare providers can use the CLAS Standards Toolkit to ensure that they are successfully implementing the CLAS Standards into their practices.

A review of the CLAS standards led me to research relevant federal laws. From the CLAS Standards Blueprint, I learned of Title VI of the Civil Rights Act of 1964, the Public Health Service Act, and the Affordable Care Act of 2010. I included information about these laws in my thesis with the help of the CLAS Standards Blueprint and the laws' written statutes.

In addition to federal laws, I studied the state laws in depth. First, I read Youdelman's "The Medical Tongue: U.S. Laws And Policies On Language Access," which provided a summary of the subject areas of different states' healthcare language access laws—training, licensure, particular populations, and more. In this article, Youdelman states that California's laws are the most comprehensive regarding healthcare I/T services. For this reason, I chose to study California's policies, which I would later incorporate into my state comparison study. I also read the National Health Law

Program's "The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond," prepared by Youdelman. After reading this document, I chose to compare Georgia to California, as Georgia appeared to be the least progressive state regarding its healthcare I/T laws. The National Health Law Program's document provided a majority of the information presented in this thesis, as it provided descriptions of every healthcare I/T provision for all fifty states.

In my research to find a country from which the United States could learn regarding the implementation of I/T services in healthcare settings, I looked at multiple countries that I believed would have advanced I/T services due to their geographical locations. My first instinct was to find information regarding the United Kingdom and countries in the European Union, a union composed of twenty-seven closely situated countries, between which people can easily travel. Unfortunately, I was unable to find sufficient information regarding healthcare I/T services in any of these countries.

Earlier in my research, I found a study conducted by Australian researchers regarding language translation apps in healthcare settings—Panayiotou's "Language Translation Apps in Health Care Settings: Expert Opinion." The study expressed Australia's need and effort to find alternative I/T methods in the event that an interpreter is unavailable. After reading Panayiotou's article, and realizing that Australia is similar to the United States as they are both English-speaking countries, I sought to find information regarding Australia's healthcare I/T policies and services.

One work that I came across was Ozolin's "Interpreting and Translating in Australia Current Issues and International Comparisons," which provided most of the information in this thesis regarding Australia's federal laws and services. Ozolin's work

reviewed Australia's federal and state I/T laws and particularly highlighted the progressiveness of New South Wales and Victoria compared to other states. In addition to reading Ozolin's work, I came across an article from the University of New South Wales—Garrett's "Healthcare Interpreter Policy: Policy determinants and current issues in the Australian context." From these works, I understood that New South Wales deeply recognizes the issue of language and cultural barriers and strives to advance its policies and services to accommodate people who face these barriers. Accordingly, I focused on New South Wales as an exemplary state government and retrieved information from the NSW 2017 policy directive, "Interpreters – Standard Procedures for Working with Health Care Interpreters."

Overall, there was a sufficient amount of literature available for my Honors Thesis research. However, in my search to discover countries to which I could compare the United States, I found very little. I believe that a lot more research needs to be done regarding I/T healthcare policies and services in other countries. This Honors Thesis aims to mitigate language and cultural barriers in the United States healthcare system; however, these barriers exist globally. If researchers assess the gravest challenges and greatest advancements regarding healthcare I/T policies and services of different countries, nations can learn from each other and become one step closer to mitigating these issues on a global scale.

Introduction to the Following Chapters

In Chapter Two, the United States' greatest challenges concerning the provision of interpreting and translating (I/T) services are discussed. This chapter uses real patient stories to illustrate the harm that comes from inadequate laws and lack of enforcement of

standards of care for NES and LEP patients. KMUW's article "WSU Professor Champions Legislation Ensuring Kansas Hospitals Have Qualified Interpreters" exemplifies the first challenge—lack of enforcement of I/T standards and laws. This article discusses the consequences that a Spanish-speaker faces when his healthcare institution fails to uphold its federal obligation to provide him an interpreter.

Price-Wise's "Language, Culture, And Medical Tragedy: The Case Of Willie Ramirez" displays the second challenge—the use of ad hoc and other unlicensed interpreters. The article speaks about a Spanish-speaking man whose physician relied on Ramirez's family members to serve as interpreters; an error that resulted in further harm. In addition, Quan's "The High Cost of Language Barriers in Medical Malpractice" discusses the issue by providing a story of a Vietnamese girl whose physician relied on her and her sixteen-year-old brother to serve as interpreters and failed to provide linguistically appropriate discharge instructions understandable by the girl's Vietnamese-speaking parents.

Rivadeneyra's "Patient Centeredness in Medical Encounters Requiring an Interpreter" showcases the third challenge—lack of sufficient time in physician-patient interactions with NES and LEP patients. This account demonstrates that English-speaking patients use significantly more verbal cues—ways in which patients express their symptoms, feelings, and concerns—compared to non-English-speaking patients.

Finally, Ivanov and Buck's "Health Care Utilization Patterns of Russian-Speaking Immigrant Women Across Age Groups" and Panayiotou et al.'s "Language Translation Apps in Health Care Settings: Expert Opinion" bring to light the fourth challenge: lack of resources available for NES and LEP patients. The first study highlights the need for

resources that explain U.S. healthcare operations and practices to non-English-speaking patients, particularly immigrants. The second study considers the development of language translation applications and how they may one day be valuable for NES and LEP patients if they are adapted to be suitable for healthcare settings.

Chapter Three reviews the United States' federal and state laws and standards. First, the chapter discusses the National Standards for Culturally and Linguistically Appropriate Services (CLAS) using the Office of Minority Health's "National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice," or the "CLAS Standards Blueprint." Additionally, the chapter reviews the University of Colorado Anschutz Medical Campus Center for Bioethics & Humanities "A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Communication Climate Assessment Toolkit," or the "CLAS Standards Toolkit," a helpful resource for healthcare providers as they implement the CLAS Standards in their practices.

This chapter also reviews various federal laws relevant to the CLAS standards. The Public Health Service Act pertains to the attainability of health insurance coverage for NES and LEP patients. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the grounds of race, color, or national origin. This law requires federally funded healthcare institutions to follow CLAS Standards 5, 6, 7, and 8, to offer and notify patients of their right to receive free language services, ensure the competency of interpreters, and provide supplementary materials to patients. Finally, the more contemporary Affordable Care Act helps LEP and NES patients access health care

through navigators—paid entities that provide language assistance. Navigators help patients in their navigation of different health insurance plans.

Chapter Three also includes a review of State Laws using the National Health Law Program’s “Summary of State Law Requirements Addressing Language Needs in Health Care,” prepared by Mara Youdelman. The document describes every healthcare I/T provision enacted by each state. By comparing the laws of Georgia and California, the chapter provides a glimpse at the range of available resources, services, and expectations among U.S. states, from the least and most progressive states regarding I/T provisions.

Chapter Four introduces an international comparison between the United States and Australia, one of the world’s leaders in its provision of interpreting and translating services. Australia’s interpreter accreditation organization, the National Accreditation Authority for Translators and Interpreters (NAATTI), is reviewed first using information from Ozolins’ “Interpreting and Translating in Australia Current Issues and International Comparisons.” Ozolins is a well-known professor and researcher in Australia who advocates for the advancement of policies regarding interpreting and translating services.

Next, the chapter discusses a series of Australia’s federal laws. First, the chapter considers the Disability Discrimination Act 1992 which aims to accommodate deaf people through sign language interpretation. Next, the chapter examines the Human Rights and Equal Opportunity Act 1986, Racial Discrimination Act 1975, Australia’s Multicultural Statement - Multicultural Australia: United, Strong, Successful 2017, and the People of Australia: Australia’s Multicultural Policy 2011, which aim to elevate human and civil rights. Finally, the chapter discusses the National Health Reform Act

2011 and National Safety and Quality Health Service (NSQHS) Standards, which offer guidance towards the delivery of more equitable health care for indigenous populations.

After reviewing Australia's federal laws, Chapter Four utilizes Ozolin's work again as a resource to provide information about the Linguistic Availability Performance Allowance (LAPA), which offers material incentives to bilingual federal employees, and the Translating and Interpreting Service (TIS National), which is a federally run and free I/T service.

Finally, Chapter Four reviews the I/T services and policies of one of Australia's states, New South Wales (NSW), using the state's 2017 Policy Directive, "Interpreters – Standard Procedures for Working with Health Care Interpreters." The NSW policy directive discusses the state's mandates for healthcare institutions and its Health Care Interpreter Services (HCIS).

The conclusion, Chapter Five, provides a series of solutions which review and aim to mitigate the United States' greatest challenges concerning the provision of (I/T) services. The solutions were determined through an examination of existing laws and services that provide the foundation for I/T services in Australia's healthcare system and were tailored to fit the context of the U.S. landscape, where there is a need and opportunities for improvement.

In short, the United States fails to provide NES and LEP patients equitable health care due to existing language and cultural barriers. There is a pressing need for improvement, enforcement, and broadening of federal and state laws and standards in order to provide better language assistance services. Novel ideas, which were adapted from my research and comparisons that may benefit the U.S., include an increase in the

number, significance, and enforcement of existing and future standards and laws, an end to the use of unlicensed interpreters, increased physician-patient interaction time, and higher availability of resources for NES and LEP patients.

This Honors Thesis familiarizes readers with the current challenges and federal and state laws and standards regarding interpreting and translating services in the United States healthcare system. To respond to rapidly changing demographics and provide solutions to the problem of language and cultural barriers that can lead to negative patient experiences for non-English-speaking and limited-English-proficiency patients, it is critical that the United States identifies the weaknesses in its current system and its people work as a society through public education, advocacy, and law-making to overcome this severe weakness in the U.S. healthcare system.

CHAPTER TWO

Greatest Challenges

Among the many challenges regarding language accommodation in the United States healthcare system, the most notable are: (1) the lack of national and state standards and laws and/or the failure of the government to enforce existing standards and laws, (2) the use of ad hoc and other unlicensed interpreters, (3) the time constraints involved in physician-patient interactions, and (4) the lack of available resources for Limited-English-Proficiency (LEP) and Non-English-Speaking (NES) patients who are unable to access and/or do not understand the operations and practices of healthcare services in the United States. In order to draw attention to these challenges, news sources have published numerous articles and researchers have launched targeted studies highlighting the ways in which language barriers have manifested themselves into real-life medical encounters.

Laws and Standards and Enforcement

In response to the ever-present and growing proportion of NES and LEP patients in the United States healthcare system, the Department for Health and Human Services has devised a list of standards known as the National Standards for Culturally and Linguistically Appropriate Services (CLAS). While these standards are necessary for high-quality health care, they only serve as suggestions, leaving many hospitals throughout the United States with the freedom to decide whether or not they will follow these standards. The only hospitals that are required to follow any of the national standards are federally funded hospitals bound to Title VI of the Civil Rights Act of

1964. While Title VI is one step in the right direction towards healthcare equality for those with limited or no English proficiency, it requires hospitals to adhere to only four of the fifteen CLAS standards (The University of Colorado Anschutz Medical Campus Center for Bioethics & Humanities 30). This means that there are still many opportunities for the negative effects of language barriers to manifest themselves into everyday medical encounters.

In addition to the CLAS standards and Title VI of the Civil Rights Act, most states have their own laws regarding availability and accessibility of language accommodation services in healthcare settings. However, there is a large disparity between states, as some states have hundreds of laws regarding access to these language accommodation services and others have only a few. In addition to the need for more laws and standards at the state and federal levels, there is an issue with the enforcement of pre-existing laws and standards. Rachel Showstack, a Wichita State sociolinguist and Spanish professor, speaks in depth about both of these issues in an article for KMUW, a member station of National Public Radio (NPR) located in Wichita, Kansas. The article highlights the story of a Spanish-speaking teenage boy who was misdiagnosed with a Sexually Transmitted Disease (STD), while in reality he was suffering from a case of appendicitis. This misdiagnosis was caused by the hospital's failure to provide the boy with an interpreter during his stay at the hospital. Showstack notes that many of the federally funded hospitals in Kansas fail to uphold their Title VI obligation, which is to follow the four mandatory CLAS standards, one of which requires hospitals to provide interpreters free of charge (Office of Minority Health). Furthermore, the article states that "Kansas doesn't mandate that hospitals and clinics provide certified interpreters" and

that people who do end up working as interpreters are not required to obtain a specific number of training hours before participating in real-life medical situations (“WSU Professor Champions Legislation Ensuring Kansas Hospitals Have Qualified Interpreters”). All of these findings suggest that Kansas is a major contributor to the healthcare disparity between the states, as it is a state with very limited laws regarding availability and accessibility to language accommodation services in healthcare settings.

As KMUW’s article and Showstack suggest, the gravity of language barriers in health care is often overlooked, and this idea is reflected in the lack of set standards—the absence of a training-hour requirement for interpreters and the lack of enforcement of those standards, which is evident through the failure of federally funded hospitals to provide language accommodation services to patients. Before any progress can be made regarding to the availability and accessibility of language accommodation services in healthcare settings, there must be an improvement in both the development and enforcement of language accommodation laws and standards at both the federal and state levels.

Ad Hoc and Other Unlicensed Interpreters

Doctors and patients often rely on family members and friends to serve as interpreters when a licensed interpreter is not present, and these people are referred to as *ad hoc* or *de facto* interpreters. In cases in which an ad hoc interpreter is used, severe or life-threatening problems may result.

Gail Price-Wise, a board member of the Nonhuman Rights Project, has spent most of her professional career seeking to improve healthcare services for minorities. In her article, “Language, Culture, And Medical Tragedy: The Case Of Willie Ramirez,” she

shares the story of Willie Ramirez, a man who acquired a serious disability due to the mistranslation of one word. One night, Ramirez experienced an intense headache and was brought to the hospital alongside his mom, sister, girlfriend, and girlfriend's mom. While talking to the ER physician, his family and friends used the word "intoxicado" to describe Ramirez's condition. The doctor assumed that "intoxicado" was a cognate for the English word "intoxicated." However, in Cuban culture, "intoxicado" is a word that signifies a sickness resulting from a substance that the affected person ate or drank. After failing to receive proper treatment, Ramirez fell unconscious. Soon after, he was found to have a brain hemorrhage which bled for several days, ultimately leading to quadriplegia.

After the incident occurred, the doctor stated that after talking to Ramirez's family, his understanding was that "he was upset about a fight with his girlfriend and had taken drugs" (Price-Wise 1). However, Ramirez's sister gave an entirely different account of what happened in the emergency room that night. In her statement, she said "The ER doc said to my mom that he thought it was drugs – that Willie's condition looked like a drug overdose... But a doctor said it – and you tend to believe what a doctor says. So we didn't protest. We didn't tell him this was impossible – that Willie never took drugs" (Price-Wise 3).

Amidst the confusion that occurred between the doctor and Ramirez's family members, two things are for certain. First, it is clear that the use of ad hoc interpreters may result in the mistranslation of one single word, causing a patient, such as Ramirez, to suffer from irreversible consequences, such as quadriplegia caused by a brain hemorrhage. Second, Ramirez's case highlights the importance of the need for cultural competence in health care, as it is common for people in certain cultures to refrain from

questioning or contradicting authority figures. This is exactly what happened in the interaction between Ramirez's family members and the ER doctor the night that Ramirez was admitted to the hospital .

The consequences of using ad hoc interpreters is also evident in the case of a nine-year-old Vietnamese girl, Tran. Tran was admitted to the hospital because she was thought to be suffering from gastroenteritis. In alignment with this misdiagnosis, the emergency room doctor administered the drug Reglan and noted in the discharge instructions that Tran should be brought back to the emergency room in the case that she started to experience diarrhea. Unfortunately, Tran's parents primarily spoke Vietnamese, and they could not properly understand the discharge instructions presented to them by the doctor. Furthermore, Tran, nine-years-old, and her brother, sixteen-years-old, were forced to serve as interpreters during her time in the emergency room. Eventually, Tran was discharged from the hospital, suffered from a bad reaction to the drug Reglan, and died. This tragic incident occurred because the emergency room failed to adequately inform the patient's parents and relied on Tran's sixteen year old brother to accurately convey the information between parties. As a result of the confusion, Tran's parents did not understand under what conditions their daughter should have been brought back to the emergency room (Quan).

The Tran case sheds light on multiple challenges occurring within the United States healthcare system. First, the hospital's decision to use an ad hoc interpreter in connection with its failure to provide and make use of a certified interpreter. Second, and an even deeper issue, was the hospital's willingness to exploit a child as an ad hoc interpreter, which in Tran's case was her and her sixteen year old brother. As displayed in

these two cases, there is a need for regulations regarding the use of ad hoc interpreters, and hospitals must overcome the challenge of knowing when it is appropriate to provide a certified interpreter in order to provide NES and LEP patients with the language accommodation services that they deserve.

Lack of Time

The presence of language barriers is compounded by a major problem in health care, the lack of physician-patient interaction time. This lack of time is often due to the physician's goal to balance his/her economic goals with his/her duties as a physician. Unfortunately, this time limitation affects NES and LEP patients more than English-speaking patients, because the need for an interpreter causes the traditional two-person physician-patient interaction to turn into a three-person interaction between a physician, a patient, and an interpreter.

This problem is highlighted in a study titled "Patient Centeredness in Medical Encounters Requiring an Interpreter," in which Rocio Rivadeneyra and others focus on English-speaking physicians' use of the patient-centered approach with English-speaking patients and Spanish-speaking patients. In patient-centered encounters, physicians and patients are treated as partners in a medical dialogue, and physicians try to understand not only the patient's symptoms, but also the patient's thoughts and feelings. A study was conducted in which researchers video-recorded nineteen English-speaking and nineteen Spanish-speaking patients during their first encounter with an English-speaking physician. Each videotape was then coded and the patients' verbal cues were divided into six categories: symptoms (description of physical evidence of illness), expectations (a statement conveying that the patient is looking forward to something), thoughts (ideas

about the illness), feelings (expression of an emotional state), prompts (a patient repeats a request that the physician previously ignored), and nonspecific cues (cues that do not fit into any of the other categories). Verbal cues, rather than physical cues, were assessed because they serve as the best indicator as to whether a medical encounter is patient-centered.

The results show that English-speaking patients scored significantly higher in five of the six verbal cues, and furthermore, that English-speaking patients used almost three times as many verbal cues as Spanish-speaking patients. Moreover, in order prove that the disparities in verbal cues were the result of a language, and not a cultural barrier, researchers compared Latino English-speaking patients and non-Latino English-speaking patients. The results showed that there was no significant difference in the amount of verbal cues used between the two groups. While assessing the results from this study, it is most logical to claim that English-speaking patients used significantly more verbal cues than Spanish-speaking patients due to a disparity in time. When interpreters are incorporated into patient-physician interactions, a large portion of time is consumed during interpretation. This time deficit proves to have a negative impact on NES and LEP patients' ability to express their symptoms, feelings, and concerns (Rivadeneyra et al.).

The consequences of time constraints are not limited only to a patient's ability to express his/her concerns but also affect other facets of patient-physician interactions. For example, due to a lack of time, physicians may not be able to perform a complete physical assessment of the patient. Furthermore, when these medical encounters are not long enough, patients may not fully understand the scope of their conditions and must return for additional appointments. To avoid these negative consequences in the future,

methods aimed at improving physician interactions with NES in LEP patients must be created with respect to time constraints.

Lack of Resources

A major problem in the U.S. healthcare system today is the lack of resources available for NES and LEP patients. These resources may take the form of instructions on how to receive health care or tools designed to improve the healthcare experience for NES and LEP patients.

In a study titled “Health Care Utilization Patterns of Russian-Speaking Immigrant Women Across Age Groups,” L. Louise Ivanov and K. Buck aim to gain a better understanding of the effect of culture on healthcare utilization patterns among immigrants. In this study, women from the former Soviet Union—specifically, modern-day Russia, Belarus, and Ukraine—were divided into three focus groups based on their ages. Focus group 1 consisted of nine women who were between 20 and 30 years old, focus group 2 consisted of six women who were between 37 and 46 years old, and focus group 3 consisted of sixteen women who were 60 years old and older. The women were asked a series of questions regarding their healthcare experiences, perceived barriers to receiving health care, use of preventive medicine, access to prenatal care, and overall satisfaction with the healthcare services in the United States.

Four important findings from the study were as follows: immigrant women (1) did not understand the importance of preventive medicine, (2) did not understand the referral system, (3) viewed the cost of co-payments and medications as a major barrier of access to health care, and (4) did not like the physicians’ reliance on technology to assess their healthcare conditions. Most of the women in this study expressed the belief that the

physician is responsible for teaching them about preventive medicine and referring them to other physicians. This aspect of increased dependence likely stems from healthcare practices in the former Soviet Union (USSR). Furthermore, the women did not like the U.S. physicians' use of technology, because in the former USSR physicians took a more traditional approach and assessed patients through physical touch—not through expensive, modern technologies (Ivanov and Buck). Based on these findings, it is clear that culture significantly influences the healthcare utilization patterns and behaviors of immigrants. Therefore, it is not only important for healthcare workers to possess more knowledge of how to practice medicine cross-culturally, but these findings suggest that there is a clear need for more helpful resources that will heighten a patient's understanding of healthcare practices and operations in the United States. For example, in order to convey the importance of preventive medicine or the ways in which the physician referral system works, NES and LEP patients should receive documents in their primary language explaining these facets of health care in the United States. Furthermore, in order to allow immigrants to become better-accustomed to the technology used in American healthcare practices, patients should receive pamphlets or another type of informative document explaining the purpose and functions of the technology in question.

Another type of resource, which is relatively new to health care, is the language translation application. In a study which aims to accommodate the 300+ languages spoken in Australia, Australian researchers evaluate the efficacy of language translation apps used in healthcare settings. In their assessment of language translation apps, Panayiotou and others repeatedly state that apps should be used for everyday

communication between health care workers and clients, and not for comprehensive assessments, procedural consent, diagnoses, and the development of treatment plans. In this study, researchers searched for iPad apps that were available at no cost and had the ability to translate one of the top ten languages in Australia other than English: Mandarin, Arabic, Cantonese, Vietnamese, Italian, Greek, Hindi, Spanish, Punjabi, and Tagalog.

After finding fifteen apps that fit this criteria, the authors evaluated the apps in two ways. First, they completed a feature analysis in which apps were tested for offline use, input and output method, and number of languages available. Of the fifteen apps, eight were capable of voice-to-voice translation, eight of voice-to-text translation, five of text-to-voice translation, five of text-to-text translation, five could be used offline (but they required language packages to be downloaded first), six were related specifically to healthcare translation (CALD Assist, Canopy Speak, Dr. Passport (Personal), MediBabble Translator, Talk To Me, and Universal Doctor Speaker), and two were capable of 2-way conversation between a patient and health care worker (CALD Assist and Dr. Passpport).

Second, researchers tested the suitability of the apps for everyday clinical conversations in healthcare settings, in which they focused on “situations in which an interpreter would not be necessary, such as providing orientation cues and conveying essential care needs, including identifying pain or the need for toileting.” Only ten of the fifteen apps were included in the second stage of testing due to hidden fees. Of the ten apps remaining, none were entirely suitable. However, ten enabled conversations about assessment, nine enabled conversations about treatment or care planning and discharge

(MediBabble was the only application that did not offer this feature), and seven enabled conversations about diagnosis and medicolegal information.

Due to researchers' findings that none of the apps were entirely suitable for use in healthcare settings, it is clear that advancements must be made in the development of language translation apps. Researchers concluded that the two highest rated apps in terms of suitability were CALD Assist and Talk To Me. Their high suitability ratings resulted from their ability to "enable conversations in the least number of critical phase topics that required professional interpreters and limited the translation to preset phrases that were led by health care practitioners" (Panayiotou et al.). Accordingly, it is crucial that researchers develop future translation apps with features similar to CALD Assist and Talk To Me, or that researchers further develop CALD Assist and Talk To Me to become entirely suitable for healthcare interactions.

Translation apps are important because of the unrealistic expectation that interpreters will be available during every step of a patient's healthcare experience. While overdependence on these apps may have a negative impact on the quality of health care that a patient receives, translation applications are economical, and they may mitigate the problem of a lack of time by increasing the effectiveness of everyday conversations that occur between physicians and patients.

As evidenced through the patient cases and studies in which language barriers have been shown to pose negative effects on medical outcomes of NES and LEP patients, it is crucial that steps be taken to overcome these linguistic and cultural barrier challenges. Lawmakers must strive to increase the number of national and state standards and laws, as well as the enforcement of existing and future standards and laws.

Healthcare institutions must prevent the use of ad hoc and other unlicensed interpreters. Physicians must find ways to increase time spent with NES and LEP patients. Finally, there must be an increase in the availability of resources for NES and LEP patients so that they can develop a greater understanding of how the U.S. healthcare system works and receive higher quality health care.

CHAPTER THREE

Federal and State Laws and Standards

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), federal laws, and state laws exemplify the best practices that the government has proposed to address the problems faced by non-English-speaking and limited English-proficiency patients accessing healthcare services. The United States faces problems such as health inequity, poor quality healthcare services, and health disparities across patient populations of different cultural backgrounds, often due to language and cultural barriers.

The *CLAS Standards* section outlines the CLAS Standards, which are intended to serve as guidelines for healthcare institutions at the federal level. While federally funded hospitals are legally required to adhere to four of the fifteen CLAS standards, the remaining eleven standards serve only as suggestions. Furthermore, private hospitals are not mandated to follow any of the CLAS standards. Although the government has made significant progress in its effort to mitigate healthcare inequalities caused by language and cultural differences, problems continue to exist as private and public healthcare organizations fail to implement the CLAS standards into everyday healthcare practices.

The *Federal Laws* section pertains to the federal laws that aim to prevent discrimination in healthcare settings and mandate institutions and insurers to provide linguistically and culturally appropriate services. In this chapter, the following laws will be reviewed: Title VI of the Civil Rights Act of 1964, sections 1557 and 1311 of the Affordable Care Act, and sections 2715 and 2719 of the Public Health Service Act.

The *State Laws* section of Chapter Three will review the National Health Law Program's 50-state survey published in 2019; this survey lists and offers a description of every provision created by each state's government and the District of Columbia. State laws vary by state in their guidance; some states have fewer than ten provisions concerning language accommodation laws in health care, while others have over one hundred provisions. In this section, a comparison of Georgia and California shows the disparity among states because they represent states that are among the least and most progressive regarding language access laws in health care.

CLAS Standards

The CLAS Standards, or the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, are fifteen standards that the Office of Minority Health within the U.S. Department of Health and Human Services (HHS) recommends to healthcare institutions to provide adequate healthcare services to patients who have limited or no English proficiency. The CLAS Standards are outlined in a blueprint, "A Blueprint for Advancing and Sustaining CLAS Policy and Practice," also created by the HHS Office of Minority Health. The blueprint offers the following three points as the goals of the CLAS Standards: (1) to increase health equity, or achieve the highest level of fairness and justice for all people to have the opportunity to be healthy, through the provision of clear and concise plans and strategies, (2) to improve the quality of health care, both the quality of services and the attitudes of providers, and (3) to eliminate healthcare racial and ethnic disparities, particularly disparities in accessibility and quality of health care across different geographic areas (Office of Minority Health 11).

Implementation

Healthcare providers can achieve these three goals by developing greater cultural awareness, or the acknowledgment of culture's effects on health attitudes and practices. For example, providers should acknowledge the social determinants of health, such as economic stability, physical environment, social context, level of education, and access to health care, factors which influence health outcomes among different populations. Building cultural awareness will enable healthcare professionals to be respectful of and responsive to the cultural and linguistic needs of all individuals. This attitude will allow successful implementation of the CLAS standards into practice and therefore allow medical providers to approach their practices with culturally diverse patients more effectively (Office of Minority Health 24–26).

The Georgetown University National Center for Cultural Competence (NCCC) is a human rights organization that “provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations” by “translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy” (Georgetown University). The CLAS blueprint relies on the NCCC to provide six reasons for the implementation of culturally and linguistically appropriate services in healthcare settings:

- (1) To respond to current and projected demographic changes in the United States.

According to a 2008 study by Passel & Cohn, 53% of the U.S. will be composed of Hispanic, Black, Asian, and other non-white racial categories in 2050.

Furthermore, according to the 2010 Census Bureau, one in eleven people have

limited English proficiency. Due to the gradual increase in cultural diversity and high proportion of patients with limited English proficiency in the United States, implementation of the CLAS standards is necessary for the provision of effective healthcare services to all people (Office of Minority Health 15).

- (2) To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds, as “racial and ethnic minorities have disproportionately higher rates of chronic disease and disability, higher mortality rates, and lower quality of care, compared to non-Hispanic whites” (Office of Minority Health 16).
- (3) To improve the quality of services and primary care outcomes across patient populations, which rely on increase of cultural awareness and competence in healthcare providers (Office of Minority Health 17).
- (4) To meet legislative, regulatory and accreditation mandates, some of which are required by the Patient Protection and Affordable Care Act, which was passed in 2010, under sections 2715 and 2719 of the Public Health Service Act, which was passed in 2012, and under Title VI of the Civil Rights Act of 1964 (Office of Minority Health 17).
- (5) To gain a competitive edge in the market place. When healthcare institutions provide culturally and linguistically appropriate services, therefore providing healthcare services of higher quality, these institutions gain a better reputation and attract more consumers, leading to greater economic benefits for these institutions (Office of Minority Health 19).

(6) To decrease the likelihood of liability/malpractice claims. As seen in Chapter Two, the provision of linguistically appropriate services is essential in avoiding simple translation errors and miscommunications, two errors which may lead to the incrimination of healthcare providers (Office of Minority Health 19).

The first three reasons for the implementation of culturally and linguistically appropriate services in healthcare settings, which encompass the response to demographic changes, desired decrease in healthcare disparities, and improvement of healthcare service quality, pertain to social justice, or the benefit of the patients. Reasons two and three in particular, which represent the core missions of the CLAS Standards, aim to build cultural awareness among healthcare professionals and other healthcare workers so that they are able to provide adequate services for culturally diverse patients. Building cultural awareness and competence increases health equity and healthcare quality, and reduces disparities among patients of different backgrounds. The latter three reasons, to meet mandates, gain a competitive edge in the marketplace, and decrease liability, all of which pertain to the business side of health care, primarily aim to benefit healthcare institutions and organizations in addition to the patients.

The CLAS blueprint states that each healthcare institution must first assess its resources, such as funding and personnel required to provide culturally and linguistically appropriate services, before implementing the CLAS standards. Furthermore, healthcare institutions should devise their own ways to implement the standards into their already-existing healthcare services. Different implementation strategies are necessary for each institution because of factors such as “size, mission, scope, and type of services offered” (Office of Minority Health 23).

New CLAS Standards

The CLAS standards were initially published in 2000, and included fourteen standards. In 2012, an enhanced list of fifteen standards was published in order to further improve the provision of culturally and linguistically appropriate services in health care (Appendix A). The process of improving the standards focused on three factors that affect healthcare equity for patients: the dynamicity of culture, the complexity of health, and the target audiences for which these standards are most relevant. Furthermore, the enhanced standards now include action words, and the Office of the Ministry of Health no longer recognizes certain standards as more important than others.

Dynamicity of Culture. The 2012 enhanced CLAS Standards adopted an enhanced definition of culture: “the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics” (Office of Minority Health 24). The Office of Minority Health also built the new CLAS Standards from an extensive, but not all-encompassing, list of factors that influence culture, such as age, native country, gender identity, perceptions of health and well-being, and political beliefs. This list is included in the CLAS blueprint, and its purpose is to inform healthcare professionals of the different elements that may affect their interactions with patients. (Appendix B). Finally, the CLAS Standards recognize that one’s cultural identity is complex and developed by an overlapping of factors rather than simply the existence of individual factors. Acknowledging such complexity highlights the dynamicity of culture and its role in shaping healthcare interactions, such as the ways in which certain patients experience

health and interact with their physicians.

Complexity of Health. The enhanced CLAS standards recognize the complexity of health by addressing all areas of health—mental, physical, spiritual, and social aspects—and the social determinants of health. These factors—economic stability, physical environment, social context, level of education, and access to and quality of health care— influence health outcomes differently among different populations. Furthermore, the CLAS Standards consider the fact that health exists on a continuum, rather than simply the presence or absence of something such as an ailment.

Intended Audience. A further enhancement of the new CLAS Standards serves as an acknowledgment of the different audiences that need access to and understanding of the standards. To appeal to a broader audience, the list of enhanced standards now uses vocabulary such as “individuals” and “groups,” instead of “patients” and “consumers,” to encompass “patients, consumers, clients, recipients, families, caregivers, and communities” (Office of Minority Health 28). For example, Standard 5 of the old standards states, “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” (Office of Minority Health 166). In comparison, the enhanced version, Standard 6 of the new standards states, “Inform all *individuals* of the availability of language assistance services clearly and in their preferred language, verbally and in writing.” Using the word “individuals” instead of “patients/consumers” implies that the standard is targeted towards a larger audience rather than just the patient; for example, members of the patient’s family or support group. The larger scope of the enhanced standard shows that the standard is able to provide culturally and linguistically

appropriate services to a wider variety of people, exhibiting great improvement from the old CLAS standards. This wording change is not limited to this example, but is also evident in old standards 1 (enhanced Standard 1), 4 (enhanced Standard 5) and 6 (enhanced Standard 7).

Action Words. Additional changes in word choice are apparent in the enhanced standards. Each of the standards now begins with an action word, such as “provide,” “advance,” and “inform,” in order to indicate to institutions and providers how each standard should be executed (Office of Minority Health 29).

All Standards are of Equal Importance. Furthermore, while the old standards were divided into two categories, mandates (requirements for federally funded hospitals) which encompassed standards 4, 5, 6, and 7, and guidelines (standards that were optional, but recommended) which encompassed the remaining standards, now the Office of Minority Health assumes that the new, or enhanced, CLAS Standards are all of equal importance and no longer makes a distinction. However, only standards 5, 6, 7, and 8 of the new standards are required for federally funded hospitals to follow, which implies that the standards are, in reality, not viewed with equal importance (Office of Minority Health 29–30).

The purpose of comparing the enhanced standards from 2012 and the old standards from 2000 is to highlight the strides that have been taken over the twelve-year period to enhance healthcare services among minority populations. While the improvements in actionable and measurable outcomes are incremental, they lead to more accountability.

Organization of Standards

The CLAS blueprint assesses the division of the CLAS Standards, which are divided into four main categories: Principal Standard, Theme 1, Theme 2, and Theme 3, then proceeds to break down each of the fifteen standards (Appendix C).

The “Principal Standard” category includes only the first standard, and its name derives from the fact that it serves as a framework for the fourteen standards that follow it (Office of Minority Health 30–31).

Theme 1 in the CLAS Standards is the second category, which is designated “Governance, Leadership, and Workforce,” and it includes standards 2, 3, and 4. These three standards highlight the systematic nature of the implementation of culturally and linguistically appropriate services in healthcare settings, such as the importance of education, leadership, and advocacy for the CLAS standards (Office of Minority Health 31).

Theme 2, “Communication and Language Assistance,” is the third category and includes standards 5, 6, 7, and 8. These standards point specifically to the importance of providing appropriate services, such as interpreters and pamphlets, and avoiding the use of ad hoc interpreters, in order to ensure successful communication between the patient and provider (Office of Minority Health 32).

The fourth category, Theme 3, is “Engagement, Continuous Improvement, and Accountability,” and it includes the final seven standards. These standards emphasize the requirements and actions involving all parts of an organization, such as conducting progress assessments and creating conflict resolution plans, all which are necessary to effectively carry out culturally and linguistically appropriate services (Office of Minority

Health 32).

The blueprint's categorization of the CLAS standards is followed by further information addressing each of the 15 standards individually. For each standard, the blueprint states the standard and provides its purpose, in order to reinforce why the standard is important and necessary. Then, the blueprint lists the components of the standard in detail and offers strategies to successfully fulfill implementation of the standard. Finally, it provides a list of resources toward the understanding or implementation of the standard, including a bibliography provided by the Office of Minority Health (Office of Minority Health 43).

Audiences

The CLAS Standards blueprint is intended for and informative to a wide range of audiences including accreditation and credentialing agencies, community-based organizations, educators, healthcare providers, healthcare institutions and their administration, and patients (Office of Minority Health 21–22).

Accreditation and credentialing agencies may find good use of the CLAS standards when granting accreditation to interpreters and translators, because the standards provide guidelines for the ways in which language and cultural accommodation services should be implemented in healthcare organizations and include the role of the interpreter.

Community-based organizations advocating for healthcare services for diverse populations in their areas can use the standards as they promote and monitor the delivery of those services to their neighbors.

Educators can use the blueprint as a tool for bringing awareness to the issue of language and cultural barriers in health care and to bring awareness to lawmakers and other government officials to develop or improve laws.

Healthcare providers—such as doctors, nurses, and hospital administrators—can use the blueprint of the CLAS standards to assess their practices and move toward providing better care.

The institutions themselves may be able to use their successful implementation of the standards to improve their economic success.

Finally, patients may be the most important audience, as this document allows them to know what they can expect from healthcare providers regarding linguistically and appropriate services, such as their right of access to free-of-cost interpreters.

The Future

Due to the demographic changes and the rapid evolution of health care and its services, the CLAS standards require periodic updating in order to remain effective and relevant. To that end, the Office of Minority Health at the U.S. Department of Health and Human Services provides online access to the CLAS Standards blueprint on its website that is updated to include new information, resources, and revisions (Office of Minority Health 34).

The University of Colorado Anschutz Medical Campus' Center for Bioethics and Humanities provides another excellent resource. The Center has developed a toolkit which associates measurement domains with each of the fifteen standards (The University of Colorado Anschutz Medical Campus Center for Bioethics & Humanities). Those assessment domains are leadership support, leadership commitment, workforce

development, language services, health literacy, individual engagement, community engagement, performance evaluation, data collection, and cross-cultural communication. Moreover, the toolkit provides a list of questions that healthcare providers and institutions can ask themselves to assess how effectively they are executing the CLAS standards (Appendix D).

The CLAS standards, provided through the federal government's Office of Minority Health at the U.S. Department of Health and Human Services, establishes a foundation on which healthcare institutions can build their care and provide culturally and linguistically appropriate services to patients of diverse cultural backgrounds. Although the creation of standards, old and new, are evidence of the strides that the federal government has taken to respond to the cultural and language barriers in the United States healthcare system, the government still fails to mandate the standards evenly or in all healthcare facilities in the United States. Privately funded hospitals have no mandates, as the CLAS standards are only guidelines for them. Moreover, only four of the fifteen standards are required in federally funded hospitals, and evidence suggests a lack of enforcement of the four CLAS standards mandated for federally funded hospitals, essentially making them ineffective ("WSU Professor Champions Legislation Ensuring Kansas Hospitals Have Qualified Interpreters"). To be valuable to patients, the CLAS standards must be implemented in all hospitals so that the nine percent of the United States' population with limited proficiency in English have a greater opportunity to receive quality health care. The implementation of standards may also avoid the billions of dollars that are spent on medical expenditures each year due to health disparities and deaths resulting from inequitable health care (LaVeist et al.).

Federal Laws

Federal laws, in addition to standards, serve to mitigate language and cultural barriers in healthcare settings by mandating, as opposed to suggesting, that healthcare providers take certain actions to accommodate NES and LEP patients. Federal laws regarding the implementation of linguistically and culturally appropriate services are general in scope and only apply to federally funded institutions, such as federal hospitals and insurance agencies. This section of Chapter Three will review the following laws: the Public Health Service Act, Title VI of the Civil Rights Act of 1964, and the Affordable Care Act. There are few federal laws that speak specifically to the concerns of language and culture barriers, but those that do, lack specificity.

The Public Health Service Act

The Public Health Service Act was enacted in 1944 under the administration of Franklin D. Roosevelt, and it was created with the purpose of regulating all matters concerning public health. Sections 2715 and 2719 pertain specifically to the attainability of health insurance coverage for NES and LEP patients, which is the first step in accessing affordable health care. According to these sections, health insurers must provide a summary of benefits and coverage (SBC) to insured people in a manner that is culturally and linguistically appropriate. The SBC must comply with the following three conditions: (1) the health insurance issuer or plan must provide oral language services including answering questions and helping an insured file a claim, (2) the health insurance issuer or plan must provide notices in an applicable non-English language, and (3) the health insurance issuer or plan must include information in an applicable non-English language to the insured on how to access language services (§ 2590.715-

2719(e)). An “applicable non-English language”, which is the term that was used in conditions 2 and 3, may be defined as any language that is spoken by more than ten percent of the population living in the insured person’s county.

Without health insurance, it is difficult for patients to receive health care; therefore, healthcare reform laws pertaining to health insurance attainability are very important for patients who may have trouble acquiring healthcare coverage on their own.

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 states, “No person in the United States shall, on the 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” (42 U.S.C. §2000d). In order to adhere to Title VI of the Civil Rights Act of 1964, federally funded hospitals must follow CLAS standards 5, 6, 7, and 8. These standards, and therefore compliance with federal laws, mandate institutions to perform the following four actions: (Standard 5) to offer language assistance services at no cost to the patient, (Standard 6) to notify patients verbally and on paper of their right to receive language accommodation services, (Standard 7) to ensure the competency of interpreters, and (Standard 8) to provide supplementary materials that are easily understandable by the patient (Office of Minority Health 166).

Title VI guarantees the provision of linguistically and culturally appropriate services to NES and LEP patients in the four aforementioned ways. However, the law only applies to federally funded hospitals. This means that privately owned hospitals are not legally required to provide linguistically and culturally appropriate services to patients. Furthermore, the hospitals that are required to adhere to the Title VI statutes

often fail in doing so. Therefore, patients receiving care from both federally funded and privately owned hospitals are at risk of facing discrimination based on language and cultural differences.

The Affordable Care Act

The Affordable Care Act, a healthcare reform law created with the goals of making health care more affordable and decreasing the rate of uninsured people, was passed in 2010 under the administration of President Barrack Obama. Section 1311(i)(3)(E) of the Affordable Care Act helps LEP and NES patients access health care by assisting patients in their navigation of different health insurance plans. The section states, “An entity that serves as a navigator under a grant under this subsection shall provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.” A navigator is someone paid by health insurance exchanges (online marketplaces in which consumers purchase health insurance plans) to help individuals navigate the exchange markets. Navigators are important because they help LEP and NES patients find healthcare plans. Without the language assistance services provided by navigators, these patients would have a hard time obtaining healthcare coverage, a component that is necessary for receiving healthcare services in the United States.

Section 1557 of the Affordable Care Act was devised under the guidance of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and section 504 of the Rehabilitation Act of 1973. According to section 1557 (a), “an individual shall not... be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program

or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).”

While section 1557 of the Affordable Care Act is similar to Title VI of the Civil Rights Act of 1964, it is actually slightly more expansive. Under section 1557, a patient receiving care at a federally funded hospital is protected from discrimination based on race, color, national origin, sex, age, and disability. Similar to Title VI, a patient may not be discriminated against based on differences in his/her language and culture, and therefore, is entitled to linguistically and appropriate services.

Federal laws concerning the implementation of linguistically and culturally appropriate services are important because they serve as nation-wide mandates, applying to every federally funded healthcare institution in the country. Title VI of the Civil Rights Act of 1964 and section 1557 of the Affordable Care Act prevent discrimination based on race, color, national origin, sex, age, and disability, and therefore mandate hospitals to provide language services. Section 1311 of the Affordable Care Act and sections 2715 and 2719 of the Public Health Service Act mandate insurers to provide language services to consumers who possess little or no English proficiency. Federal laws are important because they mandate healthcare institutions and insurers to provide linguistically and culturally appropriate services to NES and LEP patients on a national level. However, laws such as Title VI of the Civil Rights Act of 1964 have no impact on private organizations; this means that a majority of the United States’ health organizations. As such, a majority of U.S. health organization are not required—by law—to provide linguistically and culturally appropriate services, causing a disparity in the accessibility

and quality of health care among English-speaking and NES/LEP patients. Title VI of the Civil Rights Act of 1964 maintains its importance, however, because it serves as a driver to establish a “norm” for all entities. To be effective, federal laws need implementation, and areas such as education and training of workers, accountability measures, and enforcement have caused difficulty in the implementation of federal laws.

State Laws

The National Health Law Program, a program which advocates for the advancement of health rights, published a 50-state survey in 2019 regarding the number of provisions created by each state. The survey reveals that the number and comprehensiveness of language access laws varies tremendously across states. According to the survey, Georgia only has 3 provisions, pertaining solely to pregnant women and patients seeking care in mental health, while California has 257, encompassing a wide range of patient populations. The average number of provisions across states is 31 (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 13). The difference between Georgia and California concerning the breadth and depth of each state’s provisions highlights the disparity among states regarding language and cultural accommodation laws in United States healthcare settings.

Georgia

Georgia, the least progressive state regarding language accommodation laws for LEP and NES patients, has created only three provisions, small in scope, and has failed to make additional provisions since 2008, when the National Health Law Program conducted their most recent 50-state survey (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 8). With only three provisions,

it is possible to list and discuss each of them and their descriptions in the National Health Law Program's 2019 50-state survey.

Under the first provision, Ga. Code Ann. § 31-9A-3(1)(C), Georgia mandates that “the information that the law requires a woman to be told if she is considering an abortion must be provided in a language understood by the patient through a translator” (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 112). The pieces of information that the doctor must provide to the patient are the medical risks associated with the abortion procedure, the age that the fetus will be when the abortion procedure is performed, the medical risks associated with continuing the pregnancy, eligibility for prenatal care coverage, the father’s obligation to provide child support, and access to printed resources (Georgia Department of Public Health). This provision directs language services to provide limited and specific information on abortion to a particular and narrow group of individuals, namely those inquiring about abortion.

Georgia’s second provision, Ga. Code Ann. § 31-9A-4, also concerns women’s health. This provision mandates that “the Department of Human Resources shall publish in English, and in each language which is the primary language of two percent or more of the state’s population, and make available on the state website, information to help a woman throughout pregnancy and information about different stages of fetal development” (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 112). The law mentions nothing about helping women after they give birth or the choices they are to then make. As evident by the first two provisions listed, two-thirds of Georgia’s laws regarding language access in health care are

concerned with only one particular patient population, women. Furthermore, these provisions are limited solely to pregnancy and do not pertain to women's health as a whole.

The third provision, Ga. Comp. R. & Regs. 510-4-.02(9) (b)(3)(c), (c)(3)(c), dictates that "Psychologists must use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues. Psychologists using the services of an interpreter must obtain informed consent from the client/patient to use the interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, and discussion of any limitations on the data obtained" (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 112). This provision focuses specifically on the duties of psychologists. Apart from federally funded hospitals mandated to provide culturally and linguistically appropriate services, private hospitals and other healthcare providers in Georgia are only mandated to provide language services to women seeking an abortion, women undergoing pregnancy, and patients seeing a psychologist.

California

California is the most progressive U.S. state regarding language accommodation laws for LEP and NES patients. California's legislature includes 257, large in scope, provisions, a significantly higher number of provisions than that of any other state's legislature (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 13). Of California's vast number of provisions, only a small

fraction will be listed below, and they will be described using the information provided by the National Health Law Program's 2019 50-state survey. The provisions that will be discussed encompass important topics such as mandates for public and private organizations, training for healthcare workers, interpreter qualifications, and the particular populations to which many of the provisions pertain.

Public and Private Organizations. Three of California's provisions require all insurers, public and private, to provide linguistically appropriate services. In accordance with the first provision, Cal. Code Regs. tit. 10, § 2538.3, all health insurers must implement a Language Assistance Program (LAP) for NES and LEP people (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 44). In accordance with the second provision, Cal. Code Regs. tit. 10, § 2538.5(a), (b), (d), (e), all health insurers must translate vital documents and provide a written statement of the availability of I/T services (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 45). According to the final provision, Cal. Code Regs. tit. 10, § 2538.6(a), (b), (c), insurers must provide I/T services to NES and LEP individuals in a timely manner and at no cost (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 46).

The three provisions listed above are important because they show that California has taken steps to reinforce federal mandates, such as Sections 2715 and 2719 of the Public Health Service Act, to ensure that both public and private insurance organizations provide linguistically and culturally appropriate services to patients. Through these provisions, California has mandated insurers to implement a Language Assistance Program, translate vital documents, and provide timely access of language services at no

cost. In contrast, Georgia has mandated nothing of its insurers. Furthermore, California has proven its effort in expanding patients' rights and opportunities to receive health care by providing language assistance for NES and LEP patients who are seeking healthcare coverage.

Training and Qualifications. California's legislation contains many provisions requiring the training of healthcare workers, including healthcare professionals, the public mental health system workforce, certified insurance agents, certified enrollment counselors and certified application counselors (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 40–92) (Appendix E). For example, Cal. Health & Safety Code § 152(a)(6) mandates that “the Office of Multicultural Health shall perform internal staff training, an internal assessment of cultural competency, and training of health care professionals to ensure more linguistically and culturally competent care” (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 63). In addition to the provision stated above, California's legislation contains thirteen other provisions concerning the training of healthcare professionals.

Particular Populations. California's legislation also contains provisions that are applicable to those who use Medicaid, older people's health, mental health, children's health, women's health, and disabled people's health. In other words, California's laws apply to a wide array of particular populations.

Concerning Medicaid, Cal. Welf. & Inst. Code § 10618.5(b) (6) mandates that welfare departments across California must provide individuals in their county information, using appropriate language, regarding their potential to receive Medicaid

benefits (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 83).

California's Stay Well program supporting older people's health, Cal. Welf. & Inst. Code § 9661(a)(3), mandates culturally and linguistically appropriate resources for seniors who participate in the program (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 82).

Regarding mental health, Cal. Welf. & Inst. Code^[1]§ 14727 mandates that individuals seeking help with mental health must be notified of free language accommodation services (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 86).

Provisions also apply to children's mental health. According to Cal. Welf. & Inst. Code § 5868(b)(4), programs centered on children's mental health must provide culturally and linguistically appropriate services in order to remove any barriers that may interfere with the child's ability to receive good-quality mental health services (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 82).

Under the heading of women's health, Cal. Code Regs. tit. 17, § 6504.2 mandates perinatal licensed health facilities to provide pregnant woman with a printout called "Important Information for Parents" in a language understandable by the patient (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 49). The printout contains information regarding newborn screening (Wilson). Finally, according to Cal. Welf. & Inst. Code^[1]§ 19013.5(a), California's Department of Rehabilitation must provide language services to individuals participating in

rehabilitation programs, whether they are public or private programs (Youdelman, *Summary of State Law Requirements Addressing Language Needs in Health Care* 87).

The diverse set of populations covered by these language access laws represent the comprehensive nature of California's approach to LEP and NES populations. Specifically mentioned groups include Medicaid patients, elderly people, patients seeking mental health care, children, women, and disabled people.

It is evident from this comparison that California has significantly greater in number and more comprehensive provisions than Georgia to provide culturally and linguistically appropriate services to LEP and NES patients receiving health care.

California's statutes attach provisions to public and private insurers, mandate the training of healthcare workers, and cover an array of specific populations. Furthermore, California has implemented measures to ensure that organizations are providing culturally and linguistically appropriate services, while Georgia has not. In California, any institution that fails to abide by the Title VI law is subject to civil claims against them for noncompliance, creating another difference and benefit for California residents, compared to those in Georgia (Youdelman, "The Medical Tongue" 430).

CHAPTER FOUR

International Comparison: Interpreting and Translating Services in Australia's Healthcare System

Australia has developed into one of the world's leaders in interpreting and translating (I/T) services through the growing prominence of indigenous minorities (there are about 250 indigenous languages spoken on the continent), the influx of refugees, and a more positive attitude towards people who speak different languages. According to Jill Blewett, a prominent figure in education and accreditation developments for the I/T field, "Australia leads the world in the provision of community interpreting and translating services and in the regulation and training of interpreters and translators for that provision..." (Ozolins et al. 29). Due to Australia's prominence in interpreting and translating, this chapter will review Australia's healthcare I/T services and look for areas in which the United States can improve its delivery of I/T services in healthcare settings.

Australia's only I/T accreditation organization, the National Accreditation Authority for Translators and Interpreters (NAATI), was created in the 1970s to ensure that interpreters and translators were qualified to provide sufficient I/T services to those in need. The NAATI provides accreditation to all types of interpreters and translators, including those in the medical field, based on four levels and in over fifty languages.

Australia's laws regarding language and culture access and rights are greater in quantity and specificity than those of the United States. Australia's federal government has passed policies to accommodate deaf patients, condemn discrimination based on language and cultural background, and call for an increase in cultural awareness

regarding Aboriginal and Torres Strait Islanders seeking health care.

The federal government controls the Translating and Interpreting Service (TIS National), known formerly as the Telephone Interpreting Service, which is the largest provider of language services in Australia and the only I/T service available in some states. Additionally, through the Linguistic Availability Performance Allowance (LAPA), Australia's federal government provides incentives to bilingual federal workers.

Australia's states deliver their I/T services to different levels/standards depending on the state, similar to the situation in the United States. New South Wales, like California, is one of Australia's most progressive states. New South Wales offers one service, the Healthcare Interpreter Service (HCIS), the most comprehensive I/T service offered in Australian health care.

New South Wales enacted a policy directive in 2017 to improve language services delivery in NSW healthcare institutions. The policy directive mandates NAATI accreditation for all NSW medical interpreters, discourages the use of translation apps, encourages healthcare providers to book interpreters through HCIS in a timely manner and according to patient preferences, and establishes TIS National as a back-up service if HCIS interpreters are unavailable.

The United States can look to Australia, a country with extremely developed I/T policies and services, in order to improve its delivery of interpreting and translating services in healthcare settings.

National Accreditation

The NAATI, or National Accreditation Authority for Translators and Interpreters, was established in 1977, and it is Australia's only national standards and accreditation

organization for translating and interpreting (Ozolins et al. 40). The agency provides accreditation for all types of interpreters and translators, including those in the medical field. According to NAATI, these specialists are referred to as “Certified Specialist Health Interpreters” (CSHI). The NAATI offers accreditation at four levels for over fifty languages. These levels are modeled from I/T standards that the Department of Immigration’s Committee on Overseas Professional Qualifications (COPQ) adopted for their translators and interpreters (Ozolins et al. 37).

There are four levels of accreditation under the NAATI system: Level 2 (Paraprofessional interpreter) which exists for accreditation for newly introduced languages, Level 3 (Professional Interpreter, Professional Translator), the lowest of professional qualification, Level 4, (Conference Interpreter, Advanced Translator), and Level 5 (Conference Interpreter (senior), Advanced Translator (senior)), for the most highly skilled interpreters who are also members of the International Association of Conference Interpreters (AIIC), an organization that sets standards for interpreters throughout the world (Ozolins et al. 41).

The NAATI is highly effective in Australia due to its role as the only accreditation agency. In comparison, the United States has two accreditation agencies. The first agency is the Certification Commission for Healthcare Interpreters (CCHI), which governs the Core Certification Healthcare Interpreter (CoreCHI) and Certified Healthcare Interpreter (CHI) certification programs (*CCHI Candidate’s Examination Handbook*). The second is the National Board of Certification for Medical Interpreters (NBCMI) which jointly governs the Certified Medical Interpreter (CMI) certification program with the International Medical Interpreters Association (IMIA) (*NBCMI*

Candidate Handbook). The presence of only one national accreditation organization allows Australia to have a more standardized system, in which all healthcare interpreters and translators are evaluated and accredited based on the same scale. In the United States, however, there are two systems, and confusion may arise concerning which certification an interpreter should aim to achieve and which certification a healthcare institution chooses to accept or prefers.

Australia's NAATI is also effective because it is controlled collectively by the federal and state governments (Ozolins et al. 40). The benefit of such oversight allows all of the states, and therefore, the country as a whole, to come to a joint agreement on which standards are to be set by the NAATI. However, the CCHI and NBCMI are controlled by independent groups, which means that each organization has its own set of standards. Consequently, problems may arise concerning the authority of one certification over the other.

Federal Government

Australia's federal government has passed numerous laws regarding the implementation of I/T services in healthcare settings. Australia's laws about medical I/T services are more wide-ranging and have greater specificity than those of the United States. In addition, Australia's federal government offers the Translating and Interpreting Service (TIS National), a service which healthcare organizations in different states use as a primary or secondary I/T service, and the Linguistic Availability Performance Allowance (LAPA), in which the federal government offers material incentives to federal employees, encouraging more employees to acquire foreign language proficiency.

Federal Legislation

Australia's federal government has enacted a wide-range of laws concerning the mandatory implementation of I/T services. Relevant legislation can be divided into three groups: (1) laws which serve to accommodate deaf people: the Disability Discrimination Act 1992; (2) laws which aim to elevate human and civil rights: the Human Rights and Equal Opportunity Act 1986, Racial Discrimination Act 1975, Australia's Multicultural Statement - Multicultural Australia: United, Strong, Successful 2017, and the People of Australia: Australia's Multicultural Policy 2011; and (3) laws which offer guidance towards the delivery of more equitable health care for indigenous populations: the National Health Reform Act 2011 and National Safety and Quality Health Service (NSQHS) Standards.

The Disability Discrimination Act 1992 applies to all people with disabilities including those who are deaf and in need of sign language interpretation. According to the law, "It is unlawful for a person who, whether for payment or not, provides goods or services, or makes facilities available, to discriminate against another person on the ground of the other person's disability" (No. 135, Part 2, Division 2, 24). In a healthcare context, the law states that healthcare providers must provide deaf patients with sign language interpretation at any time and free of charge.

The Human Rights and Equal Opportunity Act 1986, Racial Discrimination Act 1975, Australia's Multicultural Statement - Multicultural Australia: United, Strong, Successful 2017, and The People of Australia: Australia's Multicultural Policy 2011 indicate that Australia does not tolerate discrimination on any basis, and include the necessary language accommodations to receive high quality and equitable health care for

people who speak languages other than English and people of all cultures. The United States' Title VI of the Civil Rights Act of 1964 is the closest equivalent to the four aforementioned acts and statements, as it also prohibits discrimination on the ground of race, color, and national origin (*42 U.S.C. §2000d*).

Finally, the National Health Reform Act 2011 established the Australian Commission on Safety and Quality in Health Care (ACSQHC) that wrote the National Safety and Quality Health Service (NSQHS) Standards, eight standards which provide the delivery of equitable health care in Australia. Two tenets of the first standard state the need for cultural awareness while treating Aboriginal and Torres Strait Islander patients. Action 1.21 states, “The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients.” Action 1.33 states “The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people” (Australian Commission on Safety and Quality in Health Care).

Australia's federal government is quantitatively ahead of the United States government concerning I/T legislation. Furthermore, Australia's legislation is greater in specificity, as some areas specifically appeal to the rights of Aboriginal and Torres Strait Islander people.

The United States' equivalent to such laws would be those that aim to improve the provision of healthcare services to Native Americans. The U.S. does not have any laws that concern cultural and linguistic accommodation for Native Americans in healthcare settings. However, there are two laws that pertain to healthcare funding for Native

Americans. The Snyder Act of 1921 and the Indian Health Care Improvement Act (IHCIA) of 1976 are responsible for formatting the Indian Health Service (IHS), an agency responsible for providing healthcare services to Native Americans with the help of federal government funding. However, due to an extreme lack of funding, Native Americans fail to receive the health care that they deserve (National Academies of Sciences et al.). Furthermore, physicians who are part of the IHS report multiple barriers to the delivery of equitable health care, namely a lack of high-quality specialists, non-emergency hospital admissions, high-quality imaging services, and high-quality outpatient mental health services (Sequist et al.).

Federal Services

The Translating and Interpreting Service, TIS National, operates at the federal level and provides 24-hour, emergency interpreting services to users. The purpose of TIS National is to provide I/T services to people in Australia who are in need of police or medical assistance or find themselves in a life-threatening emergency (Ozolins et al. 29–32).

Initially, the Department of Immigration operated and funded the Translating and Interpreting Service. However, in 2015, the Department of Home Affairs took over TIS National and continues to offer the service to all users free of charge (Department of Home Affairs-Translating and Interpreting Services). TIS National is the largest provider of language services in Australia, and it requires a Level 3 (Professional Interpreter) NAATI accreditation, the minimum level of competence for professional interpreting and translating.

One of TIS National's greatest strengths is that it is a generalist interpreting

service that can be applied in a broad and diverse set of situations. This means that TIS National is under continuous demand by the non-English speakers of Australia. In some states, TIS National is considered to be a back-up language service, and its purpose is to be used in addition to other primary services I/T services. In other states, such as Tasmania and Queensland, TIS National is the only provided service, and is therefore a front-line language service. The United States currently does not have a federally controlled emergency language service.

Material Incentives

Australia's Public Service Board introduced a material incentive, called the Linguistic Availability Performance Allowance (LAPA), in 1976. With LAPA, employees of the federal government receive additional funds when they use their talent and expertise to offer language services to clients in languages other than English (Ozolins et al. 21). These initiatives encourage more healthcare workers to learn foreign languages and contribute to the provision of language services to NES and LEP patients.

The United States federal government does not currently have an equivalent to Australia's LAPA. However, U.S. Congress members have sought to get bills passed that raise the pay of federal bilingual workers. In 2010, Congressman Gregorio Kilili Camacho Sablan proposed the “One America, Many Voices” bill that would raise bilingual federal workers’ salaries by five percent (*Pay Boost for Federal Employees with Bilingual Skills Is Goal of “One America, Many Voices” Bill | Congressman Gregorio Kilili Camacho Sablan*).

New South Wales Government

New South Wales offers a single I/T service called Health Care Interpreter Services (HCIS). All public hospitals use this service to book interpreters, and if this service is unavailable, hospitals use TIS National. According to a 2017 policy directive, healthcare organizations in New South Wales must only use interpreters with NAATI accreditation (except in emergency situations), are prohibited from using translation apps, must book translators in a timely manner, and must attempt to prioritize patients' preferences regarding the interpreter's gender. To ensure that all mandates of the policy directive are followed, the NSW Ministry of Health monitors implementation of the policy directive in all healthcare organizations in the state of New South Wales.

State Services

New South Wales established the Health Care Interpreter Services (HCIS), Australia's largest on-site provider of I/T services, to provide I/T services for NSW health organizations. HCIS is the only state-run healthcare interpreting service and is used by all public hospitals. The service is available twenty-four hours a day, provides interpretation for over 120 languages, and is free for all patients receiving healthcare services from public healthcare organizations in the state (NSW Health 1 of 38). States in the U.S. currently do not have a single state-operated I/T organization through which all medical interpreters can be sourced.

State Legislation

Australia is similar to the United States in the fact that there is disparity among states regarding the provision of healthcare I/T services. New South Wales (NSW), like California, is one of the more progressive states and offers the most accommodation for

NES and LEP patients. Therefore, New South Wales, the most culturally and linguistically diverse state in Australia, will be the focus of this section (NSW Health 1 of 38). In 2017, New South Wales issued a policy directive, “Interpreters – Standard Procedures for Working with Health Care Interpreters,” mandating compliance from every health organization in the state. The policy directive provides direction concerning both the implementation of interpreters and actions to take if an interpreter is not present (NSW Health 1 of 2).

As mandated by the Anti-Discrimination Act of 1977 (NSW), Mental Health Act of 1890, and Multicultural NSW Act of 2000, “public sector agencies and services [must] provide equitable access to people who are not fluent in English, or whose preferred language is not English, and people who are Deaf” (NSW Health 4 of 38). This policy directive contains a series of mandates that healthcare organizations must follow: interpreters must receive NAATI accreditation, the use of translation apps is illegal, institutions must book interpreters in a timely manner, and institutions must use a backup service in the event that an interpreter or translator is not available.

New South Wales requires that all interpreters and translators who work in healthcare organizations must attain NAATI accreditation (NSW Health 6 of 38). Non-accredited interpreters and translators are only permitted in emergency situations when an accredited professional is not available (NSW Health 14 of 38). According to the policy directive, ad-hoc interpreters should be implemented in the following order: (1) interpreters for languages in which it is not possible to attain accreditation; (2) doctors, nurses, and other healthcare workers; and (3) a relative or friend of the patient who is at least eighteen years of age [17] (NSW Health 14 of 38).

New South Wales has prohibited the use of translation apps due to insufficient evidence indicating that translation apps are accurate enough for clinical settings (NSW Health 18 of 38).

The 2017 policy directive stresses the importance of securing an interpreter or a translator for a patient in a timely manner: “Health practitioners should book interpreters as far in advance as possible, and may need to negotiate the time and date of the appointment. Bookings should be made with their local HCIS office” (NSW Health 10 of 38). The directive also mandates health practitioners to prioritize the patient’s preferred language and dialect and the patient’s preferred gender of the interpreter (NSW Health 10 of 38).

In the event that a healthcare organization is unable to attain an interpreter, the organization should use the Commonwealth Translation and Interpreting Service (TIS National) (NSW Health 10 of 38).

The NSW Ministry of Health is responsible for ensuring that healthcare organizations comply with the mandates established by the policy directive (NSW Health 2 of 2).

Solutions/Recommendations for U.S. Implementation

In order to improve its implementation of I/T services, the United States must look to Australia, one of the world’s leaders in interpreting and translating (I/T) services. From Australia, the United States can learn the effectiveness of having only one medical interpreter accreditation system that is operated at the national level, offering a federally run I/T service to serve as a back-up service behind state-operated I/T services, giving material incentives to bilingual healthcare providers, consolidating all of a state’s medical

interpreters to work under one organization, refraining from the use of language translation apps until they are further developed, encouraging healthcare providers to book interpreters in a timely manner, and ensuring that health institutions follow mandates through the oversight of an organization such as NSW's Ministry of Health.

The United States should consider having a single accreditation agency like Australia's National Accreditation Authority for Translators and Interpreters (NAATI). Eliminating the existence of two agencies in the United States would eliminate confusion regarding which accreditation system each healthcare organizations should recognize. One accreditation agency would also standardize levels of accreditation, as all interpreters would be judged according to the same scale.

Australia's NAATI organization is collectively controlled by the federal and state governments. While such control may not be as suitable for the United States, the U.S. should at least consider creating a system in which federal and state governments can come to an agreement upon accreditation standards. This system would benefit the United States as accreditation would be standardized and meet the standards agreed upon by all states.

In addition, Australia's federal government offers the Translating and Interpreting Service (TIS National). This is another national initiative that not only takes the burden and oversight out of states, but also provides something important for them to be able to access. The service can be used as either a back-up or front-line option, depending on the state's needs. The United States should consider implementing a similar service so that states that offer fewer language services are still able to provide NES and LEP patients with language accommodations.

Finally, Australia's federal government offers material incentives to federal employees through the Linguistic Availability Performance Allowance (LAPA). The United States federal government should consider giving extra funds in the form of material incentives to accredited, bilingual healthcare workers in federally funded hospitals. Similarly, state governments could allocate extra funds to state-funded hospitals. Alternatively, hospital administrations of private hospitals could offer material incentives to their bilingual healthcare professional staff in order to achieve better reputations for their healthcare organizations and to eliminate the need for institutions to find interpreters through outsourcing. If healthcare workers are bilingual, the stress of locating and securing an interpreter is eliminated and the complexity of having a third-party disappears. These conditions would allow the patient to feel more comfortable and reduce the risk of miscommunication between the physician, patient, and interpreter.

New South Wales, Australia's most culturally and linguistically diverse state, runs the Healthcare Interpreter Service (HCIS), the most comprehensive healthcare I/T service offered in Australia. States in the United States should consider creating a single service, similar to HCIS, in which all healthcare organizations can book all of their interpreters. Using one service limits the confusion of contacting multiple I/T agencies to book an interpreter.

In addition, New South Wales enacted a policy directive in 2017 containing multiple important mandates. First, all interpreters who work in NSW healthcare institutions must possess NAATI accreditation. All states in the United States should enact similar policies, as mandatory accreditation ensures greater patient safety. When ad

hoc interpreters are used, miscommunications may result between the physician and patient, and everyone is put at a disadvantage.

Second, the use of translation apps in healthcare settings is strictly prohibited. While there is a clear future for translation applications, the United States should refrain from using them for now until further research is conducted and they are proven to be suitable and safe in healthcare settings.

Third, healthcare institutions in NSW must book interpreters in a timely manner and try to fulfill the patient's requests in terms of gender preference and dialect. State governments should allocate similar responsibilities to healthcare institutions in the U.S so that a suitable translator is available for each patient.

Fourth, NSW healthcare institutions must use TIS National as a back-up service if no HCIS interpreters are available. As mentioned previously, a federally run I/T service is necessary in the United States so that no patient goes without receiving proper accommodations.

Finally, The NSW Ministry of Health ensures that healthcare organizations comply with the mandates established by the NSW policy directive. Similarly, states in the U.S. should establish a single organization, such as the State Health Department, that ensures that health organizations are abiding by state laws.

CHAPTER FIVE

Conclusion: The Future of Interpreting and Translating services in the United States Health Care Systems

This thesis has shown that the United States must improve its measures to accommodate NES and LEP patients. It has discussed patient stories, lack of enforcement of U.S. federal and state standards and laws, disparity among states concerning breadth and depth of healthcare interpreting and translating laws, and the excellence of other countries' I/T laws and practices in order to identify the problems and possible solutions. The following solutions and recommendations gathered from California's more progressive policies and Australia's policies are discussed in accordance with each of the challenges from Chapter One—lack of enforcement of I/T standards and laws, the use of ad hoc and other unlicensed interpreters, lack of time in physician-patient interactions, and lack of resources available for NES and LEP patients.

Laws and Standards and Enforcement

Improvement in both the development and enforcement of language accommodation laws and standards is needed at both the federal and state levels. As discussed in Chapter Two, Rachel Showstack, a Wichita State sociolinguist and Spanish professor, noticed that Kansas hospitals were failing to uphold their Title VI obligation—to follow the four mandatory CLAS standards, one of which is to provide interpreters free of charge. Her discussion of a Spanish-speaking teenage boy in a Kansas hospital who was misdiagnosed with a Sexually Transmitted Disease (STD) due

to the hospital's failure to provide him with an interpreter represents this failure to provide for the patient's rights according to federal law.

One solution to this problem is the sanctioning of hospitals and other healthcare providers that are found to be providing inadequate or no interpretation services to NES and LEP patients. To enable such a solution, health care providers would be required to provide patients with a survey prior to discharge. In hospitals, social workers would administer the survey as patients are typically required to meet with them before discharging. The survey should include, but not be limited, to the following questions:

- (1) Were you notified of your right to receive interpreting and translating services free of charge? (Yes/ No)
- (2) Were you offered interpreting and translating services free of charge? (Yes/ No)
- (3) Were you able to ask questions and receive verbal explanations in a language understandable by you? (Yes/ No)
- (4) Were you given consent forms in a language that is understandable to you? (Yes/ No)
- (5) Were you offered discharge papers in a language that is understandable to you? (Yes/ No)

The survey should be short and simple, available in a wide array of languages, and be a standard part of discharge and end of service procedures. To facilitate data analysis, the survey should be available electronically.

To ensure that healthcare institutions are abiding by federal and state laws, the U.S. Department of Health and Human Health Services (HHS) should provide for the routine assessment of the survey results of federal hospitals with State Health

Departments (SHD) of each state carrying out the same task for state hospitals. If the survey results indicate that the hospital or health care facility is failing to comply with the federal or state laws to a significant degree, monitoring of the facility and significant sanctions should be in place to cause the facility to make changes and improve its compliance.

A companion recommendation to an enforcement standard may also serve to mitigate the risks due to a lack of provided I/T services to LEP and NES patients. The creation of a system similar to Australia's Translating and Interpreting Service (TIS National) can be initiated and designed by the United States federal government that is available to users free of charge. The service can serve as a back-up, or secondary service, for states as well as federal facilities. The most common reasons for usage would be (1) if a hospital fails to provide an interpreter for a patient or (2) if a hospital attempts to book an interpreter, but there are no interpreters available for a patient's preferred language.

The I/T system provided by the federal government should issue education and advertisements for the new service both nationwide and in communities with high populations of NES and LEP patients, as well as require that it be explained thoroughly in insurance and health care plans documentation. Initially, these would be public advertisements in the form of commercials, billboards, magazines, and flyers, and eventually, this system would become a selling point for insurance plans and health care providers. Healthcare providers should detail their processes for NES and LEP patients in their facilities as another reason one should choose their services. Posters in healthcare facilities would also remind NES and LEP patients of their rights to access free language

accommodation services during the times when they will likely need to utilize them. Healthcare institutions should always provide licensed interpreters, especially for languages that are deemed commonly spoken in the community by census data. However, if an interpreter is unavailable for the patient's preferred language, especially one that may be less commonly spoken in that area, then the institution should rely on the federal service.

Ad Hoc and Other Unlicensed Interpreters

The use of ad hoc interpreters, such as family members and friends, as opposed to licensed interpreters, is a major cause of danger for NES and LEP patients. In Chapter Two, the stories of two such patients—Ramirez and Tran—give insight into the problem. Ramirez, a Spanish-speaking man, suffered grave harm after his physician misunderstood the meaning of the word “intoxicado.” The physician assumed that the word meant “intoxicated” rather than “suffering from food poisoning”—the message that Ramirez’s Cuban family was trying to impart. Due to the mistake, the physician failed to assess the patient for any condition other than a drug overdose, and Ramirez, who had a brain hemorrhage, was left untreated and suffered from quadriplegia.

Tran, a nine-year-old Vietnamese girl, was also negatively affected by her physician’s reliance on an ad hoc interpreter. Tran’s parents primarily spoke Vietnamese, and the physician relied on Tran and her sixteen-year-old brother to provide written discharge instructions to Tran in English, which her parents were unable to read. When Tran suffered from a reaction to the prescribed drug Reglan, her parents did not know of the urgency of bringing her back to the emergency room, and she died. Tran’s case sheds light on two issues: (1) healthcare institutions’ use of ad hoc interpreters instead of

providing and using certified interpreters, and (2) the hospital's reckless reliance on children younger than eighteen as ad hoc interpreters.

To decrease healthcare providers' reliance on ad hoc and other unlicensed interpreters, three changes must be made. All states must pass laws that require all healthcare institutions to provide licensed interpreters. As Showstack noted in connection with Kansas' policies on interpreting and translating, "Kansas doesn't mandate that hospitals and clinics provide certified interpreters" ("WSU Professor Champions Legislation Ensuring Kansas Hospitals Have Qualified Interpreters"). In the comparisons in Chapter Three, Georgia also fails to mandate hospitals and clinics to provide certified interpreters, and that is the case in many other states.

Furthermore, each state must establish an order of priority in the event that a certified interpreter is unavailable yet required for patient and health care provider communication. As New South Wales's policy directive states, non-licensed interpreters should be utilized only when necessary and when that is needed in the following priority order: (1) interpreters for languages in which it is not possible to attain accreditation; (2) doctors, nurses, and other healthcare workers; and (3) a relative or friend of the patient who is at least eighteen years of age. As shown in NSW's order of interpreter preferences, family and friends should serve as a last resort when interpretation is needed, and children are never to be employed in that role.

Finally, to prevent the use of ad hoc interpreters in healthcare settings, the government should incentivize bilingual speakers to study interpreting and translating in the medical environment and ultimately gain accreditation. In Australia, the federal government offers material incentives to federal employees thanks to the Linguistic

Availability Performance Allowance (LAPA). LAPA is useful as it encourages more employees to acquire foreign language proficiency. The United States does not currently link a pay increase to bilingualism or language proficiency; however, the U.S. federal government could provide material incentives to accredited, bilingual workers in federally funded hospitals, or state governments to state-funded hospitals. Furthermore, hospital administrations of private hospitals could offer material incentives to bilingual healthcare professionals, executive and office staff, and volunteers. If healthcare workers are bilingual, the reliance on ad hoc interpreters diminishes, and patient safety increases.

Lack of Time

As Rocio Rivadeneyra's "Patient Centeredness in Medical Encounters Requiring an Interpreter," study from Chapter Two suggests, NES and LEP patients exhibit significantly fewer verbal cues—ways in which patients express their symptoms, feelings, and concerns—than English-speaking patients. The amount of verbal cues is positively correlated with the amount of direct communication time between physician and patient. English-speaking patients have more time to interact with physicians and therefore exhibit more verbal cues. However, NES and LEP patients have less time to interact with the physician and exhibit fewer verbal cues in that time. A way in which healthcare providers can mitigate this barrier is by making a conscious effort and planning to dedicate more time with NES and LEP patients. According to Rivadeneyra's study, English-speaking patients used roughly three times more verbal cues than Spanish-speaking patients. Therefore, physicians should seek to spend significantly more time with NES and LEP patients than English-speaking patients.

Healthcare institutions should implement continuing education programs for healthcare workers to ensure that providers are aware of the disparity in interaction time among NES/LEP patients and English-speaking patients. This education will allow all providers to become aware of the importance of spending more time with NES and LEP patients, as these patients use more time during physician-patient interactions due to the inclusion of the third member of the interaction, the interpreter. Interpretation takes time and leaves less time for the provider to carry out a complete physical and verbal assessment of the patient, his/her condition, and medical history.

A longer-term solution that may mitigate the lack of time issue is the implementation of language translation apps in healthcare settings. Language translation apps are able to facilitate two-way communication between the provider and patient, and therefore reduce the large amount of time used by the inclusion of an interpreter. As studies in New South Wales have indicated, current apps are unsuitable for use in healthcare settings. The United States, like New South Wales, should refrain from using apps in healthcare settings now, but should promote the study and development of apps more suitable for use in healthcare settings that are found by researchers and patients to be both valuable and easy to implement. Suitable applications will be those that enable everyday, two-way, clinical conversations, perhaps those that convey care needs and the need for pain management, and not those designed for comprehensive assessments, procedural consent, diagnoses, and the development of treatment plans. If researchers create a suitable language technology for a translation app, the need for a third-party interpreter (either in the room or online) may be reduced, and the time of direct communication between the physician and patient will increase, mitigating the lack of

time issue for NES and LEP patients receiving health care. These technological advancements may move toward the goal of allowing physicians to have sufficient time to conduct a physical assessment of the patient with the help of patient feedback and allowing patients to better communicate their needs and understand the scope and provisions of their medical conditions or diagnoses.

Lack of Resources

The lack of resources available for NES and LEP patients seeking health care is a major problem in the United States. As discussed in Chapter Two, L. Louise Ivanov and K. Buck' study, "Health Care Utilization Patterns of Russian-Speaking Immigrant Women Across Age Groups," showed that Russian immigrant women (1) did not understand the importance of preventive medicine, (2) did not understand the referral system, (3) viewed the cost of co-payments and medications as a major barrier of access to health care, and (4) did not like the physicians' reliance on technology to assess their healthcare conditions. These four findings suggest that there is a clear need for more helpful, language-and-culture-specific resources that will increase a patient's ability to understand and successfully interact with the healthcare practices and functions in the United States.

To mitigate the lack of resources issue, states and local communities must devise ways—possibly through the state or county health departments—in which they can provide NES and LEP documents in their primary language explaining different aspects of health care: how to book a doctor's appointment, how the referral system works, the importance of preventive medicine, how to fill a prescription, how to obtain health insurance, and other importance aspects. Furthermore, states must mandate through

written law that healthcare institutions provide NES and LEP patients with information about procedures, surgeries, and medical technologies. These documents would be useful and valuable for all patients, especially for underserved populations regardless of English proficiency level. While these resources would benefit the U.S. population as a whole, the translation of and education about these resources would just be enhanced in the populations with limited English proficiency.

As demonstrated in Chapter Three, many states currently lack laws that accommodate patients in the aforementioned ways. In Georgia, pregnant women and patients seeking mental health services are the only two patient populations who have the right to receive resources in their primary languages. The representation of only these two groups highlights the vast amount of health care that is not covered under Georgia law. Therefore, states must pass more laws which mandate that institutions and organizations provide resources to patients across all areas of health care.

Discharge instructions that are administered in a linguistically appropriate manner is another resource necessary for NES and LEP patients. Discharge instructions should be (1) provided in the preferred language of the patient (2) simple and straightforward, and (3) discussed with the patient and family in a language that is understandable by them and enables them to ask questions. As presented in Tran's case, the lack of understandable discharge instructions may lead to fatality. All states must devise laws that mandate hospitals and other healthcare institutions to provide patients with discharge instructions that meet these three conditions.

The mitigation of language and cultural barriers that NES and LEP patients face while receiving health care and the improvement of the overall patient experience for

these patients requires that the United States must focus on solving the following four problems: (1) lack of enforcement of I/T standards and laws, (2) the use of ad hoc and other unlicensed interpreters, (3) lack of time in physician-patient interactions, and (4) lack of resources available for NES and LEP patients. Patient case studies, such as those of Ramirez, Tran, and the Spanish-speaking boy in the Kansas hospital, and additional research findings in which language and cultural barriers have been shown to pose negative effects on medical outcomes of NES and LEP patients (Ivanov and Buck and Rivadeneyra for example) show how crucial it is that the various levels of government in the United States take steps to overcome language and cultural barrier challenges.

The federal and state governments must increase the enforcement of existing standards and laws by sanctioning hospitals that fail to provide linguistically and culturally appropriate services to patients. Lawmakers, especially those at the state level, must devise more laws in which more areas of health care are represented and have the right to receive language assistance. The federal and state governments and organizations—and local governments and organizations—must also find ways to create and administer more linguistically and culturally specific resources to undeserved and LEP populations regarding U.S. healthcare operations. These resources would help patients develop a greater understanding of how the U.S. healthcare system works and would ultimately allow them to receive higher quality health care. Finally, healthcare providers should participate in continuing education programs in which they learn the significant risks associated with the use of unlicensed interpreters. Furthermore, physicians should be educated on the necessity of increasing interaction time with NES and LEP patients and how these patients would benefit from this extra time.

Improving the healthcare experiences and outcomes of non-English-speaking and limited-English-proficiency patients is a necessary part of the improvements that must be made in United States health care overall. Helping NES and LEP patients is essential because it leads to improvements in health care for underserved populations, as these groups often overlap. The United States demographics become more diverse each year, and providing better health care for underserved populations is a step in the direction of providing equitable health care for all people. The United States healthcare system is complex and can be challenging to understand even for those with high English language proficiency. Accordingly, there must be improvements in the ways that federal, state, and local governments and organizations help NES and LEP patients access health care and insurance. Furthermore, more research should be done on what makes for the best health care for NES, LEP, and culturally diverse populations, so that all people receive high-quality health care, a basic human right.

APPENDICES

APPENDIX A

National Standards for CLAS in Health and Health Care:
A Blueprint for Advancing and Sustaining CLAS Policy and Practice

Appendix D: Crosswalk – National CLAS Standards 2000 and 2012

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

National CLAS Standards: 2000		National CLAS Standards: 2012	
		<i>The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:</i>	
Theme 1: Culturally Competent Care		Principal 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.	1.	Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
		Theme 1: Governance, Leadership, and Workforce	
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.	2.	Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
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.	3.	Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4.		4.	Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

National Standards for CLAS in Health and Health Care:
A Blueprint for Advancing and Sustaining CLAS Policy and Practice

National CLAS Standards: 2000		National CLAS Standards: 2012	
Theme 2: Language Access Services		Theme 2: Communication and Language Assistance	
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.	5.	Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
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.	6.	Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
6.	Health care organizations must ensure 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).	7.	Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
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.	8.	Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
Theme 3: Organizational Supports		Theme 3: Engagement, Continuous Improvement, and Accountability	
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.	9.	Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.

**National Standards for CLAS in Health and Health Care:
A Blueprint for Advancing and Sustaining CLAS Policy and Practice**

National CLAS Standards: 2000		National CLAS Standards: 2012	
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.	10.	Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
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.	11.	Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
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.	12.	Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
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.	13.	Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
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.	14.	Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

**National Standards for CLAS in Health and Health Care:
*A Blueprint for Advancing and Sustaining CLAS Policy and Practice***

National CLAS Standards: 2000		National CLAS Standards: 2012	
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.	15.	Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

APPENDIX B

National Standards for CLAS in Health and Health Care:
A Blueprint for Advancing and Sustaining CLAS Policy and Practice

Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime.

Elements of culture include, but are not limited to, the following:

- o Age
- o Cognitive ability or limitations
- o Country of origin
- o Degree of acculturation
- o Educational level attained
- o Environment and surroundings
- o Family and household composition
- o Gender identity
- o Generation
- o Health practices, including use of traditional healer techniques such as Reiki and acupuncture.
- o Linguistic characteristics, including language(s) spoken, written, or signed; dialects or regional variants; literacy levels; and other related communication needs.
- o Military affiliation

National Standards for CLAS in Health and Health Care:
A Blueprint for Advancing and Sustaining CLAS Policy and Practice

- o Occupational groups
- o Perceptions of family and community
- o Perceptions of health and well-being and related practices
- o Perceptions/beliefs regarding diet and nutrition
- o Physical ability or limitations
- o Political beliefs
- o Racial and ethnic groups – including but not limited to – those defined by the U.S. Census Bureau.
- o Religious and spiritual characteristics, including beliefs, practices, and support systems related to how an individual finds and defines meaning in his/her life.
- o Residence (i.e., urban, rural, or suburban)
- o Sex
- o Sexual orientation
- o Socioeconomic status

APPENDIX C

National Standards for CLAS in Health and Health Care:
A Blueprint for Advancing and Sustaining CLAS Policy and Practice

Theme	Standards
Principal Standard	<ul style="list-style-type: none">o Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Theme 1: Governance, Leadership, and Workforce	<ul style="list-style-type: none">o Advance and sustain governance and leadership that promotes CLAS and health equityo Recruit, promote, and support a diverse governance, leadership, and workforceo Educate and train governance, leadership, and workforce in CLAS
Theme 2: Communication and Language Assistance	<ul style="list-style-type: none">o Offer communication and language assistanceo Inform individuals of the availability of language assistanceo Ensure the competence of individuals providing language assistanceo Provide easy-to-understand materials and signage
Theme 3: Engagement, Continuous Improvement, and Accountability	<ul style="list-style-type: none">o Infuse CLAS throughout the organization's planning and operationso Conduct organizational assessmentso Collect and maintain demographic datao Conduct assessments of community health assets and needso Partner with the communityo Create conflict and grievance resolution processeso Communicate the organization's progress regarding CLAS

APPENDIX D

*Crosswalk: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
to the Communication Climate Assessment Toolkit*

National CLAS Standard Principal Standard	Relevant C-CAT measurement domains
<p>1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.</p>	<p>All C-CAT domains: Leadership Support, Data Collection, Community Engagement, Workforce Development, Individual Engagement, Cross-Cultural Communication, Language Services, Health Literacy, Performance Evaluations</p>

National CLAS Standard Governance, Leadership, and Workforce	Relevant C-CAT measurement domain(s)	C-CAT item(s) that measure concept
<p>2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.</p>	<p>Leadership Support</p>	<p>Patient: Does the [hospital/clinic/practice] communicate well with patients? <u>Staff:</u> [Have] senior leaders taken steps to promote a more patient-centered environment? <u>Staff:</u> [Have] senior leaders made effective communication with diverse populations a priority? <u>Policy:</u> Do [hospital/clinic/practice] policies make effective communication a high priority? <u>Policy:</u> Do [hospital/clinic/practice] leaders receive regular reports on how well the organization meets its goals for communicating with patients?</p>

Crosswalk: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
 to the Communication Climate Assessment Toolkit

National CLAS Standard Governance, Leadership, and Workforce	Relevant C-CAT measurement domain(s)	C-CAT item(s) that measure concept
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	Leadership Support, Workforce Development	<p><u>Patient:</u> Do [hospital/clinic/practice] staff come from your community?</p> <p><u>Staff:</u> [Have] senior leaders worked to recruit employees that reflect the patient community?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] set goals for recruiting staff from the patient community?</p>
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	Leadership Support, Workforce Development	<p><u>Patient:</u> Did doctors at the [hospital/clinic/practice] try to understand your culture?</p> <p><u>Staff:</u> Have you ever received specific and adequate training on interacting with patients from diverse cultural and spiritual backgrounds?</p> <p><u>Staff:</u> Have you ever received specific and adequate training on how to ask patients about their health care values and beliefs?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] effectively train employees to serve patients who speak little or no English?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] effectively train employees to serve patients from diverse cultural and ethnic groups?</p>

Crosswalk: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
to the Communication Climate Assessment Toolkit

National CLAS Standard Communication and Language Access	Relevant C-CAT measurement domain(s)	C-CAT item(s) that measure concept
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	Language Services	<p>Patient: Does this [hospital/dinic/practice] charge patients for using interpreters?</p> <p>Staff: Were patients charged for using interpreters?</p> <p>Policy: Does the [hospital/clinic/practice] post signs informing patients that free language interpretation is available?</p>
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	Language Services	<p>Patient: Has someone from the [hospital/clinic/practice] asked if you need an interpreter?</p> <p>Staff: [Were] patients who needed an interpreter offered one?</p> <p>Policy: Is it [hospital/clinic/practice] policy to have staff ask patients if they need an interpreter?</p> <p>Policy: Does the [hospital/clinic/practice] post signs information patients that free language interpretation is available?</p>
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	Workforce Development, Language Services	<p>Patient: Did the [hospital/clinic/practice]'s interpreters understand everything you said?</p> <p>Patient: Who usually interprets for you at the [hospital/clinic/practice]?</p> <p>Staff: Overall, how would you rate the [hospital/clinic/practice]'s interpretation services? Staff: [Do you agree that a] patient's family member or friend can usually interpret as effectively as a trained medical interpreter?</p> <p>Policy: Are employees who wish to communicate with patients in a language other than English trained and tested?</p> <p>Policy: Does the [hospital/clinic/practice] track how often interpretation is done by untrained interpreters (e.g., staff members or patients' family or friends)?</p>

Crosswalk: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
 to the Communication Climate Assessment Toolkit

National CLAS Standard Communication and Language Access	Relevant C-CAT measurement domain(s)	C-CAT item(s) that measure concept
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	Health Literacy, Language Services, Individual Engagement	<p><u>Patient:</u> Were educational materials easy to understand?</p> <p><u>Patient:</u> Were forms written in your language?</p> <p><u>Staff:</u> Overall, how would you rate the cultural appropriateness of the [hospital/clinic/practice]'s education materials?</p> <p><u>Staff:</u> Overall, how would you rate the understandability of the [hospital/clinic/practice]'s patient education materials?</p> <p><u>Staff:</u> Overall, how would you rate the availability of translated documents and forms at the [hospital/clinic/practice]?</p> <p><u>Staff:</u> Overall, how would you rate the signs and maps at the [hospital/clinic/practice]?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] have copies of important documents in languages other than English?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] assess whether patients can understand <i>signs and maps</i>?</p>

Crosswalk: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
 to the Communication Climate Assessment Toolkit

National CLAS Standard Engagement, Continuous Improvement, and Accountability	Relevant C-CAT measurement domain(s)	C-CAT item(s) that measure concept
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	Leadership Commitment, Workforce Development	<p>Policy: Does the [hospital/clinic/practice] perform a learning needs assessment on each patient which considers the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, or barriers to communication?</p> <p>Policy: Does the [hospital/clinic/practice] evaluate how well it meets written goals for effective communication?</p>
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	Performance Evaluation, Leadership Commitment	<p>Staff: [Have your] direct supervisors used [your] feedback to improve communication within the [hospital/clinic/practice]?</p> <p>Policy: Does the [hospital/clinic/practice]'s performance evaluation system allow managers to assess how well individual staff members communicate with patients?</p> <p>Policy: Does the [hospital/clinic/practice]'s assess whether patients can understand important documents, educational materials, and surveys?</p> <p>Policy: Do [hospital/clinic/practice] leaders receive regular reports on how well the organization meets its goals for communicating with patients?</p>

Crosswalk: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
to the Communication Climate Assessment Toolkit

National CLAS Standard Engagement, Continuous Improvement, and Accountability	Relevant C-CAT measurement domain(s)	C-CAT item(s) that measure concept
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	Data Collection	<p><u>Patient:</u> Did a [hospital/clinic/practice] staff member ask your race and ethnicity?</p> <p><u>Patient:</u> Has someone from the [hospital/clinic/practice] asked you what language you speak?</p> <p><u>Staff:</u> How often did relevant [hospital/clinic/practice] staff collect race and ethnicity information from patients?</p> <p><u>Staff:</u> How often did relevant [hospital/clinic/practice] staff ask patients what language they prefer using, when patients registered or scheduled appointments?</p> <p><u>Policy:</u> Is it [hospital/clinic/practice] policy to ask patients their race and ethnicity?</p> <p><u>Policy:</u> Is it [hospital/clinic/practice] policy to document a patient's race and ethnicity?</p> <p><u>Policy:</u> Is it [hospital/clinic/practice] policy to have staff ask patients their preferred language?</p> <p><u>Policy:</u> Is it [hospital/clinic/practice] policy to document a patient's preferred language?</p>
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	Community Engagement, Performance Evaluation	<p><u>Policy:</u> Does the [hospital/clinic/practice] work with local community and advocacy groups to collect information about new and emerging populations?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] track the literacy and education levels of its community?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] track the languages spoken by its patient community?</p>

Crosswalk: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
to the Communication Climate Assessment Toolkit

National CLAS Standard Engagement, Continuous Improvement, and Accountability	Relevant C-CAT measurement domain(s)	C-CAT item(s) that measure concept
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	Community Engagement, Cross-Cultural Communication	<p><u>Policy:</u> Does the [hospital/clinic/practice] have a <i>written plan</i> for developing relationships with the patient communities it serves?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] have an individual or committee charged with outreach and maintaining ties to community partners?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] work with community partners to promote health literacy? <u>Policy:</u> Does the [hospital/clinic/practice] involve community representatives in its planning processes?</p>
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	Cross-Cultural Communication	<p><u>Patient:</u> When leaving the [hospital/clinic/practice], did you know whom to call if you wanted to complain?</p> <p><u>Staff:</u> [Have your] direct supervisors intervened if staff were not respectful toward patients?</p> <p><u>Policy:</u> Does the [hospital/clinic/practice] have a point-of-contact (person or office) for community members to provide complaints and feedback? <u>Policy:</u> Does the [hospital/clinic/practice] track communication-related complaints?</p>
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	Community Engagement, Performance Evaluation	<p><u>Policy:</u> Does the [hospital/clinic/practice] inform staff about resources for patients that are available in the community?</p>

APPENIDX E

California's Provisions on Training:

Cal. Code Regs. tit. 9, § 3200.100

Cal. Code Regs. tit. 9, § 3841(a)(4), (b)(B)

Cal. Code Regs. tit. 9, § 3842(a)(3) (4)

Cal. Code Regs. tit. 10, § 2538.3

Cal. Code Regs. tit. 10, §§ 6660(b) (8), (12), 6860(b) (8), (12)

Cal. Code Regs. tit. 10, § 6706(b) (8), (12)

Cal. Code Regs. tit. 10, § 6806(a) (8), (12)

Cal. Code Regs. tit. 22, § 51098.5

Cal. Code Regs. tit. 28,^[1]_{SEP}§ 1300.67.04

Cal. Health & Safety Code § 152(a)(6)

Cal. Health & Safety Code § 127929

Cal. Health & Safety Code § 128553(C)(1)

Cal. Welf. & Inst. Code § 4622(g)(1)

Cal. Welf. & Inst. Code^[1]_{SEP}§ 14146(a)

BIBLIOGRAPHY

§ 2590.715-2719(e).

42 U.S.C. §2000d.

Australian Commission on Safety and Quality in Health Care. *National Safety and Quality Health Service Standards*. Australian Commission on Safety and Quality in Health Care, 2017.

CCHI Candidate's Examination Handbook.

https://cchicertification.org/uploads/CCHI_Candidate_Examination_Handbook.pdf. Accessed 21 Dec. 2021.

Department of Home Affairs-Translating and Interpreting Services. *History of TIS National | Translating and Interpreting Service (TIS National)*. Department of Home Affairs – Translating and Interpreting Services Online, <https://www.tisnational.gov.au/en/About-TIS-National/History-of-TIS-National>. Accessed 22 Nov. 2021.

Georgetown University. *NCCC | About*. <https://nccc.georgetown.edu/about/>. Accessed 30 Dec. 2021.

Georgia Department of Public Health. *Abortion: A Woman's Right to Know*. 2016.

Ivanov, L. Louise, and K. Buck. “Tra.” *Journal of Immigrant Health*, vol. 4, no. 1, 2001, p. 11.

LaVeist, Thomas A., et al. “Estimating the Economic Burden of Racial Health Inequalities in the United States.” *International Journal of Health Services: Planning, Administration, Evaluation*, vol. 41, no. 2, 2011, pp. 231–38. PubMed, <https://doi.org/10.2190/HS.41.2.c>.

National Academies of Sciences, Engineering, et al. “Native American Health: Historical and Legal Context.” *Communities in Action: Pathways to Health Equity*, National Academies Press (US), 2017. www.ncbi.nlm.nih.gov, <https://www.ncbi.nlm.nih.gov/books/NBK425854/>.

NBCMI Candidate Handbook.

https://www.certifiedmedicalinterpreters.org/assets/docs/NBCMI_Handbook.pdf?v=2020. Accessed 21 Dec. 2021.

NSW Health. *Interpreters – Standard Procedures for Working with Health Care Interpreters*. 19 Dec. 2017. Zotero, PD2017_044.

Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. U.S. Department of Health and Human Services, Apr. 2013.

Ozolins, Uldis, et al. *Interpreting and Translating in Australia Current Issues and International Comparisons*. Distributed by ERIC Clearinghouse, 1998.

Panayiotou, Anita, et al. “Language Translation Apps in Health Care Settings: Expert Opinion.” *JMIR MHealth and UHealth*, vol. 7, no. 4, Apr. 2019. *PubMed Central*, <https://doi.org/10.2196/11316>.

Passel, J. S., and D. Cohn. *U.S. Population Projections: 2005-2050*. 2008.

Pay Boost for Federal Employees with Bilingual Skills Is Goal of “One America, Many Voices” Bill | Congressman Gregorio Kilili Camacho Sablan.
<https://sablan.house.gov/press-release/pay-boost-federal-employees-bilingual-skills-goal-%E2%80%9Cone-america-many-voices%E2%80%9D-bill>. Accessed 2 Jan. 2022.

Price-Wise, Gail. “Language, Culture, And Medical Tragedy: The Case Of Willie Ramirez.” *Health Affairs Blog*, Nov. 2008, p. 5.

Quan, Kelvin. *The High Cost of Language Barriers in Medical Malpractice*. University of California, Berkley: School of Public Health, 2010.

Rivadeneyra, Rocio, et al. *Patient Centeredness in Medical Encounters Requiring an Interpreter*. 2000, p. 5.

Sequist, Thomas D., et al. “Trends in Quality of Care and Barriers to Improvement in the Indian Health Service.” *Journal of General Internal Medicine*, vol. 26, no. 5, May 2011, pp. 480–86. *PubMed Central*, <https://doi.org/10.1007/s11606-010-1594-4>.

The University of Colorado Anschutz Medical Campus Center for Bioethics & Humanities. *A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Communication Climate Assessment Toolkit*. May 2013.

United Nations Human Rights: Office of the High Commissioner. *OHCHR | Universal Declaration of Human Rights at 70: 30 Articles on 30 Articles - Article 25*. <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=23970&LangID=E>. Accessed 2 Jan. 2022.

U.S. Department of Commerce. *Census Bureau*. 2010.

Wilson, Pete. *Newborn And Prenatal Genetic Screening Services*. 1998, p. 19.

“WSU Professor Champions Legislation Ensuring Kansas Hospitals Have Qualified Interpreters.” *KMUW*, 22 Feb. 2021, <https://www.kmuw.org/health/2021-02-22/wsu-professor-champions-legislation-ensuring-kansas-hospitals-have-qualified-interpreters>.

Youdelman, Mara K. *Summary of State Law Requirements Addressing Language Needs in Health Care*. 2019, p. 329.

Youdelman, Mara K.“The Medical Tongue: U.S. Laws And Policies On Language Access.” *Health Affairs*, vol. 27, no. 2, Mar. 2008, pp. 424–33. *DOI.org (Crossref)*, <https://doi.org/10.1377/hlthaff.27.2.424>.